NHS
North Lincolnshire
Clinical Commissioning Group

2016/17 ANNUAL REPORT & ACCOUNTS

AUDITED VERSION

Contents

1.0 PERFORMANCE REPORT

1.1 Overview

1.1.1. About this publication

CCGs must publish an annual report and financial accounts at the end of the financial year. The first section gives an overview of the CCG and tells the story of the previous 12 months between 1 April 2016 and 31 March 2017, including what we have achieved, the challenges we face and some of the risks that could affect how we progress towards achieving our objectives in the coming year. More detailed information about the CCG's performance, the way decisions are made and our structure and staffing is available in the body of the Annual Report and, as ever, the financial accounts for the year 2016-17 are presented at the end.

The Annual Report and Accounts can be downloaded from the CCG website. We do not routinely produce large printed documents but copies can be made available on request. This report can also be provided in other languages and formats, such as audio, large print or Braille For further information or to request a copy of the report in your preferred format, please contact:

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As a publicly accountable body, we are committed to being open and transparent with our staff, partners, patients and the wider community. The CCG holds six Governing Body meetings and an Annual General Meeting (AGM) each year, all of which may be attended by the public. For details of our meetings held in public, please visit our website www.northlincolnshireccg.nhs.uk.

We are always very keen to hear from people who use health or care services in North Lincolnshire as well as from their carers and families. Telling us about your experiences can help us to learn from the people best placed to inform us, you. Your voice can help shape future services and we would encourage you to attend one of the Health Matters events we hold throughout the year or contact us using the details above.

1.1.2. Welcome from the Chair and Chief Officer

The news has been full of the unprecedented difficulties the NHS has faced this winter. It is no different here in North Lincolnshire and local services are under tremendous strain too. Pressures in the system can come to a head even during a very mild winter, as seasonal illnesses such as flu or stomach bugs take their toll on people who are frail, elderly or living with long term health conditions. This leads already stretched hospital and GP services to become even busier.

More people than ever need health and care, and more treatments are available which are also getting more expensive to provide. Health funding is not keeping pace with this growing demand and the resources of the NHS need to be stretched further while still providing the safe, quality services that people deserve. It is important our health and care services can live within their means while protecting, prioritising and safeguarding those who have the most complex care needs in our local community.

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

However, achieving financial balance will require a fundamental and significant change to the way we deliver services. We have been setting good foundations for the future with the continued development of our Care Networks. Care Networks bring together the health, care and voluntary sectors to deliver genuinely joined-up health and care services in communities and reduce hospital admissions. Helping elderly or frail people avoid unnecessary hospital stays is a priority and we believe we understand what needs to be done to support older people to enjoy healthier lives (even if age or health conditions have made them frail) where they live, in their own familiar surroundings. Last year, we tested and implemented some improvements to the way we work in North Lincolnshire in an exercise known as Perfect Fortnight which you can read about in greater detail further on in this overview.

Our local hospital also continues to face significant quality issues, which were highlighted in the Trust's recent Care Quality Commission (CQC) report which saw a second inadequate rating for Scunthorpe Hospital and an overall inadequate rating for the Trust which has been placed in Special Measures to help them tackle these issues.

GPs from the CCG are playing an important role in improving quality and are working closely with their counterparts in the acute trust to ensure these areas of concern are tackled as a priority from a clinical perspective.

We are also working with different health, care and voluntary organisations from across a wider area than North 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)

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.

One important work stream within the STP is around Mental Health and is being led by Liane. For too long, people with enduring mental health difficulties have not enjoyed the same levels of health and wellbeing and have experienced poorer outcomes following illness than others in our local community. We have a lot to do to improve mental health services. More services need to be provided close to home rather than in hospital and children, young people and adults need better access to mental health support services.

Our STP aims to create a healthcare system for the future; one that supports everyone to manage their own care better, to reduce dependence on hospitals and to use our limited resources most effectively.

We have already talked about national pressures faced by the NHS but there have been some particular local pressures and challenges too. Last November saw our local acute hospital trust forced to temporarily shut down its computer systems following a malicious cyber-attack. This led to many surgical procedures and appointments being cancelled and put additional tremendous pressure onto a system that is already working extremely hard to overcome challenges around Referral to Treatment Times and A&E Waiting Times. Earlier in the year we asked the public to avoid hospital attendance unless absolutely necessary during the Junior Doctors Industrial Action and again they were requested to use alternatives to A&E.

Even outside of acute crisis situations, this is a conversation we need to continue to have with our local communities. We must support people to feel confident about looking after themselves and each other and we must make sure that the best service or support for them at that time is also the easiest one to find. There is a lot we can all do to support our NHS. This includes only using services such as A&E when we really need them, taking care of our health as best we can, and not wasting medicines or getting prescriptions for items such as paracetamol or ibuprofen that can bought very cheaply.

While this might all sound like doom and gloom, this year has not been without positive news. We spoke earlier about the importance of good Mental Health services, and the CCG was delighted to hear our Mental Health provider Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH) received an overall rating of 'good' as well as rating good in all five categories (which are safe, effective, responsive, caring and well-led) in its inspection by the Care Quality Commission (CQC). CQC inspected 18 of North Lincolnshire's 19 GP Practices, rating 18 of these as Good. There was also positive feedback from the Patient Survey. Engagement work began which will shape a new inpatient service for children and young people experiencing serious mental health difficulties

The CCG has continued to make progress against its operational plan with what we want to achieve in the next 12 months, described later in this Overview.

In terms of the performance and financial targets set out in our constitution, there have been a number of areas that have challenged us during the past 12 months, including referral-to-treatment times, achievement of the A&E four hour waiting time and our on-going financial challenges which remain a concern. You can read about this in more detail in our Performance Summary, but this includes, for example, 18 week referral-to-treatment (RTT) targets with Orthopaedics, Ophthalmology and General Surgery.

As a CCG, we continue to strive to place our patients, their carers and families at the heart of everything we do. During 2016-17 the CCG held another two well-attended Health Matters events, where almost 200 people came along to share their views on topics ranging from changes to non-emergency Patient Transport, to exciting new services being developed with our partners in acute, mental and social care.

Finally, thank you very much for your interest in our organisation and for taking the time to read this report.

Dr Margaret Sanderson
Clinical Chair

Liane Langdon
Chief Officer

1.1.3 Who We Are and What We Do

CCGs were formed in April 2013 and are made up of GPs, other people who work in health or care and members of the public who are not NHS employees. Together they decide what healthcare services should be available in their local area.

We are led by GPs who represent the 19 practices within North Lincolnshire, supported by a small team of non-clinical staff who carry out the day-to-day business of the CCG. We are accountable to our members, patients and the public, and are overseen by NHS England which is the executive public body of the Department of Health.

Our budget is based on a complex formula which looks at the overall health and wellbeing needs of people in our area. CCGs are told by the Government how much money they will have to spend on health services each year. They then have to decide how to share this money across the wide range of services that local people need. These are services like life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health conditions. Long term health conditions include dementia, heart and breathing problems, diabetes and their complications, which we see a lot of in this area. Like all other CCGs, we are not responsible for commissioning preventative, or some very specialist, health services.

The CCG was allocated **£224,413,000** by NHS England to commission patient services and to pay for Administrative expenses (commonly referred to as Running Costs). The Running Cost element was £3,767,000.

The CCG has a similar administrative boundary to the local authority, North Lincolnshire Council, covering an area of about 328 square miles (850 square kilometres). The large urban area of Scunthorpe and Bottesford is the main population area for employment and retail, and is home to just under half (48%) of our residents. The remaining 52% live in the six market towns of Barton, Brigg, Crowle, Epworth, Winterton and Kirton Lindsey and in 80 surrounding villages.

The most up to date population estimates suggest 168,760 people live in North Lincolnshire. This is 8% more than in 2003 and is an average annual growth of about 1,200 people a year. This means our population is growing faster than regional neighbours and the rest of the country (6.2% and 7.9% respectively). The local population is expected to grow by another 9.4% to reach 184,136 people between now and 2037.

Our population is also growing older with more than 32,000 of our residents aged 65 or older. Between 2003 and 2013, the number of residents aged 85 or older grew by more than 46%. It is good news people are experiencing longer lives but it is also one of our challenges because more people are now living with one or more long-term, and often complex, health conditions.

This puts extra demand on services and has affected waiting times and costs. Health funding is not keeping pace with this increased demand and resources need to be stretched further.

However, when organisations work collectively, this lets 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.

We are working closely with our neighbouring CCG in North East Lincolnshire, the local authority, and Northern Lincolnshire and Goole NHS Foundation Trust and our other care providers on the local delivery plan of the STP and this work is helping us to understand the funding gap and find affordable models of care which can be delivered long into the future. Complementing this has been the development of our Accountable Care Partnership (ACP) which will set out a new model of care, particularly for the frail and elderly in our communities, based around care networks.

Public engagement continues to play a key role in shaping and developing both the STP and ACP proposals so far, and this engagement will continue throughout 2017-18.

Following the publication of the Francis Inquiry report, which examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009, the CCG implemented a detailed plan to ensure that we continue to learn from the lessons of this report. This includes adjustments to ensure that the CCG continues to be assured on the quality of local service provision.

Who provides our services?

We commission hospital and community services from Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and hospital services from Hull and East Yorkshire Hospitals NHS Trust (HEYHT). Mental health services are provided by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH). Where appropriate, the CCG jointly commissions services with partners, such as NHS North East Lincolnshire CCG for health care, and local authority North Lincolnshire Council for social care services.

We jointly commission GP services with NHS England and decisions are made at a Joint Commissioning Committee that meets bi-monthly in public.

Governance

A number of other established committees, together with the appointment of key officers and feedback from external assurance, ensure that robust governance arrangements are in place to support delivery of our vision and commissioning plans. You can read more about these in the Annual Governance Statement in Section 2.1.3.

1.1.4 A brief look back at 2016-2017

Last year's Annual Report summarised the CCG's progress and performance against key local and national priorities in its third year of operation. The report also provided an insight into how we plan to continue commissioning high quality, safe and sustainable health and care services for the people of North Lincolnshire.

We are pleased to be able to update on the progress of some of the plans we described.

Starting Well/Growing well

Evaluation of children's community nursing model

The evaluation of the children's community nursing model is on-going. Initial scoping work has been completed and a work plan is expected to be in place by the end of March. The review and potential redesign will start in earnest from April. This is felt to be the most appropriate time to be able to access children, young people and their parents/carers as this is a period with plenty of school holidays. It is also not too far from the winter months to be able to provide valuable qualitative data on whether the model is ensuring key targets are achieved, such as reducing the numbers of children admitted into hospital and the facilitation of earlier discharges when the child is clinically ready to go home.

Working Well

Implementing the Diabetes Prevention Programme

The CCG joined forces with five other CCGs and three local authorities in Greater Lincolnshire to roll out the world's first nationwide Diabetes Prevention Programme which will support people identified by their GP or nurse as being at high risk of developing Type 2 diabetes to change their lifestyle and avoid the disease.

Once a patient has been referred to the programme, a health coach undertakes an initial one-to-one assessment to gain a good understanding of the person's health and wellbeing. A personalised action plan is agreed to support the patient to effectively prevent the onset of diabetes.

After completing the initial assessment, patients meet in groups with a trained health and wellbeing coach for 10 weeks, followed by four monthly group maintenance sessions. They also receive one-to-one progress review sessions at 3, 6 and 9 months with a coach.

There are currently three courses taking place in Scunthorpe with approximately 45 people taking part. Many others have been referred and are being assessed. Referrals have recently increased and it is expected other courses will begin soon.

Development and implementation of dual diagnosis pathway for people with mental health needs and substance misuse issues

The CCG is working with mental health provider RDASH around introducing a dual diagnosis champion to each team to act as a liaison point for service users with a dual diagnosis accessing that team for their primary need. An action group is being established to take this forward.

Improving access to mental health crisis beds

The CCG's aim continues to be reducing out of area placement and is shortly to carry out a survey with local GPs regarding their experience of access to mental health crisis services.

Ageing Well

Development of new models of care to support the frail and elderly

Sometimes a stay in hospital is needed. However, patients often have better outcomes with the right treatment provided where they live or if they are supported to recover at home as soon as possible after spending time on a ward. This is especially true for older or frail people. Spending long periods of time in bed can make it harder for patients to get back to their normal day to day life and the levels of activity and mobility they previously enjoyed.

Helping elderly or frail people avoid unnecessary hospital stays is a priority of the North Lincolnshire Care Networks. Care Networks are partnerships of health and social care professionals from a variety of local organisations. This includes GPs, hospital doctors, community nurses, social workers, mental health professionals, pharmacists, therapists, care home staff and people who provide support for carers.

During 2016/17, the Care Networks carried out the "Perfect Fortnight" where they tested and implemented some improvements to the way we work in North Lincolnshire. This included:

- Direct access for care homes to the rapid assessment community team
- Direct access for GPs to specialists in frail and elderly medicine
- Improvements to the way medicines are prescribed, administered and managed for people living in residential care
- Multi-Disciplinary Team meetings at a residential home involving the resident and their carers led by their GP and supported by a senior nurse, social worker, carer support worker, mental health nurse, therapist and pharmacist
- Improving access to Wellbeing checks for very elderly people
- Proactive dementia screening with care home staff
- Improved support to people discharged from hospital who need additional support or their carer does

Care Home Action Team (CHAT)

A trial of Care Home Action Team (CHAT) was carried out with three care homes in the South Network between 31st Jan and 24th Feb (these were Balmoral House, Bridgewater Park and Sycamore Lodge).

Three multi-disciplinary teams (one per home) ran the routine care planning and assessments for 140 residents across the three homes in that period.

The teams were made up of:

- GP (Lead)
- Social Care
- District nursing
- Therapist
- Mental health nurse

The trial led to some very positive feedback from the staff involved, although there were some concerns about current capacity levels if this were to be rolled out across North Lincolnshire.

Data shows some cost savings as a result of medication reviews (for example, stopping inappropriate meds). The team is still looking at the impact on A&E attendance and that will be part of the final options appraisal which is expected to be signed by the ACP board in the next few weeks for sharing with the CCG by the end of April.

The expectation is long term, this should have positive impact on reducing A&E attendance and 999 calls (although for some people A&E or 999 will continue to be the appropriate course of action) as care homes will be better supported, care planning will be more pro-active and an integrated Single Point of Access will provide a more suitable community alternative.

Dying Well

Roll out of Gold Standard Framework across all practices

The GSF was introduced to practices last year at a Protected Time for Learning (PTL) event. The CCG is currently considering options as to how to assist GP practices to implement the training and manage the impact on capacity and other commitments.

All Life Stages

Development of Care Networks and the Accountable Care Partnership

This past year saw the further development and implementation of Care Networks which aim to deliver improved coordination and integration of care through new out of hospital models of care. These models are person-centred, needs-led, prevention-focused and delivered by integrated health, social care and third sector teams.

Health and social care providers in North Lincolnshire have been working together and have agreed to drive transformational change in community and related services in acute, primary, community and social care initially through the Healthy Lives, Healthy Futures (HLHF) programme, and now through the Sustainability and Transformation Plan (STP). This has been developed across a wider footprint including Humber Coast and Vale of York. This operating framework outlines how health and social care adult provision can respond to better meet the needs of the North Lincolnshire community.

We have developed three Care Networks – West, South and East. The care networks will work across perceived internal and external geographical boundaries, so an individual's primary registered GP site will be the network which provides their care. For example, if a GP practice is in the West Network and their patient lives in the South Network then a referral would be made and accepted into the West Network (as the primary GP site) but, where more practical, care may be delivered by the patient's local team.

An Accountable Care Partnership Approach

We believe that in order for North Lincolnshire to have high quality, integrated, sustainable health and care services, it is imperative to make the best use of all current available resource.

Local providers will work together more closely than ever before, bound by a **shared vision and a common set of objectives.** The ACP will be called North Lincs First.

The intention is to allow providers the freedom to develop the model of collaboration whilst ensuring that the required outcomes of integrated care are being achieved. By combining their expertise and resources, they will enable several key wider system benefits and allow us to improve the outcomes that the people of North Lincolnshire experience from their local health and care services.

Other highlights during 2016/17 which show the range of our activities

Launch of Life Central

The CCG and North Lincs Council worked with local children and young people to develop a web resource reflecting areas they told us concern them the most. This is a hub of information services for young people which will be updated regularly with topics and associated resources including information on emotional difficulties, eating well, sexual health, bullying and exam stress. There is also a related app for use on mobile devices. There are also dedicated sections for parents and carers and professionals who work with children and young people.

The website can be found at http://www.life-central.org/

Transforming Care Partnership

We are part of the **South Yorkshire** and **North Lincolnshire** Transforming Care **Partnership** (TCP) where we work in partnership with Rotherham, Doncaster and Sheffield Clinical Commissioning Groups (CCGs). The partnership will transform care for people with a learning disability and autism.

The TCP launched its plan last year which shows how we will lower the number of inpatient hospital beds available for people with learning disabilities.

In three years' time our TCP will have:

1. Lowered the number of inpatient hospital beds for people with learning disabilities and autism to between 10 to15 beds.

2. Put more money into community services like crisis teams.

3. Supported more people to get a personal health budget.

4. Have good plans for offender and forensic health.

We want to have the best services for people with learning disabilities and autism their family carers so that people live a good life and get the right support at the right time.

Download the TCP Delivery Plan Summary

Download a copy of the easy read that summary tells you about the TCP and the work we are planning to do.

Work to Support the A&E Department at Scunthorpe General Hospital

As we outlined in the introduction, winter can be a difficult time for the NHS. Pressures in the system can come to a head and create serious pressures, even when the weather is as mild as it was this past winter. Seasonal illnesses such as flu or stomach bugs still take their toll, especially on those people who are already frail, elderly or living with long term health conditions. This leads already stretched hospital and GP services to become even busier than usual.

The CCG carried out a pilot in December and January which saw us placing a GP in A&E to assist people with urgent but not emergency health needs. This was successful. The CCG also provided additional GPs in the Out of Hours service during significantly busy periods.

Both of these projects have informed further work on developing the Urgent Care Model for North Lincolnshire.

Supporting People in Care Homes to Live Well With Dementia

Research by Dementia UK suggests that at least two thirds of people living in care homes may have dementia. The current dementia diagnosis rate in North Lincolnshire is 60.1%, which is significantly lower than both the 'two-thirds' target by 2015 (66.7%) and the current national average of 67.5%.

Rates of diagnosis differ across care homes and this means that while many care home residents in North Lincolnshire will have had their dementia identified and are getting the right support, there will be many others whose care plan will not be meeting their individual needs because of their undiagnosed condition.

NHS North Lincolnshire CCG has developed a pilot project to target the Care Home population. This will identify residents most likely to have dementia and ensure their personal care plan continues to be appropriate for their needs in a care home setting and aligns to other support services for people living with dementia. It will also provide a 65+ cohort to improve the local diagnosis performance in the short term.

The pilot is being managed by Riverside Practice following consultation with the GP Federation in June this year.

It provides for a primary care nurse practitioner and health care assistant to undertake screening using the 6CIT tool and diagnosis using the DiADeM tool including any pre-requisite investigations.

The pilot supports the principles of the Care Home Action Team which is in the process of being developed to support delivery of primary care services in a Care Home setting.

The pilot started in December 2016 and is expected to conclude in July 2017 with a review taking place mid-term and at the end to identify the successful outcomes and learning opportunities.

1.1.5 How we are doing

The CCG's performance against the rights and pledges set out in the NHS Constitution is reported to our Governing Body through a set of defined key indicators and associated targets.

We are pleased to say we are meeting many of the targets. However, there remain some significant challenges which we have summarised below.

NHS Constitution Standards – Performance by Exception

Ambulance response times
The current provider is East Midlands Ambulance Service (EMAS) and, whilst local performance against the targets is reasonable, the CCG is judged on overall EMAS Trust performance, which continues to fail to meet the required target.

The CCG is currently part of a collaborative commissioning arrangement across all EMAS commissioners, with Hardwick CCG as the lead commissioner. The CCG continues to work with the collaborative and pursue recovery actions to secure continuing improvements in response times in North Lincolnshire.

A&E 4 hour wait
This target has been challenging during 2016-17, with a year-end position yet to be confirmed. However, it will not achieve the required 95% within 4 hours.

The trajectory submitted to NHS England as part of the planning submission sets a trajectory to achieve 95% across North and North East Lincolnshire by March 2018. However NL CCG performance is generally better than NEL CCG performance. In addition, the current support from ECIST in reviewing the system and making recommendations to the A/E delivery board should support earlier delivery of the target.

Recruitment remains a significant issue for the Trust, particularly in terms of medical staffing. The Trust is taking action to address this but with limited success.

The A&E Delivery Board will oversee the development and implementation of cross organisational actions to improve delivery of the emergency pathway standards. This will be further enhanced by the ECIST report (due mid-March 2017) which will make a number of system wide recommendations to support improvement in the A/E target. The A/E Delivery Board is chaired by Dr Peter Melton, Clinical CO for NEL CCG with representation from all partners including NL CCG Director of Commissioning.

The CCG has supported A/E delivery through the pilot of a GP within A/E taking patients streamed as suitable for primary care- options for the long term model are currently being developed. The Trust has established streaming, replacing triage, in line with best practice- there is scope to further enhance this to stream people back into community settings such as self-care and pharmacy.

Cancer Waiting Times
The CCG has experienced difficulties with some of the pathways at different times during 2016/2017 although, on the whole, delivery of cancer waits has been strong.

Some areas where performance was affected related to cross trust pathways, increases in clinical complexity and specific issues around the reliability of equipment and delays in diagnostics.

These areas continue to be reviewed by providers and commissioners, supported also at a network level.

Referral to Treatment Times
The local providers have failed to achieve the required levels of performance in this area throughout 2016/2017, with performance significantly below required levels in a number of specialties. In recent months the total waiting list size and proportion of long waiting patients has increased. There are multiple contributory factors to the decline in performance including shortfalls in capacity within the Trust, weaknesses in operational processes and systems which are giving rise to poor data quality.

The local Trust has reported that declining performance is due to reduced capacity and on-going bed pressures. Pressures with patient flow are largely due to delayed patient discharge, this is having a direct impact on the number of long waits and the overall delivery of 18 week referral to treatment performance. The Trust continues to work closely with NHS Improvement Intensive Support Team to develop a robust recovery plan. Commissioners monitor progress with this work as part of the monthly RTT single recovery meeting.

The Trust is in the process of establishing a Clinical Review Group, to be chaired by the Area Team Medical Director. The Group will review those patients that have waited the longest.

A data validation project was mobilised mid-February which has made good level of progress made to date and provides weekly updates to commissioners.

Diagnostic Waiting Times
The local Trust's approach to recovering the diagnostic 6 week wait position is linked to the Trust wide capacity and review plan, which is informed by the data quality validation process. The Trust is working with NHSI Intensive Support Team to agree a capacity review model; this will inform trajectories for delivery in 17/18.

Mixed Sex Accommodation
The local Trust has experienced breaches against this indicator over the winter period. The CCG has been in consultation with the Trust regarding the interface between the Critical Care guidance, High Observation Bed unit Policy and the MSA Policy. Assurances have been sought in relation to the accuracy of the MSA minimum dataset.

CCG Assurance Framework – Other Indicators

In addition to the NHS Constitution Indicators, the CCG position against the Assurance Framework has been strong. It has achieved required levels of performance in relation to Improving Access to Psychological Therapies (IAPT) and Mental Health Care Programme Approaches (CPA).

At the close of 2016/2017 there had been 1 case of MRSA for which thorough root-cause analysis was undertaken, and actions identified, to be taken forward by the Infection Control Group.

The number of *C Difficile* cases was managed within the tolerance level for 2016/2017.

A more detailed Performance Analysis is included in the Section 1.2.1 of this report.

1.1.6 What We Want To Achieve

Our vision is that North Lincolnshire is healthy place to live where everyone enjoys improved wellbeing and where inequalities are significantly reduced. People achieve the best health and well-being that is possible, delivered within the resources available. More care is delivered in or close to people's homes. People feel able to self-care and are supported to do so. Services are proactive in their approach to enable people to remain independent for as long as possible.

The NHS has been experiencing growing demand for services and public expectation over recent years, coupled with limited growth in funding and available workforce. The national Five Year Forward View (5YFV) set out a clear direction for the NHS, detailing the case for change, and what the future NHS health care system is expected to look like. The document sets out key principles for change relating to gaps in healthcare such as:

- The health and wellbeing gap
- The care and quality gap
- The funding and efficiency gap

In order to respond to these requirements, the NHS is undergoing fast-paced, transformational change which is resulting in new approaches to planning and ways of working.

North Lincolnshire CCG set out in its 2015/16 plan its vision for healthcare, which includes the 'shift to the left' reflecting the CCG's plan to empower and enable people to manage their own health, self-manage and seek early help, resulting in a reduction in the need for hospital based care, supported by an increase in innovative solutions to support people during illness within their own home or community.

This strategy led to the development of Integrated Locality Teams which have subsequently been further developed into three Care Networks; health and care teams, clustered around GP practices who work in a seamless and integrated way to meet the needs of the population as close to home as possible as described earlier in this report.

Our plans for 2017/18 and beyond will accelerate these developments to achieve sustainability of healthcare for our population. Our Operational plan for 2017/18 to 2018/19 will be published on our website in the near future.

1.1.7 The Risks That Could Affect Our Plans

Both the CCG and its main acute provider, Northern Lincolnshire and Goole NHS Foundation Trust are facing significant challenges in delivering sustainable services.

The area has seen a continued rise in non-elective activity despite implementation of a range of services to reduce demand. In addition, the case-mix of this demand is increasing. The Trust, despite experiencing relatively low increase in primary care demand has been unable to maintain its RTT position. The organisation has experienced prolonged difficulties in recruiting medical and nursing staff, and whilst the nurse staffing position is now somewhat improved, recruitment of medical staff remains a major issue for the health economy.

The health economy funding gap within North Lincolnshire is around £30m and the CCG has agreed in principle a contract with the Trust to maintain the viability of the Trust. However, this also includes a requirement to implement a challenging transformation plan which enables the Trust to take out costs in terms of staffing and infrastructure. This will be achieved through working in partnership; redesigning pathways and services, reducing avoidable demand and where required, re-providing within a different setting. The detail of these plans needs to be developed by the Trust and delivered in partnership with robust governance arrangements to ensure delivery. The Trust was recently placed into both **financial** and **quality** Special Measures as described earlier in this report. We continue to work with the Trust, supported by the regulators to agree plans.

We previously used a funnel diagram to describe our aim to shift activity to the left of the funnel, focussing on prevention and early help, with increased community based care, meaning that only those people who really need hospital facilities receive their care in a hospital setting. The CCG will utilise new models of care to facilitate this shift along with at scale commissioning of some services where this will offer opportunities to reduce hospital based activity through the use of other models of care.

It is recognised that the plans, in the current state of development, do not constitute sufficient change over the two year expected timescale of this plan to deliver the entirety of the transformational change required to 'right-size' and balance the health economy to a sustainable position going forward.

Our plans for 2017- 2019 reflect the journey we are on in the development of new models of care; North Lincolnshire has an agreed Accountable Care Partnership (ACP) model to integrate community provision through a partnership of providers. As described earlier, the ACP is in place informally with a draft memo of understanding and a shadow Executive board to support governance arrangements. The CCG is working closely with this partnership to realise planned benefits. 2017/18 will act as a preparatory year whilst the partnership establishes a shadow organisation with the aim of becoming an alliance by the end of March 2018. This development offers North Lincolnshire new opportunities and new challenges as the CCG and the ACP develop new ways of working and commissioning.

Additionally, delivery of the Humber Coast and Vale STP proposals is essential if the CCG and its partners are to secure high quality, safe and sustainable services for the population of North Lincolnshire over the next 10 years. The development and implementation of the local delivery plan over the next five years and beyond is one of the main priorities for the CCG. Key to the success of the programme will be ensuring that the public and affected health and care services staff understand the case for change and feel able to participate in the change process through engagement and consultation.

Our Approach

The CCG adopts an integrated approach to risk management which enables us to consider the potential impact of all types of risks on everything we do - all of our processes, activities, stakeholders and commissioned services.

The CCG Risk Management Framework aims to provide 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.

1.1.8 Going Concern Declaration

The 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:

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

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

1.2 Performance Analysis

1.2.1 Performance Measures

Summary Position as at 19th May 2017

Below is an updated summary position on an exception basis on the national performance indicators as set out in the NHS Outcomes Framework and Everyone Counts guidance and which form part of the CCG Assurance Framework.

In all cases of deviation from target an Exception Report is raised whereby the lead in this area must provide underlying cause information as well as recovery actions if applicable. These reports are available on the BIZ and in 2017/18 the key information will be more extensively incorporated within this report.

1. CCG Assurance

Are patient rights under the NHS Constitution being promoted?

Overall Constitution Indicator Performance

20	2	12

The following indicators all remain strong and are currently achieving the required level of performance or more:

- Diagnostic Waiting Times
- 12 Hour Trolley Waits
- 2 Week Cancer Referral to First Seen
- 2 Week Cancer Referral to First Seen – Breast Symptoms
- 31 Day Cancer Diagnosis to Treatment
- 31 Day Cancer Subsequent Treatment – Surgery
- 31 Day Cancer Subsequent Treatment – Radiotherapy
- 31 Day Cancer Subsequent Treatment - Drug Regimens
- 62 Day Cancer Referral to Treatment – Status Upgrade
- Cancelled Operations (2nd Cancellations)
- IAPT Entering Treatment
- IAPT Recovery Rates
- IAPT 6 Week Waits
- IAPT 18 Week Waits
- Early Intervention 2 Week Waiting Times
- Incidence of Healthcare Associated Infection – MRSA
- Incidence of Healthcare Associated Infection – C.difficile

Areas by Exception:

Area	RAG	⇩⇧ *From Previous Month*	Comments	Lead
18 Week Referral to Treatment Times: Admitted (Target 90%) Non-Admitted (Target 95%) Incomplete (Target 92%)	R		The local providers have failed to achieve the required levels of performance in this area throughout 2016/2017, with performance significantly below required levels in a number of specialties. In recent months the total waiting list size and proportion of long waiting patients has increased. There are multiple contributory factors to the decline in performance including shortfalls in capacity within the Trust, weaknesses in operational processes and systems which are giving rise to poor data quality. The local Trust has reported that declining performance is due to reduced capacity and on-going bed pressures. Pressures with patient flow are largely due to delayed patient discharge, this is having a direct impact on the number of long waits and the overall delivery of 18 week referral to treatment performance. The Trust continues to work closely with NHS Improvement Intensive Support Team to develop a robust recovery plan. Commissioners monitor progress with this work as part of the monthly RTT single recovery meeting. The Trust is in the process of establishing a Clinical Review Group, to be chaired by the Area Team Medical Director. The Group will review those patients that have waited the longest. A data validation project was mobilised mid-February which has made good level of progress made to date and provides weekly updates to commissioners.	RY
RTT >52 Week Waits in Incomplete Pathways	R		A number of RTT >52 Weeks Wait in Incomplete Pathways have been identified from November 2016 onwards. This has been due to the work on RTT data validation and is subject to the RTT action plan as described above.	RY
A&E 4 Hour Waiting Times (Target 95%)	R		This target has been challenging during 2016-17, with the year-end position not achieving the required 95% within 4 hours. The trajectory submitted to NHS England as part of the planning submission sets a trajectory to achieve 95% across North and North East Lincolnshire by March 2018. However NL CCG performance is generally better than NEL CCG performance. In addition, the current support from ECIST in reviewing the system and making recommendations to the A/E delivery board should support earlier delivery of the target. Recruitment remains a significant issue for the Trust, particularly in terms of medical staffing. The Trust is taking action to address this but with limited success. The A&E Delivery Board will oversee the development and implementation of cross organisational actions to	JE

			improve delivery of the emergency pathway standards. This will be further enhanced by the ECIST report (due mid-March 2017) which will make a number of system wide recommendations to support improvement in the A/E target. The A/E Delivery Board is chaired by Dr Peter Melton, Clinical CO for NEL CCG with representation from all partners including NL CCG Director of Commissioning. The CCG has supported A/E delivery through the pilot of a GP within A/E taking patients streamed as suitable for primary care- options for the long term model are currently being developed. The Trust has established streaming, replacing triage, in line with best practice- there is scope to further enhance this to stream people back into community settings such as self-care and pharmacy.	
62 Day Cancer Referral to Treatment – Total	R		The CCG has experienced difficulties with some of the pathways at different times during 2016/2017 although, on the whole, delivery of cancer waits has been strong. Some areas where performance was affected related to cross trust pathways, increases in clinical complexity and specific issues around the reliability of equipment and delays in diagnostics. These areas continue to be reviewed by providers and commissioners, supported also at a network level.	RY
Category A Ambulance Response Times 8 Minute RED 1 (Target 75%)	R		Performance at East Midlands Ambulance Trust (EMAS) against the Category A 8 minute indicator for RED1 calls did not reach the required level in 2016/17 despite a significant increase in March 2017 (73.4%) *The position for all ambulance Cat A response times are assessed at Trust level. The RED1 North Lincolnshire position also improved and ended the year at 74.7%* Lincolnshire Division's performance figures are significantly lower than they were this time last year; the Trust confirmed that this decline in performance is due to staff sickness and issues meeting staffing establishment targets.	RY
Category A Ambulance Response Times 8 Minute RED 2 (Target 75%)	R		EMAS overall performance remains below the required level throughout 2016/17. *North Lincolnshire performance was also below plan.* See detail provided in the Category A Ambulance Response Times section above.	RY
Category A Ambulance Response Times 19 Minute (Target 95%)	R		EMAS overall performance ended the year at 61.1%. *North Lincolnshire's performance was 84.32%.* See detail provided in the Category A Ambulance Response Times section above.	RY

Are health outcomes improving for local people (CCG Assurance Indicators Only)?

Areas of Exception:

Area	RAG	⇩⇧	Comments	Lead
Reducing potential years of life lost from causes considered amenable to healthcare (all ages) * Causes considered amenable to healthcare are those from which premature deaths should not occur in the presence of timely and effective health care. The Office for National Statistics (ONS) defines amenable mortality as follows: "A death is amenable if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare"	R		The indicator is calculated using the Office for National Statistics Mortality data and the mid-year population data as a directly standardised rate (DSR) per 100,000 registered patients. The target of 2083 has not been met as at September 2016 the rate has deteriorated to 2250.5 (DSR). Causes considered amenable to healthcare are those from which premature deaths should not occur in the presence of timely and effective health care. The Office for National Statistics (ONS) defines amenable mortality as follows: "A death is amenable if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare" The actions from the CCGs strategic plan and commissioning intentions will all contribute to the improvement in this indicator. Specifically as outlined in the Strategic Plan 2014/15 – 2018/19 the following 3 interventions are aligned to securing additional years of life: • Long Term Condition (LTC) Self Care • Whole System Approach to LTC Care • Early Cancer Diagnosis Public Health Intelligence has undertaken a piece of work to look at the recent dip in life expectancy in older ages.	LL
Treating and caring for people in a safe environment & protecting them from avoidable harm – MRSA			During 2016/2017 there was only 1 MRSA case reported. This was in February 2016 at Scunthorpe General Hospital. The patient was admitted to SGH with a 2 day history of being drowsy, listless and not wanting to eat or drink. Unable to hold head up and listing to one side when seen and admitted by GP Practice. Diagnosis on admission was unclear with possible diagnoses of Stroke, Infection, Sepsis, Chest or UTI & dehydration. Patient was commenced IV Tazobactam and Piperacillin for possible sepsis. Blood cultures were taken on admission that were found to be negative. Patient not improving with treatment and further blood cultures taken for which the results were positive for MRSA. Patient was not screened for MRSA on admission despite being admitted from a residential home. The lead nurse for infection control has provided the full details of the RCA (Route Cause Analysis) of this case which can be found in the exception report on the BIZ. No further breaches were reported.	

2. CCG Quality Premiums

2016/2017

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 the following 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 2016/17 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 in respect of 2016/17.

NHS England also reserves the right not to make any payment where there is a serious quality failure during 2016/2017.

For 2016/17 it is not expected that the CCG will receive any Quality Premium funding, regardless of actual performance on the relevant clinical targets, as a result of the CCG's forecast financial deficit.

However, for information - the table overleaf provides evidence of the CCG's current Year to Date (YTD) performance against the relevant clinical targets.

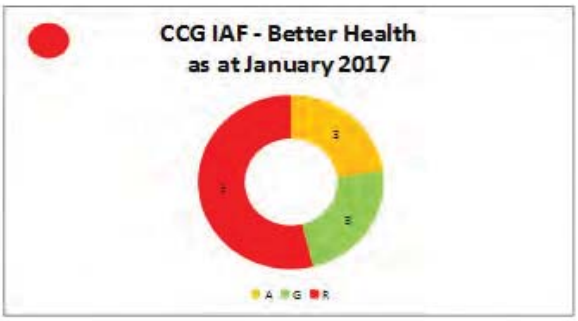
NHS North Lincolnshire 1617 Quality Premium Dashboard

	Indicator	Baseline (period)	Current Target	Current Performance (period)	RAG	Comments
16/17 National Measures	Cancer	2015	TBC once 2015 calendar year figure published	50.8% (2014)		Next update due June 2017
	GP Patient Survey	July 2016	73%	70% (Jul '16)		Next update due July 2017
	E-Referrals	March 2016	37.8% (Mar '16 = 17.8%)	14.3% (Feb '17)		Next update due June 2017
	Antibiotics Prescribed in Primary Care	2013/14	(a) <= 1.176 (b) <= 10%	(a) 1.177 (b) 9.6 (Mar '16 - Feb '17)	(a)  (b) 	Next update due June 2017
16/17 Local Measures	Reduction in Non-Elective COPD Admissions	2015	472	502 (Apr '16 - Mar '17)		Not achieved
	Reduction in Elective Gastroscopy	2015	2118	2329 (Apr '16 - Mar '17)		Not achieved
	Improve recorded prevalence of AF on GP registers against expected prevalence	2015	n = 3302 d = 4653 Ratio = 0.71 (71%)	n = 3069 d= 4653 Ratio = 0.66 (66%) (2015/16)		Next update due October 2017

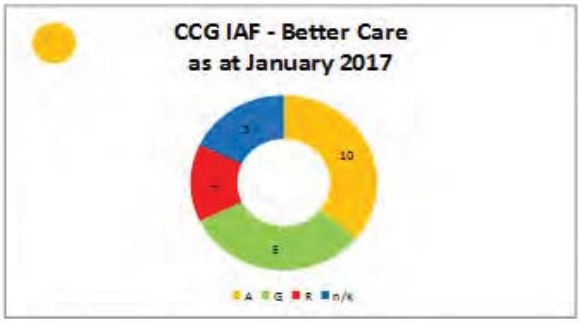
3. Improvement & Assessment Framework

The CCG Improvement and Assessment Framework was introduced in 2016/17 to replace both the existing CCG assurance framework and CCG performance dashboard. This new framework provides a greater focus on assisting improvement alongside the statutory assessment function. The framework draws together the NHS Constitution, performance and finance metrics and transformational challenges and will play an important part in the delivery of the Five Year Forward View.

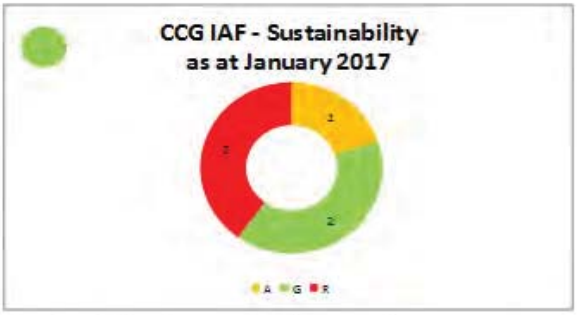
The dashboards below give a summary indication of the CCGs current achievements.



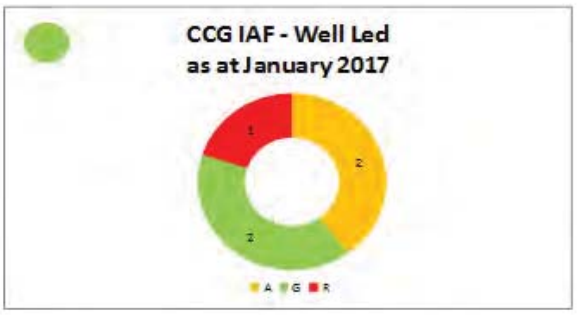
There is one indicator where current performance is unknown



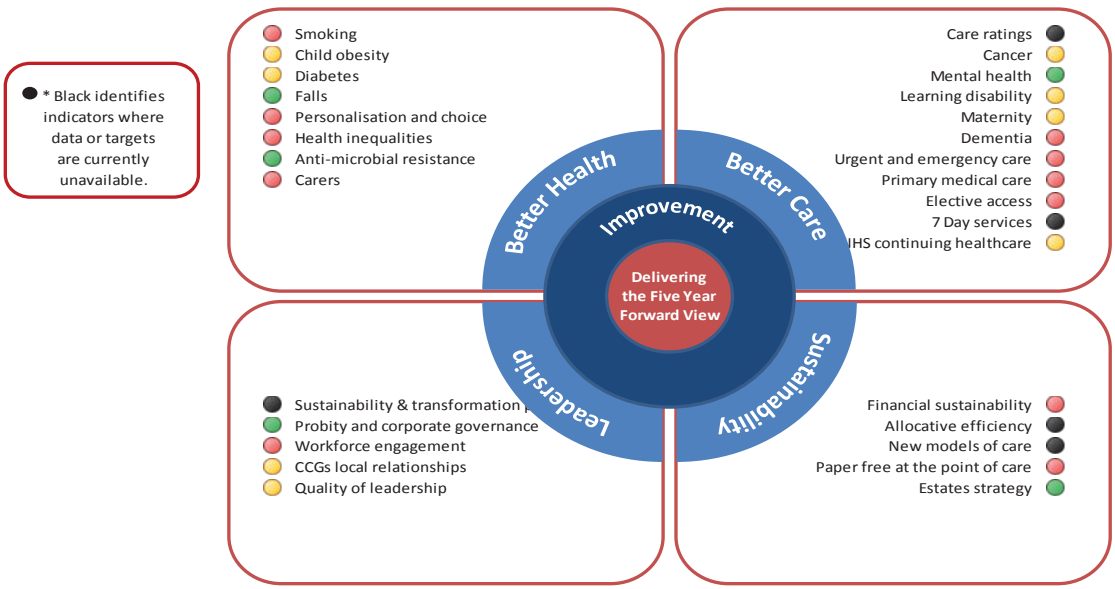
There are four indicators where current performance is unknown



There is one indicator where current performance is unknown



NHS North Lincolnshire CCG - MY NHS IAF Indicators



1.2.2. Financial Performance

The CCG has a number of statutory financial duties under the National Health Service Act 2012 (as amended), and Note 16 summarises the CCG's performance against these duties and directions.

- In 2016-17 financial year the CCG is reporting an in year deficit of £4.098m.
- The CCG has not met the statutory target that net revenue expenditure does not exceed the agreed allocation.
- The CCG has met the statutory target that net running costs do not exceed the agreed running costs allocation
- Ensured that both capital and revenue resource use on specified amounts did not exceed the amount specified in the directions

In addition to this, the CCG has two non-statutory financial duties.

- The CCG achieved paying 95% of its suppliers within 30 days
- The CCG achieved its year end cash target, of 1.25% of its March drawdown.

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

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS North Lincolnshire CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £2.171m. This additional surplus has been offset against other cost pressures from the current financial year.

Taking into account the Risk Reserve (as mentioned above) this resulted in North Lincolnshire CCG posting a final deficit of £4.098m rather than a surplus of £2.230m as planned at the start of the financial Year. This position resulted primarily from: a £2.992m partial settlement of a contract dispute with our main secondary care service provider, which was finally resolved in December 2016.

As a result of forecasting a Deficit early in 2016/17 the CCG were able to benefit from a capacity and capability review by PWC which assisted the CCG to minimise its deficit down to the reported value.

However, as a result of posting a Deficit in 2016/17 the CCG is now expected to cap its expenditure to its available revenue resources, through collaborative working with its main secondary care service provide, and may be placed under Directions from NHSE in order to access the appropriate support which is required to return the CCG to a position of recurrent financial balance.

1.2.3. Statutory duties

Our Annual Governance Statement sets out how we have delivered on the duties laid down in the National Health Service Act 2006 (as amended). Additional information regarding compliance around inequalities and public involvement is detailed below.

The Risk Register and Board Assurance Framework are the CCG's tools for managing risks to the organisation and our objectives. More detail on the Risk Register and Board Assurance Framework can also be found in the Annual Governance Statement.

Reducing Inequalities

Our strategic commissioning plans are underpinned by the Joint Strategic Needs Assessment (JSNA) which identifies local health need, gaps and inequalities. The CCG is part of the JSNA working group and we ensure commissioning priorities are informed by the latest updates from public health population profiles and the JSNA.

Through the process of co-design, the CCG actively seeks the views of service users, carers and partners to ensure health care services are shaped by what local people share with us.

Equality Impact Assessments (EIAs) are undertaken for all new commissioned services and as part of service reviews and re-design. They are also embedded as part of the policy development process to ensure no service is commissioned or policy implemented without full consideration of the impact it may have on equity of access and health inequalities.

In 2016 the CCG, working with public sector partners, developed the North Lincolnshire Equality Inclusion Forum to share best practice and develop effective engagement with protected characteristics groups locally to influence publicly-funded services.

The Forum has enabled the CCG and public sector partners a wider reach into diverse communities to inform and engage with a view to developing responsive services that meet diverse needs and reduce health inequalities.

The CCG is a member of the Health and Wellbeing Board which exists to improve health and wellbeing outcomes for local people and to reduce inequalities.

An Integrated Impact Assessment has been undertaken alongside the development of the Joint Health and Wellbeing Strategy suite of documents. Consideration has been given to a range of factors, including environmental, community safety, health, geographical, economic and social inclusion, diversity and human rights, statutory legal processes, risk, procurement and child poverty, all of which take account of the wider determinants of health and inequalities and deliver improved outcomes.

The CCG contributes to the delivery of the Strategy primarily through priority actions around the development of our population health management approach which enables us to invest our resources differentially according to need, initially allowing us to address the needs of those vulnerable members of our population who are resident in care homes to meet their physical and mental health needs. We continue to develop this model to reach wider in to our population.

Further to this we are pursuing our duty to reduce inequalities by:

• **Focusing on 'best start' from conception to age 2**
Our Joint Strategic Needs Assessment indicated that we continue to experience significant health inequalities during maternity which can impact on the life experiences and chances of our young population. We have focussed on supporting smoking cessation in maternity where we have been an outlier and increasing support for perinatal mental health.

• **Improving Health Literacy**
Health literacy work includes the way we promote and support self-management and self-care, both for the general population and for people living with one or more long term health conditions.

This includes communications and engagement around choosing the most appropriate NHS services for a patient's needs, and self-care support and advice including integrating the wider 2016/17 NHS Winter Health campaign (**Stay Well this Winter**) and other national campaigns into our local messages using a variety of platforms including Social Media. During periods of high activity, the CCG undertook additional social media messaging to make people more aware of the alternatives to visiting A&E.

In terms of long term health conditions, during 2016/17 this included the launch of the national Diabetes Prevention Programme for patients identified as being at risk of developing Type 2 Diabetes.

We are working to increase early presentation rates for cancer which disproportionately affect the more deprived parts of our community through our new care network model which is developing a population health management approach.

• **Advocating and modelling behaviour change**
This involves our work around early detection, treatment and management of serious lifestyle-associated health conditions, such as heart disease and diabetes. As part of the National Diabetes Prevention Programme, the CCG alongside its partners in Greater Lincolnshire took part in the commissioning of a radio advert highlighting the risks of Type 2 Diabetes and how participation in the programme can help those identified by a GP or nurse as being at serious risk of developing the disease to recruit people to discussions with their practice. Furthermore we have implemented the Diabetes Super 6 model to support the effective control of diabetes which disproportionately affects the more deprived communities in North Lincolnshire.

We are also continuing to develop plans around Social Prescribing with colleagues in North Lincolnshire Council.

We have developed a Care Homes Action Team model which supports vulnerable members of our population to ensure that they are able to access services to avoid the need for them to attend hospital unnecessarily.

Through our Better Care Fund arrangements with North Lincolnshire Council we have supported the establishment of Well Being Hubs to support vulnerable people in our communities and improve their access to interventions to support their continued independence and wellbeing.

Equality and Diversity

The CCG has published its Equality Diversity Plan and Objectives in line with NHS requirements of the public sector Equality Duty using the NHS Equality Delivery System (EDS) Tool

Objective 1: Ensuring systems are in place to embed equality in all our commissioning systems
Objective 2: Ensuring that appropriate equality and diversity initiatives are taken forward in the current year's work plan

This year, the CCG reviewed its Communications and Engagement Strategy which resulted in the formal approval by the Governing Body of both a Communications and a Public and Stakeholder Engagement Strategy in October.

These strategies together with the associated Equality Impact Assessments are published on the CCG website http://www.northlincolnshireccg.nhs.uk/publications/?subdir=communications-and-engagement-strategies. These are published alongside a more accessible 'Plan on a Page' for each strategy.

The Public and Stakeholder Engagement Strategy re-affirms the CCG's commitment to integrating understanding of equality and diversity issues across the organisation, recognising that our engagement work must reaches out to as many people as possible and that we must strengthen engagement on equalities with a view to:

- Increasing the diversity of general engagement between the CCG and the public
- Strengthening the voice of seldom heard groups
- Engaging with local interest groups about the Equality Delivery System
- Greater engagement on equality impact assessments of commissioning decisions

The CCG was instrumental in developing the North Lincolnshire multi-agency Equality and Inclusion Forum which aims to strengthen and provide a focus for on-going engagement on equalities issues between public services and people who represent or have an interest in equalities. More work needs to be done to ensure this Forum operates effectively to support and enhance the CCG Equality Action Plan and priorities.

The CCG's Communications strategy recognises that health and care services can sometimes appear complex and fragmented to many people, especially during more difficult times when they need support the most. The strategy aims to deliver coherent, coordinated and effective communications putting the pieces together to form a clear picture of the local health system in North Lincolnshire.

The strategy sets out the CCG approach to communicating for diversity acknowledging that the methods of communications the CCG routinely uses may not meet the needs of groups with protected characteristics, and we need to communicate in the in the most appropriate places, the most appropriate format and in the most appropriate language

CCG Stakeholder database

The CCG maintains a database of local stakeholders, including voluntary, community and social enterprise (VCSE) organisations, including those representing groups with protected characteristics under the Equality Act 2010, and other membership schemes. This database is utilised to identify other people / groups that may have an interest in being involved in engagement activities with the CCG.

Equality Monitoring of Public and Patient Engagement.

To help us understand whether we are supporting or providing services fairly to all groups of people, the CCG continues to carry out Equality monitoring of

- attendance at our public engagement events
- membership of Embrace our Patient and Public Engagement Network Embrace
- participation in online and hard copy surveys and questionnaires

Health Matters events

Since 2015 the CCG has hosted twice-yearly 'Health Matters' public engagement events. These events give local people and stakeholders the opportunity to meet with commissioners, receive information and participate in dialogue to inform specific commissioning activity.

The event comprises of a 'market place' with information stands where staff are available to discuss plans in person with participants; and a programme of optional presentations and facilitated discussion groups covering a wide range of health and wellbeing topics.

In response to feedback from protected characteristics groups from previous events the market place offer was expanded this year to include involvement from the local Veterans Community Hub; advocacy services and young carers.

In order to provide greater accessibility for members of the public the CCG offered a 'Bite-sized' evening session for Health Matters 5 in March which was well-received.

Young People

This year the CCG has strengthened engagement with young people through the Youth Council, schools and local colleges. This includes engagement to develop the Children and Adolescent Mental Health Services plan, recruitment of the CCG Public & Patient Involvement Lay member and the Experience-Led Commissioning programme for children living with long term conditions and their families.

Equality Lay Member

This year the CCG established a new role on the Governing Body of Lay Member for Equality and Diversity to lead on strategic direction and assurance of the organisation's E&D duties.

Equality champions

The CCG has worked with local practices to promote equality and inclusion. Each practice now has an Equality & Inclusion Champion. An inaugural meeting of a Practice Equality & Inclusion Champion Forum aimed to promote a shared understanding of the agenda and help practice's set their work plans. Future meetings of the Practice Champions Forum will be held quarterly and will provide an opportunity to identify and address challenges and share best practice.

Positive about Disability and Mindful Employer

The CCG has signed up to the Positive about Disability Scheme. The scheme supports organisations successfully employing and retaining disabled people and those with Health problems. The CCG has also committed to the Mindful Employer scheme which promotes a positive and supportive approach for people with mental health conditions. During 2017/18 the CCG will work to ensure that these commitments are turned into positive actions and embedded in the culture of the organisation.

Public Involvement

Our Engagement Strategy sets out how the CCG will meet our responsibilities under the Health and Social Care Act 2012 and shows our commitment to actively engage with patients, the public and other key stakeholders to ensure the commissioning, design, development, delivery and monitoring of healthcare in North Lincolnshire meets the needs of our population.

Our Vision for Engagement is to improve the health and wellbeing of the local population, reduce inequalities and commission high quality, safe and sustainable health care by building strong relationships with stakeholders and effective methods of public and patient involvement

To achieve this we continue to develop accessible and meaningful opportunities to influence our decision-making processes and improve services, and build public confidence in the local NHS.

How we engage

The CCG uses a range of methods and approaches to optimise engagement activity:

Asset-based Engaging with individual and communities to mobilise the current or potential assets, skills or resources that enhance and sustain health and wellbeing	Social Prescribing Patient Expert programme Youth Council Voluntary, Community & Social Enterprise (VCSE) groups Patient Participation Groups (PPGs)
Transactional Working with patients, stakeholders and communities to develop and then consider commissioning priorities and options, which - where appropriate - will culminate in a formal consultation process	Health Matters events Embrace NHS Cycle of Engagement & the Ladder of Participation Healthy Lives, Healthy Futures
Co-design Capturing and understanding patients', carers' and staff experiences of services, and bringing them together to share the role of designing services and improving care	Experience-led design projects PATH events Focus Groups

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An overview of engagement and consultation in North Lincolnshire 2016-17

North Lincolnshire Public and Patient Engagement Network (Embrace)

Embrace is the CCG's Public and Patient Engagement Network. The purpose behind Embrace is to establish a strong network of local people, patients, carers, voluntary sector representatives and other partners who have an interest in service developments, learning more about the NHS and being more closely involved in shaping local services.

The database captures the contact details and particular interests of patients and the public within our area.

We have seen a steady increase in numbers of people signing up to Embrace over the year, and membership currently stands at 207. Embrace members receive regular communications from the CCG about national and local engagement opportunities in their areas of interest in health and care.

These have included:

- Recruitment of community members to the Northern Lincolnshire Research and Development group
- Carers strategy Call for Evidence (DoH) Caring for the Carer survey (NLC)
- In-patient mental health services for young people (NHSE Specialised Commissioning)
- Adult mental health service transformation (RDaSH/Healthwatch)
- Leaving hospital survey (Healthwatch)

To join up, please contact us or visit our website www.northlincolnshireccg.nhs.uk/Embrace

Health Matters Public & Stakeholder Engagement Events

Health Matters public and stakeholder engagement events have been held twice-yearly since 2014. Health Matters 4 (August) and Health Matters 5 – Our NHS: Thinking Differently about Health and Care (March) enable the public and stakeholders to engage 1-1 with us at themed 'market stalls' covering a range of topics, running parallel to this is a programme of presentations and discussion/focus groups.

In 2015/16, we carried out extensive engagement to inform the commissioning of Patient Transport Services. At Health Matters 4 the new provider of the service was present to speak to patients providing tangible evidence of the outcomes of previous patient and public involvement to inform the specification for this service.

At Health Matters 5 key presentations at the event were interactive with the audience asked to vote using hand held devices and provide their input to questions posed on the various subjects being discussed. This provided instant and valuable feedback that informed further discussions. We also introduced a 'Patient Experience Sofa Zone' where people were invited to come and share their personal experiences of care. To cater for people unable to attend a daytime session we held a 'Bite-sized' Health Matters evening meeting the following week, which was well-received.

At the event, people were able to find out more or have their say about:

- The CCG's priorities for 2016/17 and the Humber Coast and Vale Sustainability and Transformation Plan (HCV STP)
- Prescribing and medicines optimisation
- Ways to recovery in mental health
- Improving outcome from surgery
- Thinking differently about General Practice

Also partners from across the health, care and wellbeing community joined us to share information about their service plans including:

- Statutory and non-statutory Advocacy Services (Cloverleaf Advocacy)
- North Lincolnshire Veterans Community Hub
- Public Health – prevention, healthy living and cancer awareness
- Virgin Healthcare – development of Community Dermatology Services

All participants along with Embrace members and contacts on the CCGs Stakeholder list are then sent a follow-up briefing note in which all facilitators provide an update on progress. This report is also published on the CCG's website http://www.northlincolnshireccg.nhs.uk/data/uploads/health-matters/health-matters-4-update-on-progress-and-outcomes.pdf

Patient Participation Group (PPG) Chairs Meetings

This year the CCG PPI Lay Member continued to facilitate meetings for PPG Chairs and deliver training sessions for developing PPG's in partnership with Healthwatch North Lincolnshire. In November we held a second PPG conference attracting around 50 participants from North Lincolnshire and neighbouring CCG areas. The conference featured guest speakers from NHS England, the Care Quality Commission (CQC), the Association of Directors of Public Health and National Institute for Health and Care Excellence (NICE) along with leaders from the CCG and Healthwatch.

Stakeholder groups

We have a well-established wide ranging stakeholder list of local community groups, voluntary groups and organisations, including those that represent groups with protected characteristics. This is maintained and utilised to identify those people who may be interested in being involved in particular projects.

We have met with a number of community and special interest groups over the course of the year to inform our engagement across the commissioning cycle including the Carers Advisory Group, Youth Council, local senior's forums, disability clubs and support groups.

NL Healthwatch

Our Chief Officer holds quarterly meetings with the Chair and staff lead at North Lincolnshir Healthwatch. This year we have continued to work in partnership with Healthwatch to develop links with local Patient Participation Groups (PPGs) and develop the Equality and Inclusion Forum.

Improving Quality

The CCG is committed to working to continually improve health services for the people of North Lincolnshire. We recognise some of the current challenges, as referenced in the introduction to this report, and remain committed to working collaboratively with local partners to improve the quality of services and patient outcomes.

Led by the Governing Body and supported by a Quality Group, our CCG discharges this responsibility in a number of ways. These include:

- Having robust systems in place to identify, evaluate and disseminate learning from incidents. A dedicated Incident Monitoring Group reviews and evaluates incident reports from providers and checks that effective learning has taken place.

- Providing regular patient experience reports that monitor patient experience, trends and lessons learnt from the Friends & Family Test, PALS contacts, complaints and compliments

- Monitoring local provider performance against key quality indicators, working with external stakeholders and undertaking site visits to support and obtain assurance from local providers.

- Ensuring robust safeguarding adults and children strategies and action plans are in place both as a service commissioner and amongst our local providers.

- Ensuring robust Mental Capacity Act and MCA Deprivation of Liberty Safeguards strategies and action plans are in place both as a service commissioner and amongst our local providers.

- Promoting effective infection prevention and control (IP&C) within the local health economy, providing training, advice, reviewing incidents (to promote learning) and providing on-site support to primary care and care home staff as part of the IP&C audit programme

- Ensuring that patients with a primary health need are able to access the appropriate package of care, to meet their needs

- Some more detail of how NL CCG is promoting quality can be found in the Annual Governance Statement under the heading ***Quality Group***.

Regarding the quality issues at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG), as commissioners we remain extremely concerned at the findings detailed within the recently published CQC report and the Trust's return to special measures in 2017.

We acknowledge the organisation's intention to learn from these significant challenges and to work at pace however, alongside the other local commissioners, we will be expecting to see considerable improvements to ensure patients are safe and there is clear evidence of transformation to services where failures have been identified.

Whilst some progress has been noted, there are specific improvements required in the following areas:

1. Maternity Services
2. Accident and Emergency services
3. Waiting times
4. Leadership

The range of issues highlighted by the CQC included staff shortages and escalation of concerns where this remains a problem, improvements to patient assessment to ensure patient safety is not compromised. There is also a requirement to improve risk and governance processes with oversight specifically, in relation to learning lessons from incidents that occur with identification and mitigation of risks.

We recognise that a whole systems approach of assurance is now in place and managed by NHS Improvement and NHS England. Commissioners are confident that by working together across the health and social care community this will support the progress required.

Positive progress is noted across a number of areas including in relation to increased staffing for patients with learning disabilities, training for podiatry services and safeguarding processes. Improvements in critical care have also been identified and we would like to acknowledge the hard work of the staff within the Trust.

We have welcomed their revised approach to quality improvement with the introduction of the 'Improving Together programme' and we look forward to supporting the Trust in delivering its priorities in 2017/18.

How We Contribute To The Delivery Of The Joint Health And Wellbeing Strategy

The CCG is part of the North Lincolnshire Health and Wellbeing Board. The Health and Wellbeing Board is a statutory committee of North Lincolnshire Council where key leaders from the health and social care system work together to improve the health and wellbeing of the local population and reduce health inequalities whilst delivering value for money.

One of the Board's statutory functions is to prepare and publish a Joint Health and Wellbeing Strategy. The strategy can be found by visiting Health and Wellbeing Strategy.

The Health & Wellbeing Strategy sets out the local approach to health and wellbeing which is focussing more on prevention and early intervention, and creates a clear expectation that there will be an increasing role for individuals to play in making healthy lifestyle choices (for example to avoid smoking and obesity), managing their own health and wellbeing without dependency on statutory NHS or Adult Social Care services whenever possible and appropriate. There is also an expectation that communities will play a greater role in supporting the health and wellbeing of their community.

The CCG has a range of actions to deliver our areas of the strategy, which are reflected in our strategic plan. Examples include:

- Investment in maternal physical and mental health with particular focus on perinatal mental health and maternal smoking rates
- Changing the conversation in general practice to explain the links between lifestyle factors and outcomes

The CCG regularly updates and receives feedback from the rest of the Health and Wellbeing Board on our actions to deliver the Health and Wellbeing strategy via our Chief Officer and we undertake shared assessment of our progress and contributions to delivery of the strategy.

1.2.4. Sustainable Development

NHS North Lincolnshire Clinical Commissioning Group is committed to shaping and commissioning health services that are environmentally appropriate, meet the health needs of the local population and are financially sustainable.

Sustainability is about the effective use of natural resources and behaving in a way that manages and minimises the impact we have on our environment. It requires us to pay particular attention to travel, facilities management and procurement. As a commissioner of healthcare services and as an employer, we recognise the need to minimise our impact on the environment.

During 2016/17 we have maintained our initiatives from 15/16 and also implemented the following initiatives, successfully, to reduce our carbon footprint:

- Installing recycling bins for all staff to use
- Cutting down on printing, especially all agendas and papers for meetings

- All lights are now turned off, when not in use, due to a sticker to remind staff to do this.
- All computer monitors are turned off, when not in use, by implemented a screensaver to remind staff of this.
- We also now sell used books/DVD to staff, promoting reuse of material, whilst collecting for charity.

Governance

North Lincolnshire CCG designed, developed and implemented a Sustainability Impact Assessment (SIA) template. This tool enables the CCG to assess and anticipate the likely sustainability implications of a policy, strategy or service design/redesign. The template is embedded within the organisations corporate templates that support decision making functions.

Travel

To support our ambition to reduce our carbon footprint we have introduced unified communications tools as an alternative to face to face meetings; these include video conferencing and teleconferencing. In addition to this, the organisation has developed and introduced a number of policies to support and further encourage its staff to consider new ways of working; these include a Remote Access & Home Working Policy.

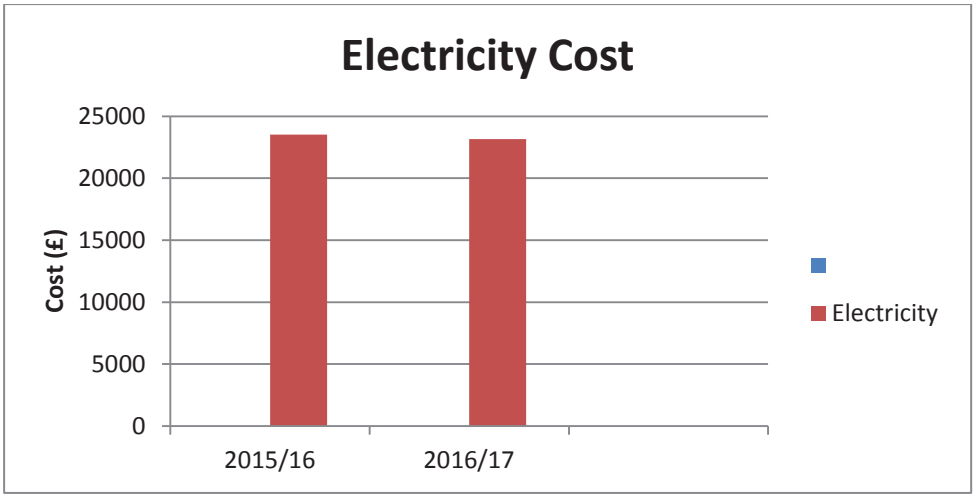
We also promote cycling to work and have offered staff a Return to Cycling workshop and bike service sessions. We have recently had the showers in the building fixed, to help encourage cycling to work.

Facilities Management

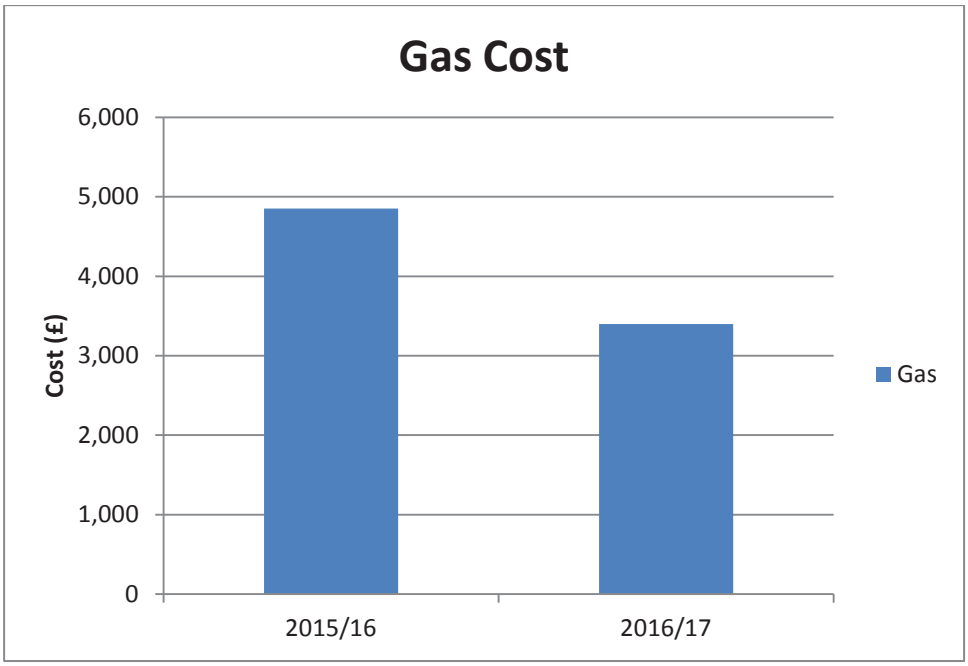
NHS Property Services (NHSPS) manage the building from which the CCG operates. The CCG has a lease/rental agreement with NHSPS and all utility bills go directly to them as 'landlord'. We have been working with NHSPS to obtain our baseline position for electricity, gas, and water.

The following tables highlight our carbon footprint for gas, electricity and water. We have seen a reduction in cost for Electricity and gas over the past year due to the organisation becoming more sustainable.

Electricity



Gas



Water

Water	2015/16	2016/17	
Use (m^3)	530	1,046	
Cost	£1,638	£2,919	

Procurement

As a commissioner of services our aim is to assure the sustainability of the organisation and that of our commissioned services. We continue to work collaboratively with our procurement and commissioning colleagues to identify and maximise opportunities to integrate sustainability considerations within our commissioning processes and functions.

Corporate Approach: Good Corporate Citizen

A ‘good corporate citizen’ is an organisation that accepts the importance of being collectively responsible for its local community and environment as an integral part of their core business. The Good Corporate Citizen Tool allows organisations to assess their level of commitment to the sustainability agenda against 6 core areas:

- Travel
- Procurement
- Facilities management
- Workforce
- Community Engagement
- Buildings

Once completed, the assessment allows organisations to establish a base line from which to develop action plans for year on year improvement. Results can be published to allow CCGs to compare their result with other CCGs, on a national, regional and local level.

NL CCG scored 60% overall in the Good Corporate Citizen assessment, the results of which have been utilised to develop a detailed action plan to monitor improvement during 2016/17 with achievement targets developed and monitored through the sustainability task group and reported to the Governing Body.

Key actions for 2016 relating to the Good Corporate Citizen assessment included:

- Review and assess transport and travel options
- Calculate the carbon footprint of our business travel
- Develop active travel plan
- Proactively promote energy efficiency through task and finish group (turn off computer/lights, heating, not on stand-by etc)
- Sustainable development in all job plans going forward
- Induction programme to include sustainability

Next steps

- Develop water reduction targets
- Reduce business miles expended by CCG employees
- Develop Active Travel/Green Travel plan
- Contracting to work with providers to ensure there are plans in place to reduce carbon emissions
- Review the Sustainable Development Management Plan
- Work with strategic partners and local stakeholders to support sustainable development preparing and adapting to the predicted effects of a future changing climate.

1.2.5. Access to information (FOI)

Access to Information

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

	2016/17
Number of FOI requests processed	270
Percentage of requests responded to within 20 working days	100%
Average time taken to respond to an FOI request	15

The CCG did not provide the information requested in 44 cases because an exemption was applied either to part of, or to the whole request e.g. information was accessible by other means, the cost of providing the information exceeded the limits set by the FOIA, information was intended for future publication, disclosure of information would be likely to prejudice the commercial interests of any person, information related to the personal data of third parties or disclosure would be likely prejudice to law enforcement.

The CCG did not provide information in 41 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 at :

http://www.northlincolnshireccg.nhs.uk/freedom-of-information-new/publication-scheme/

1.2.6. Priorities for 2017/18

Our Operational plan for 2017/18 to 2018/19 will be published on our website in the near future.

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

You can download the STP from the Humber Coast and Vale website.

The other "**Must Dos"** include work to:

- Balance the books
- Develop primary care services for the future
- Improve urgent and emergency care
- Improve waiting times for people referred to hospital and planned care
- Improve cancer outcomes
- Give people more access to Mental Health support
- Improve services for people with Learning Disabilities
- Improve quality

1.2.7. Use of Earmarked Funds 2016/17

During the latter part of 2015/16 the CCG received £298,000 of Quality premium funding to spend on either Programme or Running cost expenditure, related to performance targets which were achieved in 2014/15. Rather than waste this scarce non recurrent funding, the CCG decided to defer the use of this funding to allow firm expenditure proposals to be developed and piloted in Practices, as appropriate.

During 2016/17 the CCG purchased from this source for use by all Practices : Red Book Self Care booklets for patients, Watch BP Home Devices for AF, an EMIS Web viewer and the “My COPD Self Care Tool”with a combined value of £37k.

For 2017/18, as a result of the CCG posting a financial deficit in 2016/17, no specific funding was carried-forward into the new financial year. However, the CCG remains committed to fund from other existing budgets - service quality improvements, and any VFM related proposals which have an explicit quality dimension, that would have been eligible for Quality Premium funding in the past.

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 Governing Body and provides an overview of GP practices who are members of the CCG, composition of the Governing Body and Council of Members, and a biography of members of the Governing Body and other key points of interest.

Each individual who is a member of the Governing Body 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 the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

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

Name	Designation
Liane Langdon	Chief Officer
Dr Margaret Sanderson	Clinical Chair

2.1.1.2. Governing Body

Our Governing Body ensures the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with our principals of good governance.

The Governing Body meets in public and papers are published on our website before each meeting. The CCG's Governing Body combines a wide range of experience and expertise and includes clinicians, executive members and lay members as shown on the following pages.

Details of other committees and sub-committees can be found in the Annual Governance Statement later in this section.

NHS North Lincolnshire CCG Governing Body, 2016-2017

Dr Margaret Sanderson, Chair

Dr Sanderson has been chair since the CCG was authorised in 2013 and is also Clinical Lead for both Women and Children and Ophthalmology. She is also chair of the Council of Members.

Dr Sanderson trained at Leicester University Medical School, qualifying in 1983, and pursued a career in Obstetrics and Gynaecology before General Practice. She moved to North Lincolnshire in 1992 to join Trent View Medical Practice in Keadby as a partner, where she continues to practice.

She holds special interests in Mental Health, Contraception and Gynaecology and Sexual Health and has also been involved in the shared care management of substance misuse, holding the part one qualification for this from the RCGP.

Liane Langdon, Chief Officer

Liane joined the NHS in 1998 as a graduate trainee and has worked in and around health and social care since then. She has held a variety of roles in health, including finance, service re-design, strategy, public health, governance, organisational development, informatics and commissioning. Before joining the CCG as Chief Officer in January 2016, she was Director of Commissioning and Strategic Development at NHS Leeds North CCG.

Liane has particular interests in mental health and well-being and bringing services together to make sense for the people using them. She is leading the STP Mental Health work stream. Liane has worked in provider, commissioner and oversight organisations and is passionate about working with people to create services and systems which work and deliver high quality care for the people of North Lincolnshire.

Ian Holborn, Chief Finance Officer

Ian joined the CCG in July 2016. Previous to this, he worked for Manchester College as Chief Financial Officer and before then at Hull College as Finance Director, spending eight years in the Further and Higher Education sector . He is a qualified Accountant (FCCA). He is a Finance professional bringing commercial experience into the publicly funded sectors. His previous experience includes: FMCG manufacturing and logistics background in medical (Smith and Nephew), foods (Unilever UK), supply chain (British Sugar / ABF); and Local Authority (Ealing LBE) and financial services (Aviva).

Ian is also a Trustee of the national homelessness charity Centrepoint.

Ian took over the role in July 2016 from Interim Chief Finance Officer **Keiran Lappin** who held the position since Jan 2016

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NHS North Lincolnshire CCG Governing Body, 2016-2017

Catherine Wylie, Director of Nursing and Quality

Catherine trained as a Registered General Nurse at Stobhill General Hospital, Glasgow, qualifying in 1980. She continued her career by training as a midwife at The Queen Mother's Hospital in Glasgow and remained there a number of years, working her way up to become a Senior Labour Ward Sister. She moved to Lincolnshire in 1995 to take up the post of Clinical Midwife Specialist and later Head of Midwifery at Scunthorpe General Hospital. Catherine developed a specialist interest in NHS risk and quality which led to her role as Associate Director of Risk and Quality for East Lincolnshire PCT. She then became General Manager for the East Lindsey area of Lincolnshire, within the Lincolnshire Community Health Services NHS Trust, with responsibility for the provision of community health services and management of two community hospitals.

Dr Robert Jaggs-Fowler, CStJ MBBS LLM MA FRCGP FRSA MFMLM, Medical Director

Dr Jaggs-Fowler qualified in 1985 from the Charing Cross Hospital Medical School, London, and is a Fellow of the Royal College of General Practitioners. A former Major in the Royal Army Medical Corps, he became a GP Principal in 1990 and, until January 2016, was senior partner in a large rural, dispensing, teaching practice in Barton upon Humber. As well as his appointment to the Governing Body, he is the Medical Director for the CCG, the Named GP for Safeguarding (Children and Adults) and Clinical Lead for Unplanned Care. He also undertakes work as a GP appraiser for NHS England and is a member of the Local Medical Committee.

Dr Richard Shenderey, Secondary Care Consultant

Dr Shenderey is a consultant with Airedale NHS Foundation Trust in the general medicine department, specialising in Gastroenterology and Hepatology. He qualified from the University of Newcastle upon Tyne in 1999 and has worked across the North-East and Yorkshire. His main areas of interest include Inflammatory bowel disease, liver disease including treatment of hepatitis C, and nutrition. He is clinical lead at Airedale for gastroenterology.

Dr Shenderey joined the CCG on October 1 2016. His predecessor was **Professor John Mayberry** who left the CCG in June 2016.

NHS North Lincolnshire CCG Governing Body, 2016-2017

Dr Andrew Lee, GP Member

Dr Lee qualified from the University of Sheffield in 1983. He has practised as a GP in Scunthorpe since 1987, jointly founding the West Common Lane Teaching Practice where he provides teaching and supervision. He is also a GP appraiser for NHS England, and plays an active role on a range of advisory groups.

Dr Lee has a special interest in headache, and runs a special clinic for this area of medicine for referred patients. He is the CCG's Clinical Lead for Primary Care Development and Musculoskeletal, and Vice Chair of the CCG's Council of Members.

Dr Faisel Baig, GP Member

Dr Faisel Baig is the clinical lead for Mental Health and Dementia, and previously led Urgent Care. He also provides the GP input into the Mental Health workstream of the Humber, Coast and Vale STP.

Dr Baig grew up and was educated here in North Lincolnshire. He completed his medical training at Manchester Medical School and went on to train as a GP on the South Manchester Vocational Training Scheme. He now works locally as a locum GP.

Dr Baig has a keen interest in issues affecting sessional GPs and has represented sessional GPs at local, regional and national level, including on the BMA General Practitioners Committee (GPC). He is currently the Vice-chairman of the Scunthorpe Division of the BMA. He has a keen interest in undergraduate medical education and is a Finals Examiner, Admissions Interviewer and Small Group Tutor for The University of Sheffield Medical School. Dr Baig is also a Specialist Advisor to the Care Quality Commission (CQC) and enjoys this role as he feels it gives him an opportunity to highlight much of the great work that takes place within practices.

Dr Satpal Shekhawat, GP Member

Dr Shekhawat finished his undergraduate medical training in India in 2000. He moved to UK in 2005 and underwent GP training in Scunthorpe and completed it in 2009. Since qualifying he has been a GP partner at Kirton Lindsey Surgery and is actively involved in local GP training programme. He has been a GP trainer for last 7 years and is also Honorary HYMS tutor. Dr Shekhawat joined the CCG on 1st October 2016**,** taking over from **Dr Nick Stewart** who stepped down from the Governing Body at the end of **September 2016.**

NHS North Lincolnshire CCG Governing Body, 2016-2017

Dr James Mbugua, GP Member

Dr Mbugua qualified as a GP in 2008 and worked in a number of practices in North Lincolnshire as a salaried GP since his qualification. He has recently become a GP partner at Trent View Medical Practice. Dr Mbugua has a specialist interest in Dermatology and was instrumental in helping to establish a Community Dermatology Service in North Lincolnshire. During 2016-17, he was the CCG's Clinical Lead for Equality and Diversity and Ophthalmology

Paul Evans, Lay Member, Governance

Paul is a Chartered Accountant and experienced finance director, having held positions in a range of medium sized businesses and small cap organisations, including within the pharmaceutical and professional services sector.

Ian Reekie, Lay Member, Joint Commissioning (Formerly Public and Patient Involvement)

Ian is a retired local authority chief leisure officer who in 2008 was appointed as a non-executive director of the former North Lincolnshire PCT before taking on the role of the CCG's patient and public engagement lay member in 2012. During 2016/17 he relinquished the patient engagement brief to take on responsibility for lay oversight of primary care commissioning. Ian has also served as a community member on various National Institute for Health and Care Excellence (NICE) guideline development groups and is currently a lay member on the NICE Quality Standards Advisory Committee.

Janice Keilthy, Lay Member, Public and Patient Involvement (from October 2016)

Janice is the former Deputy Principal at a local general further education college with higher education and has worked at a senior level in both the public and private sector

Janice has a particular interest in the North Lincolnshire area, having graduated from a local university and lectured across the Humberside area and internationally about best practise in Lincolnshire education.
She has lived I and worked in Lincolnshire for almost all of her career and takes a very active role in community activity.

NHS North Lincolnshire CCG Governing Body, 2016-2017

Heather McSharry, Lay Member, Equality and Inclusion (from October 2016)

Heather McSharry joined the CCG board as a lay member in November 2016. She holds the role of lay member for Equality and Diversity. Her working background has been in disability support and local authority services to adults. Around her part time CCG role she is a full time mum.

Richard Young, Interim Director of Commissioning (*Non Voting Member***)**
Richard was appointed as Director of Commissioning in April 2017 but had joined the CCG in an interim capacity in July the previous year. He has over 25 years' experience in the NHS and has operated at Executive and Head of Service level in commissioning organisations for over 15 years – mostly in Birmingham and the Black Country.

He has particular interests in Learning Disability services, Urgent Care and Community Services. Before joining the CCG, he was Strategic Planning Lead at Camden CCG and prior to that worked as Better Care Fund Programme Director at Enfield CCG as a joint appointment with the Local Authority. From 2011 – 2014, he was Director Of Strategy & Solutions at Wolverhampton CCG.

He also served as an elected Council Member in Sandwell for 14 years with executive roles in finance, housing and policy, finally ending up as Deputy Leader before 'retiring' to concentrate on his career.

Chris Nield, Public Health Consultant, North Lincolnshire Council (*Non Voting Member***)**

Chris has a personal commitment to addressing health inequalities and empowering communities. Chris started her career teaching in Sheffield. She moved to Public Health working North Nottinghamshire coalfields areas and became Assistant Director of Public Health in Nottingham.

More recently Chris worked as a Consultant in Public Health for Sheffield City Council and prior to this for Sheffield PCT. Throughout her Public Health career Chris has had led public health work in communities, Primary Care and mental health and wellbeing. She is the lead for a MPH module at Hallam University and is an Honorary lecturer at Sheffield University. She has recently been a member of the NICE Committee for community engagement and is a member Faculty of Public Health Mental Health Group. She enjoys walking in Derbyshire.

Members of the public are always very welcome to attend our Governing Body Meetings. For details, please visit http://www.northlincolnshireccg.nhs.uk/the-board/

2.1.1.3. North Lincolnshire Practices

We are a clinically-led organisation, which brings together 19 North Lincolnshire GP Practices who work alongside other health and care professionals to plan and design services that meet the needs of local people.

Full information about our GP practices, including how they are rated by their patients, can be found on the NHS Choices web site by clicking here.

Ancora Medical Practice, Scunthorpe
Ashby Turn Primary Care Partners, Scunthorpe
Bridge Street Surgery, Brigg
Cambridge Avenue Medical Centre, Bottesford
Cedar Medical Practice, Scunthorpe
Central Surgery Barton, Barton upon Humber
Church Lane Medical Centre, Scunthorpe
Kirton Lindsey Surgery, Kirton Lindsey
Market Hill Medical Practice, Scunthorpe
Riverside Surgery, Brigg
South Axholme Practice, Epworth
The Birches Medical Practice, Scunthorpe
The Killingholme Surgery, South Killingholme
The Medical Centre, Barnetby
The Oswald Road Medical Centre, Scunthorpe
Trent View Medical Practice, Keadby
West Common Lane Teaching Practice, Scunthorpe
West Common Lane Teaching Practice Branch Practice at Ashby (formerly Dr Balasanthiran's Practice)
West Town Surgery, Barton on Humber

2.1.1.4. Our Council of Members

Each North Lincolnshire GP Practice is represented on the Council of Members by a named representative who may send a deputy.

Members have voting rights and make the important decisions about local healthcare.

The Council meets every month and is chaired by **Dr Margaret Sanderson**.

Practice	Representative
Ancora Medical Practice	**Dr Jajja**
Ashby Turn Primary Care Partners	**Dr Muhammad Nasim**
Bridge Street Surgery	**Dr Andrew Whitaker**
Cambridge Avenue Medical Centre	**Dr Elango**
Cedar Medical Practice	**Dr Hardik Gandhi**
Central Surgery Barton	**Dr Toby Blumenthal**
Church Lane Medical Centre	**Dr Tauqir Hussain**
Kirton Lindsey Surgery	**Dr Satpal Shekhawat**
Market Hill Medical Practice	**Dr Arun Nayyar**
Riverside Surgery	**Dr Salim Modan**
South Axholme Practice	**Dr Gary Armstrong**
The Birches Medical Practice	**Dr Gary Armstrong**
The Killingholme Surgery	**Angela Elsom, Nurse Practitioner**
The Medical Centre, Barnetby	**Dr S Ahmed**
The Oswald Road Medical Centre	**Dr Sheena Kurien-George**
Trent View Medical Practice	**Dr James Ojidu**
West Common Lane Teaching Practice	**Dr Andrew Lee**
West Town Surgery, Barton on Humber	**Dr Uzma Khan**

2.1.1.5. Our Audit Group

Members of the CCG's Audit Group during the financial year were as follows:

Member	Appointment
Paul Evans	Chair
Ian Reekie	Lay Member
Dr Satpal Shekhawat	GP
Dr Toby Blumenthal	GP
Janice Keilthy	Lay Member
Dr Hardik Gandhi	New GP member
Dr Sami Ahmed	New GP member

Ian Holborn, Chief Finance Officer & Business Support, and Bill Lovell, Deputy Chief Finance Officer attended meetings to advise the group as required.

Catherine Wylie, Director of Quality and Risk Assurance and John Pougher, Assistant Senior Officer Quality and Assurance, attend meetings to advise the group on matters of corporate governance and are the link to the Quality Group for integrated governance.

The following non-CCG staff attend meetings to provide support as required:

Benita Jones	East Coast Audit Consortium
Robert Bassham	East Coast Audit Consortium
Shaun Fleming	East Coast Audit Consortium
Jackie Rae	KPMG
John Prentice	KPMG

In addition, during the year the following individuals attended particular meetings for specific issues/reports: Joanne Sinclair, KPMG; Rob Walker, KPMG; Nikki Cooper, East Coast Audit Consortium; Liane Langdon, Chief Officer, NHS North Lincolnshire CCG.

2.1.1.6. Committee and Sub-committee membership and Declarations of Interest

Full details of the membership of the Remuneration Committee can be found in the Remuneration Committee Report.

For details and membership of all other Committees and Sub-committees of the Governing Body, please refer to the Annual Governance Statement.

Details of Members' declared interests can be accessed on the **How We Avoid Conflicts of Interest** page on our website.

2.1.2. Additional Disclosures

2.1.2.1. Principles for Remedy

The CCG fully endorses values set out in the Parliamentary and Health Service Ombudsman's '**Principles for Remedy'** guidance and undertakes to comply with these standards consistently when considering all complaints.

This guidance was developed to ensure public bodies seek to resolve situations in which groups or individuals have suffered harm or injustice. It is based on six core principles that underpin the services and work commissioned by the CCG, and will be demonstrated in how complaints are handled and how we show that we learn and improve from complaints.

The CCG works to meet the six principles as follows:

1. ***Getting it right*** – the CCG will quickly acknowledge and aim to put right cases of maladministration and poor service that have led to any injustice and hardship by considering all the relevant factors. The CCG will ensure fairness to the complainant and any others who have suffered from the same maladministration or poor service

2. *Being customer focused* – the CCG will deal with patient complaints professionally and sensitively, and where appropriate provide an apology and explanation of any poor service or maladministration.

3. ***Being open and accountable*** – the CCG will explain clearly, in its response to any complainant, its findings and the reasons for upholding or not upholding the complaint and any associated remedy.

4. *Acting fairly and proportionately* – the CCG will treat all complaints without bias, unlawful discrimination or prejudice.

5. *Putting things right* – where a complaint is upheld, the CCG aims to offer an appropriate remedy including an apology, an explanation and details of any remedial action to be undertaken. The CCG will consider any remedy that returns the complainant to the position they would have been in and where that is not possible, compensation will be considered.

6. *Seeking continuous improvement* – the CCG is keen to learn from complaints and ensures that, where identified, changes are made to policies, procedures and systems and any associated staff training is carried out. An explanation will be provided of changes that are made to prevent any recurrence of poor services or maladministration.

Complaint Information 2016/17

Complaints Received	Upheld	Not Upheld	Partially Upheld	On-going
12	4	1	2	5

Complaints received by the CCG are handled in accordance with *Statutory Instrument 2009/309 - Local Authority Social Services and NHS Complaints [England] regulations 2009*. This is applied via the CCG's policy for managing complaints, and also incorporates the NHS England guidance for '*Good Handling of Complaints for CCGs 2013'*. The CCG policy also incorporates the relevant recommendations from the Department of Health report, '*Hard Truths: The Journey to Putting Patients First*', by Robert Francis, QC.

The CCG is cognisant of recent national guidance, for example '*My expectations for raising concerns and complaints*', by the Parliamentary and Health Service Ombudsman (PHSO), the Local Government Ombudsman (LGO) and Healthwatch England, and is committed to developing a user-led 'vision' of the complaints process.

An annual detailed report of CCG related complaints will be published each year and will be presented to the Governing Body.

2.1.2.2. Employee consultation

Recognising the benefits of partnership working, the CCG is an active member of the Joint Trade Union Partnership Forum organised by the Workforce Team within Yorkshire and Humber Commissioning Support.

The aim of the Joint Trade Union 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 Joint Trade Union Partnership Forum to approve policies as and when they are finalised by the CCG.

All staff have an opportunity to participate in consultation on policy development. New policies which have been agreed in 2016/17 with support of staff consultation include:

- Business Conduct Policy
- Incident/Accident Reporting Policy
- Recruiting Ex-Offenders Policy

There has been a significant organisational change within the CCG, with a major reorganisation completed October 2016. Throughout this period all staff were consulted and involved. It was done in conjunction and with the support of the Joint Trade Union Partnership Forum and the Workforce Team from eMBED Health Consortium.

2.1.2.3 Equality disclosures

As an organisation, the CCG is committed to equality and valuing diversity within its existing and potential workforce.

We actively encourage people with disabilities to apply for positions in our organisation. Applicants applying for roles within the CCG, who declare a disability, are guaranteed an interview providing they meet the minimum criteria within the person specification for the particular vacancy.

The CCG achieves its requirements to make reasonable adjustments to the workplace environment to support staff who either consider themselves to be disabled or may develop a disability or long term condition during their employment. Professional occupational health advice is also available in this regard.

All opportunities for promotion and progression within the CCG are freely and equally accessible to all employees.

All CCG staff are required to complete mandatory equality and diversity training. Equality impact analysis training and enhanced training appropriate to individual staff roles is also available. Learning and development opportunities are accessible to all employees, including those who may consider themselves to have a disability. The CCG's blended approach to learning and development ensures that these opportunities address the varied learning needs of all staff.

Policies, procedures and publications that are developed for the CCG include advice on how to obtain them in different formats to meet the needs of anyone who wishes to access them, via the CCG Translation and Interpretation procedures.

Further information regarding the CCG's approach to Equality and Diversity, including our policies for equal opportunities and disabled employees, can be found in the Equality and Diversity pages on our website.

2.1.2.4 Emergency Preparedness, Resilience and Response

Under the Health and Social Care Act 2012, the Civil Contingencies Act 2004 (CCA 2004) and the 'NHS England Emergency Preparedness Resilience and Response Framework', the CCG is required to develop and maintain sufficient plans to ensure that the organisation and all commissioned services are well prepared to respond effectively to major incidents/emergencies. These plans serve to mitigate the risk to public and patients and ensure that critical functions can be maintained in the event of unforeseen disruption to services. The CCG is a designated Category 2 responder under the CCA 2004 and its key role and responsibilities in relation to EPRR include:

- Ensuring all contracts with all commissioned provider organisations (including independent and third sector) contain relevant EPRR elements, including business continuity
- Monitor compliance by each commissioned provider organisation with their contractual obligations in respect of EPRR and with applicable Core Standards
- Ensure robust escalation procedures are in place so that if a commissioned provider has an incident the provider can inform the CCG 24/7
- Ensure effective processes are in place for the CCG to properly prepare for and rehearse incident response arrangements with local partners and providers
- Be represented at the Local Health Resilience Partnership (LHRP), either on their own behalf or through a nominated lead CCG representative
- Provide a route of escalation for the LHRP in respect of commissioned provider EPRR preparedness
- Support NHS England in discharging its EPRR functions and duties locally, including supporting health economy tactical coordination during incidents (Alert Level 2-4)
- Fulfil the duties of a Category 2 responder under the CCA 2004 and the requirements in respect of emergencies within the NHS Act 2006 (as amended)

In line with its responsibilities as a Category 2 responder, the CCG has both a Business Continuity Plan and an EPRR policy, both of which are regularly reviewed. Taken together, these two policies provide an overview of key functions, roles and responsibilities of the EPRR system and the CCG's arrangements for EPRR response and Business Continuity; the two policies should be read in conjunction and provide assurance that the CCG has robust processes in place to meet its statutory duties.

During 2016 the CCG completed the national assurance process around EPRR planning as part of NHS England 'North Yorkshire & Humber EPRR Assurance Process'. The assurance process involved the CCG undertaking self-assessment against 37 minimum core standards for EPRR. Following the self-assessment the CCG declared as partial compliant. An action plan for 2017/18 has been developed based on the outcome of the assurance process that will further develop and refine the CCGs plans and processes for EPRR.

The CCG has a 24/7 on-call rota in place and reviewed and up-dated the NL CCG Pandemic Influenza Plan, the EPRR policy, Infectious Disease Outbreak Plan and Fuel Shortage plan during 2016/17.

During 2016 the CCG took part in a local multi-agency table top exercise to 'test' the North Lincolnshire CCGs Major Incident Plan. The CCG also commissioned Strategic Leadership in a Crisis training' that was undertaken by the CCG senior team.

Going forward into 2017/18 there will be a review of the CCGs Major Incident Plan and Business Continuity Plans and a local table top exercise to test business continuity.

Major Incident Management Centre activated following a declaration of a Major Incident in Scunthorpe. The CCG followed up with a Lessons Learnt session for the CCG Team.

In Jan 2017 the Acute Trust declared a Major Incident in relation to a Data security Breach which out their electronic systems out of action. This had significant impact on the ability of the organisation and the community's Business Continuity. The CCG played a role in the operational and strategic response to this incident.

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS England Emergency Preparedness Resilience and Response Framework 2015. The clinical commissioning group regularly reviews and makes improvements to its EPRR plans (including Business Continuity). These plans provide assurance that the CCG has robust processes in place to meet its statutory duties.

2.1.2.5 Disclosure Of "Serious Incidents"/Personal Data Related Incidents

During 2016/17, the CCG has had no incidents or serious incidents relating to any loss of data. More information on Information Governance can be found in the Annual Governance Statement later in this report.

2.1.2.6 Statement as to Disclosure to Auditors

Each individual who is a member of the Governing Body 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 the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

Liane Langdon
Chief Officer

Date: 25 May 2015

2.1.2.7. Modern Slavery Act

North Lincolnshire Commissioning Support Unit 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.

2.1.2.8. Accountable Officer's Statement

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 Liane Langdon to be the Accountable Officer of the 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, and subject to the disclosure set out below, 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.

Disclosure:

The CCG was unable to limit its use of financial resources in 2016/17 to the amount specified by NHS England for revenue expenditure as disclosed in Section 1.2.2. the Financial Performance section of this report. This failure to meet its “break – even” duty has been formally communicated to the Secretary of State for Health via a letter from the external auditors, as required by Section 30 of the Local Audit & Accountability Act 2014.

I also confirm that:

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

- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Liane Langdon
Accountable Officer
Date : 25 May 2017

2.1.3 Annual Governance Statement

Introduction and context

North Lincolnshire Clinical Commissioning Group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006. As at 1 April 2016, the North Lincolnshire CCG was licensed without conditions.

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 health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such an extent as it considers necessary to meet the reasonable requirements of its local population.

North Lincolnshire CCG comprises 19 practices covering a population of about 172,373 (February 2017). It is served by one main acute provider, including Community Services (Northern Lincolnshire and Goole Foundation Trust, NLAG), one specialist acute provider (Hull and East Yorkshire Trust, HEYHT) and one Mental Health provider (Rotherham, Doncaster and South Humber Foundation Trust, RDaSH).

North Lincolnshire CCG is largely coterminous with the Local Authority (North Lincolnshire Council). For 2016/17 it had a total budget of £224.413 million.

North Lincolnshire CCG area is geographically large, with more than half of its population living in rural areas. This creates distinct neighbourhoods and localities, each with their own unique characteristics and sense of identity, with different population profiles and needs. For example, the Scunthorpe North locality comprises mainly younger citizens, high levels of rented accommodation, with higher levels of Black and Minority Ethnic (BME) residents than elsewhere in the CCG area. Whereas the Axholme locality comprises higher number of more affluent, older people, living in private accommodation, with a higher incidence of long term conditions associated with the older population.

Scope of responsibility

As Accounting 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 in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Governance Arrangements and Effectiveness

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states: The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

<u>The Governance Framework</u>

North Lincolnshire CCG has a constitution that has been agreed by the Council of Members and sets out the responsibilities and arrangements in place to commission services for the residents of North Lincolnshire. The Constitution includes the Scheme of Delegation and Reservation, Authority to Act, Standing Orders and prime financial policies. It identifies the governing principles, rules and procedures to ensure accountability and probity for the running of the CCG ensuring that decisions are taken in a transparent and open manner promoting the best interests for the people for whom we commission services.

The North Lincolnshire CCG Constitution includes:

- Its membership.
- The geographical area it covers.
- The arrangements for the discharge of our functions and those of our Governing Body.
- The procedures we will follow in making decisions and securing transparency in Decision making.

- Arrangements for discharging our duties in relation to Registers of Interests and Managing Conflicts of Interests.

Governing Body and Committee Structure

The Governance structure of North Lincolnshire CCG is headed up by the Governing Body. The Governing Body has its functions identified as set out in the Constitution which has been agreed by member practices.

During 2016-17 The Governing Body met 12 times and was quorate at each meeting. Attendance figures are attached at the **Appendix 1.**

During 2016/17 the CCG priorities for organisational development were informed by the feedback received through the 360 degree Stakeholder survey. A range of stakeholders are asked to participate and provide feedback to the CCG which is undertaken as part of the CCG Assurance Framework. Stakeholders include CCG Member Practices via Council of Member representatives, Local Authority partners including Health and Wellbeing Board Chair, and NHS providers. The feedback received showed improvement in most areas, but also Member Practices identified a number of areas for further improvement including system leadership and visibility of leadership. The results will be reviewed at a future Board meeting.

Work that helped promote Governing Body assurance and effectiveness included:

- Full and active participation in the Health and Wellbeing Board and its Supporting working groups.
- Review at each meeting of the Board Assurance Framework
- Full and active participation in the Humber, Coast &Vale STP
- Participation in the CCG Improvement and Assessment Framework review for NHS England
- Review of compliance with National Conflict of Interest guidance

To support the Governing Body five strategic groups have been established as set out below:

The Audit Group

Chaired by the Lay Member for Governance, the Audit Group has met 5 times during the year and was quorate at each meeting. It has delegated responsibility for oversight of risk management and internal control, internal audit, external audit, reviewing the findings of other significant assurance functions, counter fraud and financial reporting.

Highlights of its work include:

- Jointly with the Governing Body, the review of draft accounts for 2016/17 and approval of audited accounts before submission as well as preparedness for 16/17 accounts.
- Tackling compliance issues e.g. taxation, legal and constitutional (e.g. waivers) issues and gaining relevant assurances.
- IG toolkit and reporting of reporting information risks and incidents, maintaining the Information Asset Risk Register and Information Asset Owners & Controllers List and receiving positive assurance from the Information Governance Group.
- Review of CHC retrospective claims.
- Working with Internal Audit and the development of assurance mapping to record internal, semi-independent assurance to the CCG linking with the Board Assurance Framework.

The Engine Room

This Group has met 22 times during the year and has been quorate at each meeting. The Engine Room is chaired by the CCG Chair with delegated authority from the Council of Members. Its remit is to support clinical leadership working with managers for the mobilisation of service changes in-year, promote working with the Council of Members and act as a forum for discussion and agreement on clinical, financial and operational matters including commissioning principles and issues.

Highlights of its work include:

- Setting the strategic direction – Humber Coast & Vale STP
- Continuing development of the 2016/17 Operational Plan
- Support of the Care Home Action Team Service
- Overseeing and supporting development of clinical networks
- Overview and selection of clinical pathway redesign and management of QIPP
- Overseeing contracting and delivery of operations and strategy

- Invitation of a range of speakers to inform and provide information on specific work areas including the consideration of service offers
- Holds eMBED and other relevant organisations to account for operational, financial and performance issues.

The Quality Group

The Quality Group is chaired by the CCG's Director of Nursing and Quality. The Lay Member with the lead for quality and patient involvement is Vice Chair. This Group has met 9 times during the year and all meetings were quorate. The remit of the quality group is to monitor and review the quality and safety of the services commissioned by the CCG and promotes a culture of continuous improvement and innovation. Its main aims are:

- The safety of treatment and of care received by patients
- The effectiveness of treatment and care received by patients
- The experience patients and their carers' have of treatment and care received

Highlights of the work undertaken by the group:

- A commissioned review of mental health services at RDaSH
- The group undertook a range visit to providers including:
- Maternity
- Mixed Sex Accommodation (NLaG)
- Nutrition and Hydration (NLaG)
- Learning Disability (RDaSH)
- The development of a quality dashboard to ensure the Quality Group and Governing Body are clearly and accurately informed about the quality patient safety issues within each provider and data is appropriately analysed and considered.
- Develop and regularly review locally agreed quality indicators and metrics including QIPP, Quality impact assessments and commissioning for quality and local Innovation [CQUINS] for NLaG and RDaSH.
- A programme of focussed visits to address concerns or gaps in assurance to provide contextual information that is triangulated with other assurance data including care homes and primary care.
- Monitoring and review of primary care prescribing data and medicines management quality improvement programme.

- The support and implementation of revalidation for nurses.
- Ensuring that the CCG discharges its statutory responsibilities appropriately with regard to safeguarding children and adults through a variety of areas such as child sexual exploitation, PREVENT and female genital mutilation.
- Assessment and support of clinical effectiveness and patient experience of commissioned services.
- Providing the CCG with valuable soft intelligence across the local community.
- An Infection, Prevention and Control Audit Programme for all North Lincolnshire GP practices and 11 local care homes
- Worked with the Good Governance Institute to produce an integrated
- governance reporting framework across the local health economy.
- Develop a Primary Care Dashboard to consolidate monitoring data and enhance assurances in Primary Care
- Review of the Continuing Health Care Team with a production of KPI's to improve service delivery
- Collaborated with North East Lincolnshire CCG in the development of provider profiles for NLaG, HEY and EMAS to support the escalation of issues to the regional quality surveillance group

Joint Commissioning Group

This is a joint committee with NHS England with the principle purpose of jointly commissioning primary medical services for the people of North Lincolnshire. It is chaired by a CCG Lay member and has met 6 times with each meeting being quorate.

Highlights of work undertaken by the group:

- Review of elderly care fund and delivery
- Participation in the first wave of the National Diabetes Prevention programme
- Reviewing planned referrals to secondary care and arrangements for the management of practice prescribing budgets
- Review and approval of Primary Care strategy
- Review and approval of practice mergers, closure of lists and the Primary Care Transformation Fund bids.

The Remuneration Committee

The Remuneration Committee is chaired by the Lay Member for Patient and Public Involvement. The Group has delegated responsibility from the Governing Body for advising it on all aspects of salary not covered by Agenda for Change, arrangements for the termination of employment, monitoring and evaluating the performance of Governing Body members and approving human resources policies and procedures.

The Remuneration Committee met 3 times during the year and was quorate at each meeting.

Highlights of its work/performance include:

- Review of remuneration for GP members of the Governing Body and clinical leads

UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However we have used the principles of the Corporate Governance Code as a guide, including those aspects of the Code we consider relevant to the CCG and best practice. Using the principles of the UK Corporate Code to support best practice the CCG has:

- Reviewed declarations of interest and CCG compliance with statutory requirements
- Participated in a 360 degree stakeholder review against a range of performance criteria
- Undertaken an assurance mapping exercise against a range of CCG functions
- Reviewed counter fraud and security arrangements
- Considered the Boards Assurance Framework at all public meetings of the Governing Body
- Review of VSM roles, responsibilities, remuneration and performance
- Review of Governing Body appointments and clinical leads

Discharge of Statutory Functions

Following establishment, the arrangements put in place by the CCG (and explained within the Corporate Governance Framework) and developed with extensive expert external legal input, have been reviewed to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

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

This has enabled the CCG to discharge all its statutory functions to a satisfactory level, with the exception of not being able to ensure that its use of revenue resources in 2016/17 was limited to the amount specified by NHS England.

Risk management arrangements and effectiveness

As outlined in its Risk Management Strategy, North Lincolnshire CCG has adopted a risk management process where logical steps are taken to manage risks effectively. Following on from setting priorities, potential risks or opportunities are then identified and evaluated before a course of action is determined to address the identified risks. As few risks remain static and new issues are likely to emerge, it is essential that all risks captured are routinely monitored.

Finally, reporting of risk issues and in particular reporting and reflecting on any adverse events that do occur is essential to ensure that the CCG continuously improves its risk management activities. Risk Management is embedded within the activities of North Lincolnshire CCG through the risk process. The assurance framework is reviewed by the Executive Team which ensures that the process is kept live and relevant. Members of staff are able to report any concerns through an electronic desk top incident reporting process, which is actively encouraged and each incident is reviewed and investigated as applicable.

North Lincolnshire CCG is committed to eliminating any form of discrimination and aims to commission services that are accessible, delivered in a way that respects the needs of each individual whilst being inclusive to everyone.

All new policies, projects or functions have an equality impact assessment conducted on them. The CCG has a tool and guidance for use by staff to help identify the likely impact. Specific training has been provided to CCG members and staff.

North Lincolnshire CCG actively engages with public stakeholders for example:

- Partnership working with the Local Authority through the Health and Wellbeing Board
- A Risk Register has been held for the Better Care Fund, which is reviewed at least monthly
- Council of Members which is made up of a healthcare representative from each CCG member practice. The Council of Members participate and are engaged in the development of North Lincolnshire CCG Strategy and plans
- Governing Body meetings are held in public allowing a transparent and public decision making process

Capacity to Handle Risk

The Risk Management Strategy, updated in January 2017, 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 organisation is an on-going process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of North Lincolnshire CCG
- Evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically.

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

North Lincolnshire CCG implements anti-fraud prevention measures and counter fraud risks in compliance with NHS Protect Standards on countering fraud, bribery and corruption. To ensure compliance with the Standards the CCG contracts with an external provider the East Coast Audit Consortium who supply Local Counter Fraud Specialist (LCFS) services to the organisation via an annual fraud plan. The Fraud Plan includes initiatives to promote fraud awareness, deterrence and prevention and also to investigate suspected cases of fraud, and if, required apply a range of potential sanctions including criminal, civil and disciplinary measures. Progress against the Internal Audit Plan is monitored at each meeting of the Audit Group. The Local Counter Fraud Specialist is directly responsible to the Chief Financial Officer and all fraud work is reported to the CCG Audit Group.

The CCG's policies have been updated to reflect counter fraud policy and the 2010 Bribery Act as standard.

The key elements of the Risk Management Strategy are:

- To support the Governing Body in carrying out its duties effectively. The Quality Group provides assurance (and Audit Group independent assurance) that the risk register and assurance framework are regularly reviewed and updated and that corresponding robust and adequately progressed risk treatment plans exist. Internal Auditors have facilitated a review in year of key strategic risks for the Board/Assurance Framework
- The Chief Officer has overall accountability for ensuring there is a sound system in place for the management of risk and is responsible for ensuring systems and processes are implemented to comply with the strategy.

New risks identified for inclusion on the risk register and assurance framework are assessed for likelihood and consequence using a 5 x 5 risk matrix in accordance with the risk management strategy. The Assurance Framework identifies the risks to the delivery of the organisations strategic objectives whilst the Risk Register focuses on operational risks.

If the assessment of the risk is higher than the risk appetite, further action will be taken to reduce the likelihood and/or impact of the risk occurring.

Risks to data security are managed through a suite of information governance policies and all qualifying CCG staff have undertaken the Connecting for Health Information Governance training. Any data security incidents are reported through the CCGs incident reporting system and notified to the Information Governance Manager for investigation.

Risk Assessment

The CCG recognises the need for a robust focus on the identification and management of risks and therefore places risk within an integral part of our overall approach to governance. Consequently risk management is an explicit process in every activity the CCG and its' staff take part in.

The CCG has a robust process for identification and mitigation of risks and where there have been serious incidents, responding to them quickly and ensuring that lessons learnt from them are implemented swiftly across the CCG.

The Risk Management Strategy reflects the risk management processes within the CCG and its responsibilities for management of risks. Those risks which were deemed to be a strategic risk have been allocated to the assurance framework and risk owners asked to identify assurances on control; positive assurances; gaps in control and gaps in assurance. The operational risks remain on the corporate register or directorate risk registers.

The Assurance Framework has been developed throughout the year and provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives. It maps out the key controls to mitigate the risks and provide a mechanism to inform the Governing Body of the assurances received about the effectiveness of these controls. It is a dynamic tool and is reviewed at all public meetings of the Governing Body and monthly by the Quality Group. The Audit Group provides independent assurance. The assurance framework provides an effective focus on strategic and reputational risk rather than operational issues, and highlights any gaps in control and assurances. It provides the Governing Body with confidence that systems and processes are in place and that it operates in a way that is safe and effective.

The Key risks on the assurance framework as of the end of March 2017 are highlighted below:

Risk Description	Current Risk Rating
Breakdown in productive relationship with key partners would compromise the delivery of all CCG objectives	12
If the CCG fails to deliver an agreed budget there will be no resources to support investment and the CCG could lose ability to self- direct from NHS England (direct intervention)	20
Lack of accurate data on out of hospital mortality may result in areas of high risk not being identified or addressed	12
Inability to recruit sufficient GPs and nurses could lead to difficulty maintaining current level of service and quality outcomes for patients	20
The Medicines Management programme will not deliver planned QIPP savings for 2016/17	20
If ACP is not effectively established there will be a failure to make quality improvements, maximise financial benefits and move services into the community ultimately leading to a failure in our 'place' response to HLHF	15
Risk to CCG regarding delayed delivery of retrospective claims	6
Failure to complete Decision Support Tools (DST) within national timescales could result in reputational damage to the CCG and people not being in respect of relevant/appropriate funding for their care	15
Failure to adhere to national guidelines (re prompt assessments for DSTs) will result in additional unnecessary care for individuals and unnecessary expenditure for the CCG	20

Each risk is owned by a lead director and is reviewed and updated on a regular basis as required. The Quality Group review the corporate risk register and assurance framework. The Governing Body review the assurance framework bi- monthly. The Audit Group review the assurance framework at every meeting and provides independent assurance to the Governing Body. This gives significant assurance that systems are in place and that there is a clear audit trail. The CCG recognises that it remains on a journey of improvement and intends to review, improve and strengthen its approach with a range of improvements next year. This work will include;

- More emphasis on pro-active approach to risk identification
- Conducting a further risk maturity review to promote embedding risk management in CCG activities and as a key tool in the strategic leadership of the CCG
- A review of the Risk Registers and Assurance Framework to determine its most effective structure to capture risks and involve all CCG staff

- Provision of more links to strategic risks that identify full range of mitigating actions being taken by the CCG
- A stronger focus on partnership risks and in relation to procurement and project initiatives

Other sources of assurance

Internal Control Framework

A system of internal control consists of a set of processes and procedures 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 Assurance Framework is reviewed regularly by the Governing Body, the Audit Group and Quality Group to ensure that risks have been identified and appropriate mitigating actions are in place. The corporate risk register is reviewed by the Quality Group.

Annual Audit of Conflicts of Interest Management

The CCG has carried out an annual audit of conflicts of interest and has received significant assurance. The audit report made a recommendation to include some additional detail in the register of interests and register of gifts and hospitality and these points have been addressed.

The CCG has undertaken in-house training and awareness-raising for staff and submitted positive quarterly and annual return to NHS England regarding compliance with national requirements.

Data Quality

Data was collated and managed by eMBED on behalf of North Lincolnshire CCG. Data is presented to the Governing Body its sub committees and Council of Members, it is sourced from national systems and local data sources. Where possible the data is triangulated from national systems and alternative sources to ensure accuracy. eMBED had in place internal procedures and controls in order to ensure data presented was of the best quality possible. Any data issues noted in source data is reviewed and identified with the source provider. Should data issues arise resulting from internal processes, a route cause analysis is undertaken, corrective actions put in place and on-going learning identified.

The Joint Commissioning Group reviewed the range and quality of data regarding primary care and identified further improvements. The CCG Board received regular quality and corporate performance reports during the year. Reports were refined following feedback.

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.

Data security risks are addressed through mapping all information assets for the CCG, identifying data owners and risk assessing all data flows in and out including security during transfers and at rest. The IT environment has also been risk assessed to ensure that adequate security for information on the networks is in place.

North Lincolnshire CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have an information governance management framework that the CCG applies to the management of all information assets. The framework includes an Information Governance Group which is a sub group of the Quality Group. The CCG continued to develop information governance processes and procedures in line with the Information Governance toolkit and Senior Information Risk Officer (SIRO) guidance and ensuring it is embedded amongst CCG staff.

The CCG has ensured all qualifying staff undertake annual information governance training and have implemented a number of measures to ensure all staff members are aware of their information governance roles and responsibilities.

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

Processes implemented allow the CCG to for fill its requirements under the Freedom of Information Act and Data Protection Act relating to the protection, use and processing of subject access requests.

The CCG has an incident reporting system for all staff and GPs that encompasses information governance incidents allowing staff a single point of reporting. The development of policies and the framework has allowed us to achieve a level two compliance with all the relevant information governance toolkit standards.

The CCG has included information risk within the CCG's Risk Management Policy and have processes in place to identify information Asset Owners and Controllers. We have processes where the Information Asset Owners assess risks to assets in their areas and report to the SIRO annually.

The CCG uses an IG dashboard to summarise its performance. The dashboard summarises performance against mandatory information governance requirements. It is reviewed on a quarterly basis by the CCG Quality Group.

The CCG continues to develop and enhance information risk assessment and management procedures as part of overall risk management and on-going work is undertaken to fully embed an information risk culture throughout the organisation.

The CCG has submitted a satisfactory level of compliance with the Information Governance toolkit assessment following completion of actions from the internal audit report. Further work required is highlighted in the Audit Group/Information Governance section of this statement. North Lincolnshire CCG had no lapses of data security during 2016/17.

Business Critical Models

The CCG recognises the principles as reflected in the Macpherson report as a direction of travel for business modelling in respect of service analysis, planning and delivery.

Key business critical models have been identified however further work is planned during 2017/18 to provide additional details of why these areas are business critical, associated key risks and to further develop the quality assurance process. 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.

Current quality assurance systems are in place to manage our business risks including:

- Business Intelligence reporting / financial reporting
- Customer feedback (e.g. Patient Complaints)
- Risk Assessment (including risk registers and an assurance framework)
- Internal and External Audit
- Executive Leads with clear work portfolios
- Programme Management Office
- Public and Patient Involvement and Engagement
- Third Party Assurance mechanisms (Service Auditor reports / NHS England – EPRR / Business Continuity etc.)

The CCG can confirm that these quality assurance processes are used across our business critical areas as appropriate.

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

The Head of Internal Audit opinion provided includes opinion on the Assurance Framework, and the risk based audit assignments across the critical business systems to inform the Annual Governance Statement.

The CCG has also conducted an assurance mapping exercise to identify the CCG's assurance landscape and this continues to be further developed as systems, processes and partner relationships continue to evolve and embed.

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

Third Party Assurances

In developing the CCG Assurance Map and review of sources of assurance, the CCG has considered services provided by Service Organisations and the assurance required as received by or via Service Auditor reports. To date reliance has been placed on the assurance reports received from: NHS Business Services Agency for Prescription Payments, from NHS SBS for Financial Accounting and Procurement Services, from NHS Digital for their Information services, NHS Electronic Staff Records for the ESR system and from Northumbria Healthcare NHS Foundation Trust for Payroll Services.

eMBED also provide a range of services including IMT, transactional Financial Services, and Human Resources for the CCG. Regular review meetings monitor performance against agreed targets. The CCG also received an annual assurance report 2016/17 detailing the level of financial control operating within eMBED for the CCG, which together with the CCG's internal controls, provide satisfactory assurance on the adequacy of the controls in place for 2016/17. The Audit Group will review the robustness of the contract monitoring and performance reviews during 2017/18.

For the final version of this AGS the CCG is also expecting to receive the service auditor report from NECS for IFR NCA DSCRO Services plus Medicines Optimisation.

The CCG has developed an Assurance Map which is monitored by the Audit Committee. The Assurance Map includes the identification of issues or concerns relating to third party service providers enabling the CCG to take actions as appropriate.

Control Issues

The CCG informed NHS England during the first quarter of 2016/17 that it is unable to meet its statutory financial duties in 2016/17, and specifically – it would not be able to deliver its target Surplus of £2.2 Million.

As a result the CCG has also informed the CCG's external Auditors of this fact, and is expecting its External Audit opinion to reflect the auditor's requirement to report to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014.

This Audit duty principally relates to the requirement under the Act to notify the Secretary of State of 'unlawful' expenditure. In this context significant spending above the control total is considered to be unlawful.

Therefore, within this context the CCG is not expecting any change to its reported accounts and is working with NHS England and their appointed advisors to strengthen the CCG's focus on financial issues (e.g. through the establishment of an independent Finance Committee to support the Governing Body with the management of finance issues) and ability to return to recurrent financial balance.

As a result of not meeting its statutory financial duty to ensure that its revenue resource use in any financial year does not exceed the amount specified by NHS England (NHS Act 2006 as amended by paragraph 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012), by £4.098m in 20126/17, the CCG was unable to submit an initial balanced Financial Plan for 2017/18 to NHS England and sought to return to financial balance over a two year period.

For the subsequent Plan submission the CCG drew upon the assistance of a number of national teams (including Right Care and the National QIPP programme), and a result of independent input from these teams, and further work undertaken with the CCG's main service provider the CCG has now identified the appropriate savings to set a balanced Budget for 2017/18. The CCG was also able to address specific weaknesses in systems in-year, especially in relation to QIPP Governance, Provider Contract management, and Continuing Healthcare.

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

The Governing Body has overarching responsibility for ensuring that North Lincolnshire CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Groups principles of good governance (its main function). The CCG's Constitution allows for the delegation of responsibility to ensure appropriate arrangements are in place for the CCG to fulfil this duty to the Audit Group and requires that it undertakes functions as set out in its Terms of Reference as agreed by the Governing Body. The Audit Group receives regular reports on financial governance and reviews the Annual Accounts, Annual Governance Statement and Head of Internal Audit Opinion. The Governing Body receives a Finance Report from the Chief Finance Officer and Business Support at every meeting, where open challenge takes place.

The Chief Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the group and for ensuring financial control and accounting systems are in place. The role of Chief Finance Officer includes:

- Being the Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
- Making appropriate arrangements to support and monitor the CCG's finances;

- Overseeing robust audit and governance arrangements leading to propriety in the use of the CCG's resources;
- Being able to advise the Governing Body on the effective, efficient and economic use of the CCG's allocation to remain within that allocation and deliver required financial targets and duties; and
- Producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England;
- Being the Governing Body lead officer for Business Intelligence.

In terms of annual accounts, for 2016/17 a clear process was identified which followed the Manual for Accounts 2016/17 guidance and largely mirrored or strengthened arrangements, which ensured that CCG accounts were effectively closed down and accounts produced. Accounts scrutiny and sign-off is via the Audit Group in April for the draft accounts and May for the audited accounts.
It is important to note however, that as a result of the CCG's inability to deliver its target financial surplus in 2016/17, External Audit are expected to modify their audit opinion for Use of resources/VFM to reflect a qualified VFM conclusion

Delegation of Functions

The CCG's Accountable Officer (AO) delegate's responsibilities to support compliance with the standards set out in annex 3.1 of 'Managing Public Money' (July 2013 annexes revised July 2015). The annex identifies feedback from delegation chains as a key input to the governance statement. The CCG systems enables the AO to work with staff to make informed decisions about planned progress and take corrective action as appropriate. The CCG reviews a wide range of feedback from delegated functions including; assessing the use of resources, management of risks and budget management.

The CCG for example holds regular contract meetings, led by the CCG Chief Finance Officer with eMBED. These meetings are used to set and review performance indicators, assess information captured from internal audit or on-going risk evaluation and identify any issues/trends causing concern. An issue log identifies concerns and gives assurance that actions are being undertaken.

Feedback from the on-going assessment of delegated functions is acted upon as appropriate. For example, a risk relating to completion of Information Asset Flows (leading to a threat of the CCG not achieving level 2 with the IG toolkit) was identified through the IG sub Group and corrective action taken to ensure compliance.

Counter Fraud Arrangements

The Audit Group has assured itself that the organisation has adequate arrangements in place for countering fraud and regularly reviews the outcomes of counter fraud work. The CCG has an accredited Local Counter Fraud Specialist (LCFS) in place to undertake work against NHS Protect Standards; the LCFS resource is contracted in from East Coast Audit Consortium and is part of a wider Fraud Team resource with additional LCFS resource available as and when required. The Chief 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 Audit Group annually.

There is an approved and proportionate risk based counter-fraud plan in place which is monitored at each Audit Group meeting. In line with NHS Protect Commissioner Standards, which first became effective 1st April 2015 and are reviewed annually, the CCG completed an online Self Review Tool (SRT) quality assessment in March 2017 to assess the work completed around anti-fraud, bribery and corruption work and assessed itself as a 'Green' rating. This self-assessment (SRT) detailing our scoring was approved by Chief Finance Officer prior to submission. Should a NHS Protect quality assurance inspection be undertaken then any recommendations would be acted upon – to date the CCG has not been subject to an NHS Protect quality inspection.

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 system of risk management, governance and internal control. The Head of Internal Audit concluded that:

"My overall opinion is:

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

Notwithstanding this overall opinion (acknowledging its limited and risk-based scope), the CCG continues to face significant challenges, particularly in relation to the financial and provider environment, and which are the focus of external review and oversight mechanisms. As such, this Internal Audit opinion must be viewed in the context of this intervention activity.

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

- Financial Management (Significant Assurance)
- Incident Management (Significant Assurance)
- Conflicts of Interest (Significant Assurance)
- Medicines Management (Significant Assurance)
- Information Governance (Significant Assurance)

- Provider Contract Management (Limited Assurance) – Management actions with allocated leads have been identified and agreed. Implementation will be monitored via the CCG Audit Group during 2017/18.

- Continuing Healthcare (Limited Assurance) - Management actions with allocated leads have been identified and agreed. Implementation will be monitored via the CCG Audit Group during 2017/18.

Review of the effectiveness of Governance, Risk Management & Internal Control

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of 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 CCG who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed.

I have been advised on the implications of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Group and Quality Group, and where appropriate a plan is in place to address weaknesses and ensure continuous improvement of the system.

My review is also informed by:

- External Audit providing progress reports to the Audit Group, the Annual Audit Letter and Annual Governance Report within the CCG.
- Internal Audit review of systems of internal control and progress reports to the Audit Group, especially the Head of Internal Audit Opinion.
- Assurance reports on risk and governance received from the Audit Group.
- Performance management systems.
- Internal committee structure with delegated responsibility for risk identification, evaluation, control, review and assurance.

- Review of the Assurance Framework. Action plans to address any identified weaknesses and ensure continuous improvement of the system is in place via the Assurance Framework and also via action plans embedded within the Risk Register.
- The Corporate Risk Register
- Initial part in-year self-assessment of Audit Group effectiveness by questionnaire.

The following committees and officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2016/17 and have managed risks assigned to them.

Governing Body: Responsible for providing clear commitment and direction for Risk Management within the organisation. The Governing Body delegates responsibility for oversight and independent assurance on risk management to the Audit Group and delegates responsibility for operational and clinical risk management to the Quality Group.

Audit Group: Responsible for providing an independent assurance of the arrangements for risk management within the organisation, with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews Internal and External Audits, the Assurance Framework, financial governance reports and the Register of Interests.

Quality Group: As the Committee with overarching responsibility for risk management, it provides assurance to the Governing Body that appropriate clinical risk management arrangements are in place across the organisation. The Quality Group is underpinned by various sub groups covering areas including safeguarding, information governance, infection control, quality in contracts, incidents and medicines management.

Chief Officer: As Accountable Officer for the whole of the CCG, the Chief Officer is responsible for achieving the organisational objectives in the context of sound and appropriate business processes and reporting risks to the Governing Body.

Chief Finance Officer Business Support: As Senior Responsible Officer for NHS finances across the CCG, the Chief Finance Officer is responsible for ensuring that the organisation complies with the CCG's Constitution to achieve financial targets and reports financial risks to the Governing Body.

NHS England Area Team: We have quarterly Assurance Reviews with the local Area Team of NHS England. All reviews in 2016/17 have been positive, and have also served to strengthen the co-commissioning relationship with NHS England. The reviews have covered authorisation domains and the national CCG assurance framework.

Conclusion

The fourth year of establishment (2016/17) for North Lincolnshire CCG has proved rewarding and challenging. Good progress has been made in consolidating the governance arrangements through the course of the year. The CCG understands the platform from which it needs to meet the challenges of commissioning improved quality of care and health outcomes from finite resources.

Given the financial challenges which the CCG is set to face in 2017/18, the CCG has increased the rigour and robustness of its financial controls with:

- The establishment of a new independent Finance Committee, chaired by a lay member.
- The review of financial and contracting systems.
- The review and strengthening of key operational systems such as Continuing Health care

Through the course of the year no significant internal control issues have been identified other than the financial concern identified under Control Issues.

I look forward to our continued progress in 2017/18

Liane Langdon
Accountable Officer
May 2017

APPENDIX 1

NORTH LINCOLNSHIRE CCG MEETING ATTENDANCES 2016/17

1) Governing Body Meetings

Date of meetings	Dr Margaret Sanderson Chair	Liane Langdon Chief Officer	Catherine Wylie Dir of Nursing, Risk & Quality	Kieran Lappin - Interim Chief finance Officer	Ian Holborn - Chief Finance Officer	Dr Robert Jaggs Fowler GP Member	Dr Faisal Baig GP Member	Dr James Mbugua GP Member	Dr Andrew Lee GP Member	Dr Nick Stewart GP Member	Dr Satpal Shekhawat GP Member	Paul Evans, Lay Member, Governance	Ian Reekie, Lay Member, Joint Commissioning	Janice Keilthy, Lay Member, Patient & Public Involvement	Heather McSharry, Lay Member, Equality, Diversity & Inclusion	Dr Richard Shenderey, Secondary Care Doctor	Rose Dunlop Consultant in Public Health	Cheryl George, Consultant in Public Health	Christine Nield Consultant in Public Health	Adrian Smith Consultant I nPublic Health	Tim Allison Interim Director of Public Health
14.04.16	Yes	Yes	Yes	Yes	N/A	Yes	A	Yes	Yes	Yes	N/A	Yes	Yes	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
12.05.16	Yes	Yes	Yes	Yes	N/A	Yes	Yes	A	Yes	A	N/A	Yes	Yes	N/A	N/A	N/A	A	N/A	N/A	N/A	N/A
09.06.16	A	Yes	Yes	Yes	N/A	Yes	Yes	Yes	A	Yes	N/A	Yes	Yes	N/A	N/A	N/A	Yes	N/A	N/A	N/A	N/A
14.07.16	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	N/A	N/A	N/A	N/A	N/A	N/A	Yes	N/A
11.08.16	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	A	Yes	N/A	Yes	Yes	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A
08.09.16	Yes	Yes	Yes	N/A	Yes	A	Yes	Yes	Yes	Yes	N/A	Yes	Yes	N/A	N/A	N/A	N/A	Yes	N/A	N/A	N/A
13.10.16	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	A	N/A	Yes	Yes	Yes	Yes	N/A	N/A	N/A	N/A	Yes	N/A	N/A
10.11.16	Yes	Yes	A	N/A	Yes	Yes	Yes	Yes	Yes	N/A	Yes	A	Yes	Yes	Yes	Yes	N/A	N/A	Yes	N/A	N/A
08.12.16	Yes	Yes	Yes	N/A	Yes	A	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes	Yes	N/A	N/A	Yes	N/A	N/A
12.01.17	Yes	Yes	Yes	N/A	Yes	A	Yes	Yes	Yes	N/A	Yes	A	Yes	A	Yes	Yes	N/A	N/A	Yes	N/A	N/A
09.02.17	A	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	A	Yes	Yes	N/A	N/A	A	N/A	N/A
09.03.17	Yes	Yes	Yes	N/A	Yes	A	Yes	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes	Yes	N/A	N/A	Yes	N/A	Yes
% Attended in Year	**83%**	**100%**	**92%**	**33%**	**67%**	**67%**	**92%**	**92%**	**75%**	**42%**	**50%**	**83%**	**100%**	**33%**	**42%**	**42%**	**17%**	**17%**	**42%**	**8%**	**8%**

NOTE In relation to attendance **N/A** stands for either no longer being part of the committee or joining the committee

A = Apologies

Yes = Attended

The percentages shown relate to the % of the total Meetings which exist in the year - not the proportion of meetings which the named individuals could have attended.

2) Joint Commissioning Committee

Date of Meetings	Paul Evans Lay Member Governance	Kieran Lappin - Interim Chief Finance Officer	Ian Holborn - Chief Finance Officer	Ian Reekie Lay Member (Joint Commissioining)	Dr Andrew Lee	Dr Margaret Sanderson Chair	Catherine Wylie Director of Risk and Quality Assurance/Nurse Member	Dr Robert Jaggs-Fowler Medical Director/Director of Primary Care	Liane Langdon Chief Officer	Janice Keilthy Lay member Patient and Public Involvement	Heather Marsh NHSE	Dr Wendy Barker NHSE	Helen Phillips NHSE	Overall % attended per meeting
12.05.16	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes	Yes	A	Yes	Yes	N/A	71%
14.07.16	Yes	Yes	N/A	Yes	Yes	Yes	Yes	Yes	Yes	A	Yes	A	N/A	64%
08.09.16	Yes	N/A	Yes	Yes	Yes	Yes	Yes	A	Yes	A	A	Yes	N/A	57%
20.10.16	A	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	A	Yes	N/A	64%
15.12.16	Yes	N/A	Yes	Yes	Yes	Yes	A	Yes	Yes	Yes	Yes	Yes	N/A	71%
16.02.17	Yes	N/A	Yes	Yes	Yes	Yes	A	Yes	A	A	A	A	Yes	50%
% Attended in Year	**83%**	**33%**	**67%**	**100%**	**100%**	**100%**	**67%**	**83%**	**83%**	**33%**	**50%**	**67%**	**17%**	

NOTE In relation to attendance **N/A** stands for either no longer being part of the committee or joining the committee

A = Apologies

Yes = Attended

The percentages shown relate to the % of the total Meetings which exist in the year - not the proportion of meetings which the named individuals could have attended.

3) Quality Group

Date of Meetings	Catherine Wylie Director of Quality and Risk (Chair)	Dr Robert Jaggs-Fowler Medical Director	John Pougher Head of Governance	Dr Anita Kapoor	Ian Reekie Lay Member fo Patient and Public Involvement (Vice Chair)	Dr Faisel Baig Clinical Lead for QIPP	Julie Wilburn Designated Professional Safeguarding Adults	Sarah Glossop Designated Nurse Safeguarding Children	Jane Ellerton Senior Manager Commissioning Support and Service Change	Overall % attended per meeting
03.05.16	Yes	Yes	A	Yes	Yes	A	A	Yes	A	50%
25.05.16	Yes	A	Yes	Yes	A	Yes	A	Yes	A	50%
22.06.16	Yes	Yes	A	Yes	Yes	A	Yes	Yes	A	70%
27.07.16	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	90%
24.08.16	Yes	Yes	Yes	A	Yes	Yes	A	Yes	A	60%
26.10.16	A	Yes	Yes	Yes	Yes	A	N/A	A	Yes	50%
23.11.16	Yes	Yes	A	Yes	A	Yes	N/A	Yes	A	50%
28.12.16	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	70%
22.03.17	Yes	A	Yes	Yes	A	Yes	N/A	Yes	A	50%
% Attended in Year	**89%**	**78%**	**67%**	**89%**	**67%**	**67%**	**22%**	**89%**	**33%**	

NOTE In relation to attendance **N/A** stands for either no longer being part of the committee or joining the committee

A = Apologies

Yes = Attended

The percentages shown relate to the % of the total Meetings which exist in the year - not the proportion of meetings which the named individuals could have attended.

4) Audit Committee

Date of Meetings	Paul Evans Lay Member	Ian Reekie Lay Member	Dr Satpal Shekhawat	Dr Toby Blumenthal	Janice Keilthy Lay Member	Dr Hardik Gandhi	Dr Sami Ahmed	Overall % attended per meeting
20.04.16	Yes	Yes	Yes	Yes	N/A	N/A	N/A	57%
25.05.16	Yes	A	Yes	Yes	N/A	N/A	N/A	43%
20.07.16	Yes	Yes	N/A	Yes	N/A	N/A	N/A	43%
16.11.16	Yes	N/A	N/A	Yes	Yes	N/A	N/A	43%
22.02.17	Yes	N/A	N/A	Yes	A	Yes	A	43%
% Attended in Year	**100%**	**33%**	**33%**	**100%**	**17%**	**17%**	**0%**	

5) Remuneration Committee

Date of Meetings	Paul Evans Lay Member	Ian Reekie Lay Member	Dr James Mbugua	Dr Nick Stewart	Dr Satpal Shekhawat	Overall % attended per meeting
28.04.16	Yes	Yes	Yes	Yes	N/A	80%
27.10.16	Yes	Yes	Yes	N/A	A	60%
% Attended in Year	**100%**	**100%**	**100%**	**50%**	**0%**	

NOTE In relation to attendance **N/A** stands for either no longer being part of the committee or joining the committee

A = Apologies

Yes = Attended

The percentages shown relate to the % of the total Meetings which exist in the year - not the proportion of meetings which the named individuals could have attended.

6) Council of Members

Practice	28.04.16	26.05.16	23.06.16	28.07.17	25.08.16	22.09.16	27.10.16	24.11.16	26.01.17	23.02.17	23.03.17
Ancora	Dr J	Dr J	Dr J	Dr J	A	Dr J	A	Dr J	Dr J	Dr J	Dr J
Ashby Turn	Dr N	Dr N	Dr N	A	A	Dr N	KT	Dr N	Dr N	Dr N	Dr N
Barnetby	Dr A	Dr A	Dr A	Dr A	A	Dr A	A	Dr A	Dr A	Dr A	Dr A
Bridge St	A	A	Dr C	Dr W	A	Dr W	Dr W	Dr W	A	A	Dr W
Cambridge Ave	Dr T	Dr E	Dr E	A	Dr T	Dr E	Dr E	Dr E	As	Dr T	Dr T
Cedars	Dr G	Dr G	Dr G	Dr G	Dr G	Dr G	Dr G	Dr G	Dr G	Dr G	Dr G
Central	Dr B	Dr B	Dr B	A	A	Dr B	Dr B	Dr B	Dr B	A	Dr B
Church Lane	Dr S	Dr S	A	Dr S	Dr S	A	Dr H	Dr H	Dr H	Dr T	A
Market Hill	A	A	A	Dr D	Dr N	Dr N	Dr N	Dr N	A	Dr N	NG
Oswald Rd	Dr K-G	Dr K-G	Dr K-G	A	Dr K-G	A	Dr K-G	Dr K-G	Dr K-G	Dr K-G	Dr K-G
Riverside	Dr P	A	A	Dr P	Dr M	Dr M	Dr M	Dr M	Dr M	Dr M	Dr M
South Axholme	Dr G	Dr G	Dr G	Dr A	A	A	Dr A	Dr A	Dr A	Dr A	Dr A
Sth Killingholme	AE	AE	AE	AE	AE	AE	AE	AE	AE	AE	AE
The Birches	Dr G	Dr G	Dr G	Dr A	A	A	DR A	Dr A	Dr A	Dr A	Dr A
Traingate Kirton	Dr S	Dr S	Dr S	A	Dr S	Dr S	A	Dr S	Dr S	Dr S	A
Trent View	Dr O	Dr O	Dr O	Dr O	Dr O	Dr O	Dr O	Dr O	A	Dr O	Dr F
WCL	Dr L	A	Dr L	Dr L	Dr L	Dr L	Dr L	Dr L	Dr L	A	Dr L
West Town	Dr K	Dr K	A	Dr K	A	Dr K	A	Dr K	Dr K	Dr K	Dr K
Winterton	Dr S	Dr S	Dr S	Dr S	Dr S	Dr S	Dr S	Dr S	Dr S	A	Dr S

NOTE In relation to attendance **N/A** stands for either no longer being part of the committee or joining the committee

A = Apologies

Yes = Attended

The percentages shown relate to the % of the total Meetings which exist in the year - not the proportion of meetings which the named individuals could have attended.

2.1.4 Managing Public Money

The Accountable Officer & Governing body has:

- Reviewed its own processes and practices, informed by the views of its audit committee on the organisation's assurance arrangements;
- Received and acted upon insight into the organisation's performance from internal audit, including an audit opinion on the quality of the systems of governance, management and risk control;
- Obtained feedback from stakeholder organisations about its business, its use of resources, its responses to risks, the extent to which in year budgets and other targets have been met, and other internal accountability mechanisms; including:

    - bottom-up information and assessments to generate a full appreciation of performance and risks as they are perceived from within the organisation;

    - end-to-end assessments of processes, since it is possible to neglect interdependent and compounded risks if only the components are considered;

    - high level overview of the organisation's business so that systemic risks can be considered in the round.

2.2 Remuneration and Staff Report

2.2.1. Remuneration Committee Report (Not Subject to Audit)

The Remuneration Committee is responsible for approving the remuneration and contractual arrangements of the clinical commissioning group's executives. It has delegated responsibility from the Governing Body for advising it on all aspects of salary not covered by Agenda for Change, arrangements for the termination of employment, monitoring and evaluating the performance of Governing Body members and approving human resources policies and procedures.

2.2.2. Remuneration Committee Membership & Attendance (Not Subject to Audit)

For details of membership & attendance please see Appendix 1 of the Annual Governance statement, which can be found at section 2.1.3. of this report.

2.2.3. The Remuneration of Senior & Very Senior Managers (Not Subject To Audit)

The CCG does not have a local remuneration policy or performance related pay framework for Very Senior Managers, and instead normally follows national guidance with no variation for the pay of Very Senior and Senior Managers.

Senior Manager pay is normally set strictly in line with national Agenda for Change (AfC) agreements, which are announced each year. The CCG also follows national guidance in relation to the remuneration of its Very Senior Managers (VSMs), by using the Remuneration Committee, made up of lay members and two GPs, to determine the appropriate remuneration for VSMs, including any reference to performance targets.

The Remuneration Committee invariably makes reference to, and links, the annual VSM pay award to the average pay award made for Senior Managers under Agenda for Change terms and conditions.

For the second year running, the national Agenda for Change pay award agreement set a differential pay award for staff – depending on their scale point. In brief, this meant that all CCG staff below AfC Band 8C were awarded a 1% consolidated (i.e. pensionable) pay award, and those staff paid in accordance with AfC Band 8C and above were awarded nothing.

Therefore, for 2016/17 the Remuneration Committee resolved in the interests of equity and fairness, to award all staff, regardless of grade, a 1% consolidated pay award, if not already awarded this increase automatically through AfC

It is expected that the Remuneration Committee will revert to "normal" practice in determining 2017/18 practices in terms of agreeing staff salary increases, in the light of the employers Agenda for Change agreement for 2017/18 pay wards.

2.2.4. Salaries and Allowances (Subject To Audit)

Details of Salaries and Allowances are shown in Table 1 over leaf.

Table 1a) contains details the details for 2016/17 with comparative figures for 2015/16 shown in Table 1b.

TABLE 1A) SALARIES & ALLOWANCES 2016/17

Name	Title	Period In Office	Salary & Fees (bands of £5000)	Taxable Expense payments (Rounded to the nearest £00)	Performance pay and bonuses (bands of £5000)	Long-term Performance pay and bonuses (bands of £5000)	All Pension Related Benefits (bands of £2500)	Total (bands of £5000)
			£000's	£00's	£000's	£000's	£000's	£000's
Dr Margaret Sanderson	Chair	1 April 2016- 31 March 2017	75-80	0	0	0	0	75-80
Dr Faisel Baig	CCG GP Member	1 April 2016- 31 March 2017	45-50	0	0	0	7.5-10	55-60
Dr Robert Jaggs-Fowler *	Director of Primary Care	1 April 2016- 31 March 2017	140-145	0	0	0	0	140-145
Dr Andrew Lee	CCG GP Member	1 April 2016- 31 March 2017	40-45	0	0	0	0	40-45
Dr James Mbugua	CCG GP Member	1 April 2016- 31 March 2017	30-35	0	0	0	5-7.5	35-40
Dr Nicholas Stewart	CCG GP Member	1 April 2016- 1 Oct 2016	15-20	0	0	0	0	15-20
Dr Satpal Shekawat	CCG GP Member	1 Oct 2016- 31 March 2017	15-20	0	0	0	42.5-45	55-60
Paul Evans	Lay Member NLCCG	1 April 2016- 31 March 2017	5-10	0	0	0	0	5-10
Ian Reekie	Lay Member NLCCG	1 April 2016- 31 March 2017	5-10	0	0	0	0	5-10
Janice Keilthy	Lay Member NLCCG	1 Oct 2016- 31 March 2017	0-5	0	0	0	0-2.5	0-5
Heather McSharry	Lay Member NLCCG	1 Nov 2016 - 31 March 2017	0-5	0	0	0	0-2.5	0-5
Professor John Mayberry	Secondary Care Consultant	1 April 2016- 10 June 2016	0-5	0	0	0	0	0-5
Dr Richard Shenderey**	Secondary Care Consultant	1 Oct 2016- 31 March 2017	0	0	0	0	0	0
Liane Langdon	Chief Officer	1 April 2016- 31 March 2017	105-110	0	0	0	127.5-130	230-235
Ian Holborn	Chief Finance Officer	1 July 2016 - 31 March 2017	70-75	0	0	0	10-15	80-85
Kieran Lappin ***	Interim Chief Finance Officer & Business Support	1 April 2016 - 11 July 2016	0	0	0	0	0	0
Catherine Wylie	Director of Nursing and Quality	1 April 2016- 31 March 2017	80-85	0	0	0	65-67.5	145-150
Caroline Briggs ****	Director of Commissioning	1 April 2016 - 30 June 2016	80-85	0	0	0	0	80-85
Richard Young ***	Interim Director of Commissioning	4 June 2016 - 31 March 2017	0	0	0	0	0	0

*	Dr Robert Jaggs-Fowler's salary covers both his clinical and non clinical roles (i.e. across his roles as GP Governing Body member/Safeguarding GP and Medical Director)
**	Dr Richard Shenderey is remunerated via Airedale NHS Foundation Trust
***	Kieran Lappin and Richard Young aare remunerated via an off-payroll engagement which is disclosed elsewhere in this report.
****	Caroline Briggs salary reflects her full salary for the year 16-17, although she was only in post as a Director for 3 months)
	Comparative audited figures for 2015-16 are shown in the next Table.

TABLE 1B) SALARIES & ALLOWANCES 2015/16

Name	Title	Period In Office	Salary & Fees (bands of £5000)	Taxable Expense payments (Rounded to the nearest £00)	Performance pay and bonuses (bands of £5000)	Long-term Performance pay and bonuses (bands of £5000)	All Pension Related Benefits (bands of £2500)	Total (bands of £5000)
			£000's	£00's	£000's	£000's	£000's	£000's
Dr Margaret Sanderson	Chair	1 April 2015- 31 March 2016	75-80	0	0	0	17.5-20	90-95
Dr Faisel Baig	CCG GP Member	1 April 2015- 31 March 2016	45-50	0	0	0	157.5-160	205-210
Dr Robert Jaggs-Fowler *	Director of Primary Care	1 April 2015- 31 March 2016	100-105	0	0	0	0	100-105
Dr Andrew Lee	CCG GP Member	1 April 2015- 31 March 2016	50-55	0	0	0	0	50-55
Dr James Mbugua	CCG GP Member	1 April 2015- 31 March 2016	30-35	0	0	0	12.5-15	45-50
Dr Nicholas Stewart	CCG GP Member	1 April 2015- 31 March 2016	45-50	0	0	0	10-12.5	55-60
Paul Evans	Lay Member NLCCG	1 April 2015- 31 March 2016	5-10	0	0	0	0	5-10
Ian Reekie	Lay Member NLCCG	1 April 2015- 31 March 2016	5-10	0	0	0	0	5-10
Allison Cooke	Chief Officer	1 April 2015- 31 December 2015	85-90	0	0	0	17.5-20	105-110
Liane Langdon	Chief Officer	1 January 2016 - 31 March 2016	25-30	0	0	0	20-22.5	45-50
Therese Paskell	Chief Finance Officer & Business Support	1 April 2015- 30 November 2016	45-50	0	0	0	12.5-15	60-65
Kieran Lappin **	Interim Chief Finance Officer & Business Support	1 February 2016 - 31 March 2016	15-20	0	0	0	0	15-20
Catherine Wylie	Director of Nursing and Quality	1 April 2015- 31 March 2016	75-80	0	0	0	20-22.5	95-100
Caroline Briggs	Director of Commissioning	1 April 2015- 31 March 2016	80-85	0	0	0	32.5-35	110-115
Professor John Mayberry	Secondary Care Doctor	1 April 2015- 31 March 2016	5-10	0	0	0	0	5-10

*	Dr Robert Jaggs-Fowler's salary covers both his clinical and non clinical roles (i.e. across his roles as GP Governing Body member/Safeguarding GP and Medical Director)
**	Kieran Lappin is remunerated via an off-payroll engagement which is disclosed elsewhere in this report.

2.2.5. Pension Benefits (Subject to Audit)

Details of Pension benefits are shown in Table 2 overleaf.

Table 2a) contains details the details for 2016/17 with comparative figures for 2015/16 shown in Table 2b.

For understanding the information supplied in these Tables, it is important to note the meaning of both “Cash Equivalent Transfer Values” (CETV) and real increases in CETV.

In brief, a Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s (or other allowable beneficiary’s) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

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

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

TABLE 2A) PENSION BENEFITS 2016/17

Name	Title	Period In Office	Real Increase in pension at pension age(bands of £2500)	Real increase in pension lump sum at pension age (bands of £2500)	Total accrued pension at pension age at 31 March 2017 (bands of £5000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5000)	Cash Equivalent transfer value at 1 April 2016	Real increase in Cash Equivalent transfer value	Cash equivalent Transfer value at 31 March 2017	Employer's contribution to stakeholder pension
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£00's
Dr Margaret Sanderson	Chair	1 April 2016- 31 March 2017	0	0	0	0	257	0	0	0
Dr Faisel Baig	CCG GP Member	1 April 2016- 31 March 2017	0-2.5	0	10-15	10-15	126	18	144	0
Dr Robert Jaggs-Fowler *	Director of Primary Care	1 April 2016- 31 March 2017	0	0	0	0	0	0	0	0
Dr Andrew Lee	CCG GP Member	1 April 2016- 31 March 2017	0	0	0	0	0	0	0	0
Dr James Mbugua	CCG GP Member	1 April 2016- 31 March 2017	0-2.5	0	5-10	25-30	144	19	163	0
Dr Nicholas Stewart	CCG GP Member	1 April 2016- 1 Oct 2016	0-2.5	0-2.5	5-10	15-20	93	0	0	0
Dr Satpal Shekawat	CCG GP Member	1 Oct 2016- 31 March 2017	0-2.5	5-7.5	0-5	5-10	7	25	32	0
Paul Evans	Lay Member NLCCG	1 April 2016- 31 March 2017	0	0	0	0	0	0	0	0
Ian Reekie	Lay Member NLCCG	1 April 2016- 31 March 2017	0	0	0	0	0	0	0	0
Janice Keilthy	Lay Member NLCCG	1 Oct 2016- 31 March 2017	0-2.5	0	0-5	0	0	1	1	0
Heather McSharry	Lay Member NLCCG	1 Nov 2016 - 31 March 2017	0-2.5	0	0-5	0	0	0	0	0
Professor John Mayberry	Secondary Care Consultant	1 April 2016- 10 June 2016	0	0	0	0	0	0	0	0
Dr Richard Shenderey **	Secondary Care Consultant	1 Oct 2016- 31 March 2017	0	0	0	0	0	0	0	0
Liane Langdon	Chief Officer	1 April 2016- 31 March 2017	5-7.5	2.5-5	20-25	50-55	184	89	273	0
Ian Holborn	Chief Finance Officer	1 July 2016 - 31 March 2017	0-2.5	0	0-5	0	0	0	11	0
Kieran Lappin ***	Interim Chief Finance Officer & Business Support	1 April 2016 - 11 July 2016	0	0	0	0	0	0	0	0
Catherine Wylie	Director of Nursing and Quality	1 April 2016- 31 March 2017	2.5-5	10-12.5	35-40	110-115	653	86	739	0
Caroline Briggs ****	Director of Commissioning	1 April 2016 - 30 June 2016	0-2.5	0	5-10	15-20	102	10	155	0
Richard Young ***	Interim Director of Commissioning	4 June 2016 - 31 March 2017	0	0	0	0	0	0	0	0

*	Dr Robert Jaggs-Fowler's salary covers both his clinical and non clinical roles (i.e. across his roles as GP Governing Body member/Safeguarding GP and Medical Director)
**	Dr Richard Shenderey is remunerated via Airedale NHS Foundation Trust
***	Kieran Lappin and Richard Young aare remunerated via an off-payroll engagement which is disclosed elsewhere in this report.
****	Caroline Briggs salary reflects her full salary for the year 16-17, although she was only in post as a Director for 3 months)
	Comparative audited figures for 2015-16 are shown in the next Table.

TABLE 2B) PENSION BENEFITS 2015/16

Name	Title	Period In Office	Real Increase in pension at pension age(bands of £2500) £000	Real increase in pension lump sum at pension age (bands of £2500)	Total accrued pension at pension age at 31 March 2016 (bands of £5000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5000)	Cash Equivalent transfer value at 1 April 2015	Real increase in Cash Equivalent transfer value	Cash equivalent Transfer value at 31 March 2016	Employer's contribution to stakeholder pension
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£00's
Dr Margaret Sanderson	Chair	1 April 2015- 31 March 2016	0-2.5	0-2.5	10-15	35-40	235	19	257	0
Dr Faisel Baig	CCG GP Member	1 April 2015- 31 March 2016	5-7.5	20-22.5	10-15	30-35	47	78	126	0
Dr Robert Jaggs-Fowler *	Director of Primary Care	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0
Dr Andrew Lee	CCG GP Member	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0
Dr James Mbugua	CCG GP Member	1 April 2015- 31 March 2016	0-2.5	0-2.5	5-10	25-30	135	8	144	0
Dr Nicholas Stewart	CCG GP Member	1 April 2015- 31 March 2016	0-2.5	0-2.5	10-15	30-35	173	9	185	0
Paul Evans	Lay Member NLCCG	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0
Ian Reekie	Lay Member NLCCG	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0
Allison Cooke **	Chief Officer	1 April 2015- 31 December 2015	0-2.5	2.5-5	55-60	175-180	1,305	0	0	0
Liane Langdon	Chief Officer	1 January 2016 - 31 March 2016	0-2.5	2.5-5	10-15	40-45	174	7	184	0
Therese Paskell	Chief Finance Officer & Business Support	1 April 2015- 30 November 2016	0-2.5	0-2.5	15-20	55-60	282	7	293	0
Kieran Lappin	Interim Chief Finance Officer & Business Support	1 February 2016 - 31 March 2016	0	0	0	0	0	0	0	0
Catherine Wylie	Director of Nursing and Quality	1 April 2015- 31 March 2016	0-2.5	2.5-5	30-35	100-105	623	23	653	0
Caroline Briggs	Director of Commissioning	1 April 2015- 31 March 2016	0-2.5	2.5-5	30-35	100-105	555	21	583	0
Professor John Mayberry	Secondary Care Doctor	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0

*	Robert Jaggs-Fowler salary covers both his clinical and non clinical roles (i.e. across his roles as GP Governing Member/Safeguarding GP and Medical Director).
**	No CETV figures for March 2016 are being shown for the former Chief Officer (Allison Cooke) as she has taken her retirement benefits from 1st January 2016.

2.2.6 Pay Multiples (Subject To Audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director/Member in their organisation, and the median remuneration (i.e. the middle remuneration value in a rank order sorted list of numbers) of the organisation's workforce.

As shown in the Table below, the banded remuneration of the highest paid Director/Member in North Lincolnshire CCG in the financial year 2016-17 was £195k to £200k (2015/16 was £225k-£230k). This was 5.61 times. (2015/16 6.24) the median remuneration of the workforce which was £35,225 (2015/16 £36,462).

No employees received remuneration in excess of the highest paid Director, which is the same situation as in 2015/16, and remuneration ranged upwards from £7.88k, which is the same figure as 15/16.

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

It should be noted that the median salary calculation is based on annualised figures for fulltime equivalent staff so that the figures quoted do not necessarily indicate figures which have been actually paid by the CCG to individuals in 2016/17. The remuneration which has actually been paid has therefore also been shown for clarity. In addition, because the Highest Paid Director (as measured by annualised salary figures is not the organisation's Chief Officer, the Chief Officer's salary details have also been shown for comparative purposes only.

In contrast to last year there has been significant movement in the highest paid Director's Salary because:

* In 2015/16 NLCCG had an interim Chief Finance officer in post at the year-end; this substantive post has now been filled.

* Within 2016/17 NLCCG appointed an Interim Director of commissioning to cover the Director of Commissioning taking a seconded post.

The significant increase in staff numbers from an average of 28 in 2015/16 to 58 in 2016/17 is due to the CCG bringing a number of services back in house, following the closure of the CSU.

2016-17 Pay Multiple Calculation	Annualised Remuneration (Bands Of £5k)
Highest Paid Director: Interim Director of Commissioning	**195-200** **Mid-Point £197.500k**
Chief Officer	**100-105** **Mid Point £102.500k**
Median Salary in £s	**£35,225**
Pay Multiple Ratio	**5.61**

2.2.7 Staff Report (Subject to Audit)

2.2.7.1 Number of Senior Managers

As at 31st March 2017 North Lincolnshire CCG had the following number of senior managers in post

Band	Number
Very Senior Manager (VSM)	4
Band 9	0
Band 8D	0

2.2.7.2 Staff Numbers and Cost

The table below details the staff costs for 2016-17 for North Lincolnshire CCG:

	2016-17 TOTAL EMPLOYEES			Administration Employees			Programme Employees		
Employee Benefits	Total Employees	Permanent Employees	Other Employees	Total Employees	Permanent Employees	Other Employees	Total Employees	Permanent Employees	Other Employees
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	**2,744**	2,287	457	**1,601**	1,381	220	**1,143**	906	237
Social security costs	**250**	247	2	**155**	152	2	**95**	95	0
Employer Contributions to NHS Pension scheme	**292**	290	2	**180**	178	2	**112**	112	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0
Other post-employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Other employment benefits	**0**	0	0	**0**	0	0	**0**	0	0
Termination benefits	**68**	68	0	**68**	68	0	**0**	0	0
Gross employee benefits expenditure	**3,354**	**2,892**	**461**	**2,004**	**1,779**	**224**	**1,349**	**1,113**	**237**
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	0	0	**0**	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**3,354**	**2,892**	**461**	**2,004**	**1,779**	**224**	**1,349**	**1,113**	**237**
Less: Employee costs capitalised	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0	0
Net Employee Benefits Excluding Capitalised Costs	**3,354**	**2,892**	**461**	**2,004**	**1,779**	**224**	**1,349**	**1,113**	**237**

The table below details the average number of people NHS North Lincolnshire CCG employed during 2016-17

Average Number of People Employed (WTEs)	Year Ending 31st March 2017		
	Permanent Employees (WTEs)	Other Employees (WTEs)	Total Employees (WTE)
Total CCG	59.10	4.18	63.28

2.2.7.3 Staff Composition

As at 31st March 2017 the following breakdowns for NHS North Lincolnshire CCG in terms of gender of the CCG board, Senior Members, employees are as follows:

	Male	Female
CCG Board/Senior Member	*2*	*2*
Employees	*20*	*66*
Total	22	68

2.2.7.4 Sickness Absence Data

Sickness Periods Lost	31-Mar-17	31-Mar-16
Total days lost	523.00	20.00
Total staff years	51.00	21.00
Average working days lost	10.25	0.95

2.2.7.5 Staff Policies

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 including:

- Managing Work Performance
- Disciplinary / Conduct
- Grievance
- Bullying and Harassment
- Flexible working
- Annual appraisals with staff

We actively encourage people with disabilities to apply for positions in our organisation. We have a commitment to interviewing job applicants with disabilities where they meet the minimum criteria for the job as well as making 'reasonable adjustments' to avoid any disabled employee being put at a disadvantage compared to nondisabled people in the workplace. Should circumstances change with an employee's disability status during their employment then the framework within the Absence Management Policy would be used. Occupational Health and where applicable other specialist advice is taken and reasonable adjustments would be made to support the employee to continue in employment as far as possible.

Within 2016/17 the CCG signed up to being Disability Confident Committed.

2.2.7.6 Expenditure on Consultancy

Please see the Operating Expenses note in the Financial Statement, this relates to a "Healthy Lives, Healthy Futures" project, where we brought in a consultant from Attain to work specifically on this project.

2.2.7.7 Off Payroll

Off-Payroll Engagements - Table 1

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

Off-Payroll Engagements - Table 2

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	3
Number of new engagements which include contractual clauses giving the North Lincolnshire CCG the right to request assurance in relation to income tax and National Insurance obligations	
Number for whom assurance has been requested	3
Of which:	
assurance has been received	3
assurance has not been received	
engagements terminated as a result of assurance not being received	0

Notes To Table 2:

It is expected that this number will be small as cases where assurance has not been received should generally be resolved by year end, and by publication of accounts at the latest.

In any cases where, exceptionally, the employer has engaged without including contractual clauses allowing the employer to seek assurance as to their tax obligations – or where assurance has been requested and not received, without a contract termination – the employer has to set the reasons for this.

Where an individual leaves after assurance is requested but before assurance is received this is included within "No. for whom assurance has not been received".

Personal details of all engagements where assurance is requested but not received, for whatever reason, except where the deadline for providing assurance has not yet passed has to be passed to HMRC's tax evasion hotline.
Instances where departments are still waiting for information from the individual at the time of reporting have to be reported as "No. for whom assurance has not been received".

Off-payroll Engagements -Table 3

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	2*
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.(2)	19

Notes to Table 3

(1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero

This specific note relates to:

* Kieran Lappin, Interim Chief Financial Officer (CFO) and Business Support
  This engagement has occurred due to difficulties encountered in recruiting a CFO in time for the Year-end accounts with sufficient experience. The engagement began in February 2016 and ceased in July 2016, following the appointment of a substantive Chief Financial Officer

* Richard Young, Interim Director of Commissioning
  This engagement has occurred due to the substantive Director of Commissioning taking on a seconded role.

2.2.7.8 Exit Packages – Including Special (Non Contractual) Payments

The table below details all exit packages in 2016-17

Exit Package Cost Band (including any special payment element)	Number of Compulsory Redundancies	Cost of Compulsory Redundancies £s	Number of Other Departures Agreed	Cost of Other Departures Agreed £s	Total Number of Exit Packages	Total Cost of Exit Packages £s	Number of Departures Where Special Payments Have Been Made	Cost of Special Payment Element Included in Exit Packages £s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	1	10,343	0	0	1	10,343	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	1	57,725	0	0	1	57,725	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	2	68,068	0	0	0	68,068	0	0

Redundancy and other departure cost have been paid in accordance with the Agenda for Change terms and conditions. Exit costs in this note are accounted for in full in the year of departure. Where North Lincolnshire CCG has agreed early retirements, the additional costs are met by the North Lincolnshire CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table. We have no other departures within 2016/17.

3.0 ANNUAL ACCOUNTS

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

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(3,120)	(3,404)
Other operating income	2	(2,510)	(3,217)
Total operating income		**(5,630)**	**(6,621)**
Staff costs	4	3,354	1,553
Purchase of goods and services	5	230,625	223,351
Depreciation and impairment charges	5	5	5
Provision expense	5	0	0
Other Operating Expenditure	5	500	445
Total operating expenditure		**234,484**	**225,354**
Net Operating Expenditure		**228,854**	**218,733**
Finance income			
Finance expense		0	0
Net expenditure for the year		**228,511**	**218,733**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**228,511**	**218,733**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2017		**228,511**	**218,733**

The notes on pages 110 to 133 form part of this statement

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Non-current assets:			
Property, plant and equipment	8	9	14
Intangible assets		0	0
Investment property		0	0
Trade and other receivables		0	0
Other financial assets		0	0
Total non-current assets		9	14
Current assets:			
Inventories		0	0
Trade and other receivables	9	3,939	2,821
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	10	70	71
Total current assets		**4,009**	2,892
Non-current assets held for sale		0	0
Total current assets		**4,009**	2,892
Total assets		**4,018**	2,906
Current liabilities			
Trade and other payables	11	(16,348)	(12,382)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions		0	0
Total current liabilities		**(16,348)**	(12,382)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(12,330)**	(9,476)
Non-current liabilities			
Trade and other payables		0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions		0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(12,330)**	(9,476)
Financed by Taxpayers' Equity			
General fund		(12,330)	(9,476)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(12,330)**	(9,476)

The notes on pages 110 to 133 form part of this statement

The financial statements on pages 106 to 109 were approved by the Audit Group, on behalf of the Governing Body, on 24 May 2017 and signed on its behalf by:

Chief Accountable Officer

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	(9,476)	0	0	**(9,476)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(9,476)**	**0**	**0**	**(9,476)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating expenditure for the financial year	(228,511)			(228,511)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(237,987)**	**0**	**0**	**(237,987)**
Net funding	225,657	0	0	225,657
Balance at 31 March 2017	**(12,330)**	**0**	**0**	**(12,330)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16				
Balance at 01 April 2015	**(9,846)**	**0**	**0**	**(9,846)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2016	**(9,846)**	**0**	**0**	**(9,846)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(218,733)			(218,733)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(228,579)**	**0**	**0**	**(228,579)**
Net funding	219,102	0	0	219,102
Balance at 31 March 2016	**(9,477)**	**0**	**0**	**(9,477)**

The notes on pages 110 to 133 form part of this statement

Statement of Cash Flows for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(228,511)	(218,733)
Depreciation and amortisation	5	5	5
Impairments and reversals		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	9	(1,118)	406
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	3,966	(787)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised		0	0
Increase/(decrease) in provisions		0	0
Net Cash Inflow (Outflow) from Operating Activities		**(225,658)**	(219,109)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(225,658)**	(219,109)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		225,657	219,102
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**225,657**	219,102
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(1)**	(6)
Cash & Cash Equivalents at the Beginning of the Financial Year		**71**	77
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		**70**	71

The notes on pages 110 to 133 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

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 (N/A in 2016/17)**

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 (N/A in 2016/17)**

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 clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:
· The assets the clinical commissioning group controls;
· The liabilities the clinical commissioning group incurs;
· The expenses the clinical commissioning group incurs; and,
· The clinical commissioning group's share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:
· The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
· The clinical commissioning group's share of any liabilities incurred jointly; and,
· The clinical commissioning group's share of the expenses jointly incurred.

1.7 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

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

1.7.1 ***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 clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

Disclosure of the critical judgements made by the clinical commissioning group's management, as required by IAS1.122. The clinical commissioning group occupies property owned and managed by NHS Property Services Ltd. While our arrangements with NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.

1.7.2 **Key Sources of Estimation Uncertainty**

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

Notes to the financial statements

Continuing Care (CHC)
The primary basis for estimating the forecast level of expenditure not yet invoiced is recorded package costs in the Broadcare patient database.
Analysis during 2016-17 (supported by similar analysis in previous financial years) has shown that due to peaks and troughs in the numbers of packages for individual months this basis can produce fluctuating expenditure trends which are difficult to justify. Therefore, the solution adopted to address this issue is summarised below:

* First a simple rolling annual trend is generated using moving averages
* Then the Broadcare based expenditure projection is reduced by a further proportion that is reflective of current delays in assessments and other factors in line with the excess accruals in previous years (estimated to be no more than 6%)

Further adjustments are then made for:
* Provisional packages are recorded when an application for a patient to receive CHC funding is made. Approximately only circa 6%-12% of these packages become eligible for full NHS CHC funding and therefore a reduction is required to reflect this, based on historic trends.
* Checklist patients are put on a paid for package on discharge from hospital, however based on trend analysis up to 25% of checklist patients are subsequently found to be ineligible for CHC following full assessment and therefore an adjustment is required to reflect this.
*NHS England are responsible for legacy cases that were included in the risk pool, therefore an adjustment will be made to ensure all such cases are not reflected in the CCG estimates.

Out of Area Mental Health & Learning Disability

The recording of Mental Health & Learning Disability packages has been moved back onto the Broadcare system during 2016/17 from July 2016, and a simple 3 month moving average has then been used with the data from this system as the basis for determining accrued expenditure for the year end.

Prescribing
There is a delay of almost two months between the end of an accounting period and receipt of the Practice Prescribing Monitoring Document (PMD) showing the actual prescribing expenditure by GPs. As a result data for March prescribing expenditure was not available at the time of production of the annual accounts. An estimate of outstanding prescribing expenditure is therefore calculated using the forecast in the NHS BSA PMD prescribing reports and any relevant local intelligence.

Healthcare Non Contract Activity
Due to the time lag between the end of a period and the invoicing of activity data to CCGs an estimate has been made of expenditure,
The estimated expenditure is based on expenditure incurred for the year to date, with a reference to the actual final expenditure incurred for the previous financial 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.
If income is received for a specific activity that is to be delivered in the following year, that income will be treated as deferred income.

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 clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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 clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 **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 clinical commissioning group;
· It is expected to be used for more than one financial year;
· The cost of the item can be measured reliably; and,
· The item has a cost of at least £5,000; or,

· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
· Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.
Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **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 clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
· Land and non-specialised buildings – market value for existing use; and,
· Specialised buildings – depreciated replacement cost.

Notes to the financial statements

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 (N/A in 2016/17)**
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 (N/A in 2016/17)**

1.12.1 **Recognition**
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group'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 clinical commissioning group;
· 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 clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group 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 clinical commissioning group 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 (N/A in 2016/17)**
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 (N/A in 2016/17)**
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 (N/A in 2016/17)**
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.

Notes to the financial statements

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

1.17.2 **The Clinical Commissioning Group as Lessor (N/A in 2016/17)**
Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group'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 clinical commissioning group'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 (N/A in 2016/17)**

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 clinical commissioning group 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 (N/A in 2016/17)**
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 clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 **PFI Liability (N/A in 2016/17)**
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 clinical commissioning group'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 Clinical Commissioning Group 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 clinical commissioning group's Statement of Financial Position.

1.18.6 **Other Assets Contributed by the Clinical Commissioning Group to the Operator**
Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group 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 clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.
The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

On initial recognition of the asset, an equivalent deferred income balance is recognised, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.
The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.19 **Inventories (N/A in 2016/17)**
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 clinical commissioning group's cash management.

1.21 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

· Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (previously: minus 1.55%)
· Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.%)
· Timing of cash flows (over 10 years): Minus 0.80% (previously: minus 0.80%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the clinical commissioning group 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 clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.23 **Non-clinical Risk Pooling**

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

1.24 **Continuing healthcare risk pooling**

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

1.25 **Carbon Reduction Commitment Scheme (N/A in 2016/17)**

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

· Financial assets at 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 (N/A in 2016/17)**

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 clinical commissioning group'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 (N/A in 2016/17)**

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 (N/A in 2016/17)**

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

1.28.1 **Financial Guarantee Contract Liabilities (N/A in 2016/17)**
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 (N/A in 2016/17)**
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 clinical commissioning group'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 clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.3 **Foreign Currencies (N/A in 2016/17)**
The clinical commissioning group'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 clinical commissioning group's surplus/deficit in the period in which they arise.

1.31 **Third Party Assets (N/A in 2016/17)**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.32 **Losses & Special Payments (N/A in 2016/17)**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.
Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 **Subsidiaries (N/A in 2016/17)**
Material entities over which the clinical commissioning group 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 clinical commissioning group 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 (N/A in 2016/17)**
Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group 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 (N/A in 2016/17)**
Material entities over which the clinical commissioning group 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 clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.37 **Research & Development**
Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

1.38 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:
· IFRS 9: Financial Instruments (application from 1 January 2018)
· IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
· IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
· IFRS 16: Leases (application from 1 January 2019)
The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Other Operating Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Recoveries in respect of employee benefits	0	0	0	133
Patient transport services	0	0	0	0
Prescription fees and charges	33	0	33	238
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	3,120	0	3,120	3,404
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	2,477	6	2,471	2,846
Total other operating revenue	**5,630**	**6**	**5,624**	**6,621**

Explanatory Note
Better Care Fund Income/(Risk Income) of £2,404k is included within Other Revenue Programme for 2016-17 (£2,759k 2015-16).

3 Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
From rendering of services	5,630	6	5,624	6,622
From sale of goods	0	0	0	0
Total	**5,630**	**6**	**5,624**	**6,622**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2016-17 Total £'000	Total Permanent Employees £'000	Total Other £'000
Employee Benefits			
Salaries and wages	2,744	2,287	457
Social security costs	250	247	2
Employer Contributions to NHS Pension scheme	292	290	2
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	68	68	0
Gross employee benefits expenditure	**3,354**	**2,892**	**461**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**3,354**	**2,892**	**461**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,354**	**2,892**	**461**

Explanatory Note

Employee benefits have increased in 2016-17 due to the full year impact of staff transferring from the Commissioning Support Unit.

4.1.1 Employee benefits

	2015-16 Total £'000	Total Permanent Employees £'000	Total Other £'000
Employee Benefits			
Salaries and wages	1,274	1,213	61
Social security costs	114	114	0
Employer Contributions to NHS Pension scheme	162	162	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	3	3	0
Gross employee benefits expenditure	**1,553**	**1,492**	**61**
Less recoveries in respect of employee benefits (note 4.1.2)	(133)	(133)	0
Total - Net admin employee benefits including capitalised costs	**1,420**	**1,359**	**61**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**1,420**	**1,359**	**61**

4.1.2 Recoveries in respect of employee benefits

	2016-17 Total £'000	2016-17 Permanent Employees £'000	2016-17 Other £'000	2015-16 Total £'000
Employee Benefits - Revenue				
Salaries and wages	0	0	0	(133)
Social security costs	(14)	0	0	0
Employer contributions to the NHS Pension Scheme	0	0	0	0
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**(14)**	**0**	**0**	**(133)**

4.2 Average number of people employed

	2016-17 Total Number	2016-17 Permanently employed Number	2016-17 Other Number	2015-16 Total Number
Total	**63**	**59**	**4**	**28**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

Explanatory Note
During 2016-17 the number of staff employed by the Clinical Commissioning Group increased due to the full year effect of staff transferring from the Commissioning Support Unit.

4.3 Staff sickness absence and ill health retirements

	2016-17 Number	2015-16 Number
Total Days Lost	523	20
Total Staff Years	51	21
Average working Days Lost	10	1

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	0	0
	£'000	**£'000**
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	1	10,343	0	0	1	10,343
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	1	57,725	0	0	1	57,725
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**68,068**	**0**	**0**	**2**	**68,068**

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	3,067	0	0	1	3,067
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**1**	**3,067**	**0**	**0**	**1**	**3,067**

	2016-17 Departures where special payments have been made		2015-16 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2016-17 Other agreed departures		2015-16 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**0**	**0**	**0**	**0**

* As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures have been recognised in full in 2016-17.

Redundancy and other departure costs have been paid in accordance with the provisions of the Agenda for Change, NHS Terms and Conditions of Service Handbook, Amendment number 38.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

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

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2016-17, employers' contributions of £297,181 (including Chair and Non Exec) were payable to the NHS Pensions Scheme (2015-16: £189,189, including Chair and Non Exec) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.

5. Operating expenses

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	2,913	1,562	1,351	1,098
Executive governing body members	441	441	0	455
Total gross employee benefits	**3,354**	**2,003**	**1,351**	**1,553**
Other costs				
Services from other CCGs and NHS England	587	14	229	3,072
Services from foundation trusts	131,909	30	131,879	128,766
Services from other NHS trusts	20,031	0	20,031	19,834
Services from other WGA bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	37,171	0	37,171	32,920
Chair and Non Executive Members	500	429	71	443
Supplies and services – clinical	76	0	76	78
Supplies and services – general	4,673	60	4,613	4,463
Consultancy services	0	0	0	4
Establishment	232	119	112	173
Transport	3	2	1	1
Premises	353	100	253	157
Impairments and reversals of receivables	0	0	0	0
Inventories written down and consumed	0	0	0	0
Depreciation	5	5	0	5
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	54	54	0	54
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	32,921	0	32,921	31,124
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	728	0	728	1,292
Other professional fees excl. audit	1,304	393	911	5
Grants to Other bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	2
Education and training	30	26	4	24
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
Funding to group bodies		0	0	0
CHC Risk Pool contributions	554	0	554	1,384
Other expenditure	0	0	0	0
Total other costs	**231,132**	**1,233**	**229,554**	**223,801**
Total operating expenses	**234,486**	**3,236**	**230,905**	**225,354**

Explanatory Note

Services from Foundation Trusts admin expenditure of £30k is for Internal Audit Services (£25k 2015-16).

Services from Foundation Trusts programme expenditure includes gross Better Care Fund expenditure of £5,149k (£6,300k 2015-16)

Purchase of Healthcare from non-NHS bodies programme expenditure includes gross Better Care Fund expenditure of £6,224k (£7,224k 2015-16).

The increase in Premises costs is due to the CCG occupying a bigger proportion of Health Place due to the in housing of services from the Commissioning Support Unit closure, and a change in rent policy to a market rent basis.

Other professional fees excl. audit includes payments made to eMBED of £389k Admin and £903k Programme (£nil 2015-16). Prior to its closure on 31 March 2016 these services were bought from the CSU and costs included against Services from other CCG's and NHS England.

6.1 Better Payment Practice Code

Measure of compliance	**2016-17 Number**	**2016-17 £'000**	2015-16 **Number**	2015-16 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,720	48,091	8,614	42,309
Total Non-NHS Trade Invoices paid within target	9,551	47,502	8,303	41,078
Percentage of Non-NHS Trade invoices paid within target	**98.26%**	**98.78%**	**96.39%**	**97.09%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,295	151,068	2,118	157,352
Total NHS Trade Invoices Paid within target	2,279	150,957	2,075	157,224
Percentage of NHS Trade Invoices paid within target	**99.30%**	**99.93%**	**97.97%**	**99.92%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2016-17 £'000**	2015-16 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7. Operating Leases

7.1 As lessee

North Lincolnshire Clinical Commissioning Group has lease arrangements with NHS Property Services for the buildings it occupies.

7.1.1 Payments recognised as an Expense

	2016-17				2015-16			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	**Land £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense								
Minimum lease payments	0	343	0	**343**	0	151	0	**151**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**343**	**0**	**343**	**0**	**151**	**0**	**151**

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for the arrangements only

7.2 As lessor

North Lincolnshire Clinical Commissioning Group holds no leases as a lessor (2015-16 None).

8 Property, plant and equipment

2016-17	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2016	0	0	0	0	0	0	25	0	25
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**25**	**0**	**25**
Depreciation 01 April 2016	0	0	0	0	0	0	11	0	11
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	5	0	5
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**16**	**0**	**16**
Net Book Value at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**0**	**9**
Purchased	0	0	0	0	0	0	9	0	9
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**0**	**9**
Asset financing:									
Owned	0	0	0	0	0	0	9	0	9
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**9**	**0**	**9**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2016	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

8.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	3	5
Furniture & fittings	0	0

9 Trade and other receivables	**Current 2016-17 £'000**	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS receivables: Revenue	2,801	0	1,723	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	604	0	582	0
NHS accrued income	0	0	27	0
Non-NHS and Other WGA receivables: Revenue	150	0	188	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	0	0	10	0
Non-NHS and Other WGA accrued income	367	0	274	0
Provision for the impairment of receivables	0	0	0	0
VAT	17	0	17	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	0	0	0	0
Total Trade & other receivables	**3,939**	**0**	**2,821**	**0**
Total current and non current	**3,939**		**2,821**	
Included above:				
Prepaid pensions contributions	0		0	

NHS Prepayments relate to Year End Maternity Pathway balances with our main providers

9.1 Receivables past their due date but not impaired	**2016-17 £'000**	2015-16 £'000
By up to three months	2,419	122
By three to six months	0	0
By more than six months	37	0
Total *	**2,456**	**122**

The 2016-17 balance includes £2,404k due from Northern Linconshire and Goole Hospitals Foundation Trust for Better Care Fund risk income (2015-16 nil). This resulted from an Arbitration settlement agreement by NHS England and NHS Improvement and will be paid during Quarter 1 of 2017-18.

* £17k of the total above has subsequently been recovered post the statement of financial position date.

10 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	71	77
Net change in year	(1)	(6)
Balance at 31 March 2017	**70**	**71**
Made up of:		
Cash with the Government Banking Service	70	71
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**70**	**71**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2017	**70**	**71**
Patients' money held by the clinical commissioning group, not included above	0	0

11 Trade and other payables	**Current 2016-17 £'000**	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
Interest payable	0	0	0	0
NHS payables: revenue	1,032	0	730	0
NHS payables: capital	0	0	0	0
NHS accruals	1,334	0	954	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	4,054	0	1,946	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	9,463	0	8,468	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	41	0	30	0
VAT	0	0	0	0
Tax	37	0	33	0
Payments received on account	0	0	0	0
Other payables and accruals	387	0	221	0
Total Trade & Other Payables	**16,348**	**0**	**12,382**	**0**
Total current and non-current	**16,348**		**12,382**	

Other payables include £48.74k outstanding pension contributions at 31 March 2017 (£40.5k at 31 March 2016).

Non-NHS and Other WGA payables: Revenue includes £2,107k payable to North Lincolnsire Council for Better Care Fund which has subsequently been paid in full (£nil at 31 March 2016).

12 Financial instruments

12.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Clinical Commissioning Group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and internal auditors.

12.1.1 Currency risk (N/A in 2016/17)

The NHS Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Clinical Commissioning Group has no overseas operations. The NHS Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

12.1.2 Interest rate risk (N/A in 2016/17)

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

12.1.3 Credit risk

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

12.1.3 Liquidity risk

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

12 Financial instruments cont'd

12.2 Financial assets

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,801	0	2,801
· Non-NHS	0	517	0	517
Cash at bank and in hand	0	70	0	70
Other financial assets	0	0	0	0
Total at 31 March 2017	**0**	**3,388**	**0**	**3,388**

	At 'fair value through profit and loss' 2015-16 £'000	Loans and Receivables 2015-16 £'000	Available for Sale 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,750	0	1,750
· Non-NHS	0	462	0	462
Cash at bank and in hand	0	71	0	71
Other financial assets	0	0	0	0
Total at 31 March 2016	**0**	**2,283**	**0**	**2,283**

12.3 Financial liabilities

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,366	2,366
· Non-NHS	0	13,904	13,904
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**16,270**	**16,270**

	At 'fair value through profit and loss' 2015-16 £'000	Other 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	1,684	1,684
· Non-NHS	0	10,635	10,635
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2016	**0**	**12,319**	**12,319**

13 Pooled budgets

The NHS Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2016-17	2015-16
	£'000	£'000
Income	2,404	2,759
Expenditure *	(26,457)	(26,320)

	North Lincolnshire CCG Share			
	2016-17			2015-16
*** Analysis of Pool Budget Expenditure**	Total Pool Expenditure	**%**	**£'000**	£'000
Mental Health Pool	(14,812)	86.1%	(12,750)	(12,155)
Learning Disability Pool	(8,176)	4.6%	(373)	(410)
Better Care Fund	(13,334)	100.0%	(13,334)	(13,755)
Total	**(36,322)**		**(26,457)**	**(26,320)**

Mental Health Pool Budget

NHS North Lincolnshire CCG has a pooled budget arrangement with North Lincolnshire Council for Adult Mental Health Services. This is hosted by NHS North Lincolnshire CCG. The memorandum account for the pooled budget is:

Memorandum Account for the Adult Mental Health Pooled Budget for the period 1 April 2016 to 31 March 2017

	2016/17	2015/16
	£'000	£000
Gross Funding		
NHS North Lincolnshire CCG	**12,018**	11,890
North Lincolnshire Council	**1,944**	2,360
	13,962	14,250
Expenditure		
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	**11,744**	11,616
North Lincolnshire Council Adult Mental Health Services	**2,794**	2,680
Contribution to North Lincolnshire Council Social Care Services (Sandfield)	**119**	119
Challenge Fund	**83**	83
MIND	**72**	73
Total Expenditure	**14,812**	14,571
Net Underspend/(Overspend)	**(850)**	(321)
Risk Share Arrangements		
NHS North Lincolnshire CCG	**(732)**	(265)
North Lincolnshire Council	**(118)**	(56)
	(850)	(321)
North Lincolnshire Total Contribution		
Gross Funding	**12,018**	11,890
Risk Share	**732**	265
	12,750	12,155

The Adult Mental Health Pooled Budget has been established under Section 75 (NHS Act 2006) partnership arrangements for the commissioning of integrated services. NHS North Lincolnshire CCG is the lead for the Mental Health Services pooled budget.

Learning Disability Pooled Budget

NHS North Lincolnshire CCG is a partner in the Learning Disability Pooled Budget arrangements hosted by North Lincolnshire Council. The memorandum account for the pooled budget is:

Memorandum Account for the Learning Disability Pooled Budget for the period 1 April 2016 to 31 March 2017

	2016/17	2015/16
	£'000	£000
Gross Funding		
	372	367
NHS North Lincolnshire CCG	**7,781**	7,198
North Lincolnshire Council	**8,153**	7,565
Expenditure		
	234	237
Registered Services: Local Authority	**7,034**	6,704
Agency/Externally Procured Services	**334**	339
Professional Services	**574**	367
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	**8,176**	7,647
Net Underspend/(Overspend)	**(23)**	(82)
Risk Share Arrangements		
NHS North Lincolnshire CCG	**(1)**	(4)
North Lincolnshire Council	**(22)**	(78)
	(23)	(82)
North Lincolnshire Total Contribution		

13 Pooled budgets cont'd

Better Care Fund

The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

Locally, North Lincolnshire Clinical Commissioning Group have implemented the Better Care Fund via a Section 75 Pooled Budget agreement with North Lincolnshire Council. The actual contractual arrangements did not result in joint control being established, therefore under 'IAS 18 Revenue Recognition' the CCG has accounted for its transactions on a gross accounting basis.

Memorandum Account for the Better Care Fund Pooled Budget for the Period 1 April 2016 to 31 March 2017

	2016-17 £'000	2015-16 £'000
INCOME *		
Northern Lincolnshire & Goole NHS Foundation Trust	**2,404**	2,759
EXPENDITURE		
Health Services	3,123	2,554
Social Care	6,224	7,224
Expenditure on Non Elective Activity	3,987	3,977
Total Revenue Expenditure	**13,334**	13,755
NET EXPENDITURE	**10,930**	10,996
FINANCIAL TARGET	**10,930**	11,006
UNDER OR (OVERSPEND)	**0**	10

* Risk income paid by NLAG in compensation for non elective activity savings which were not made by the BCF schemes in 2016-17 and 2015-16.

14 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 M L Sanderson - Chair				
CCG Chair				
A Partner in Trent View Medical Practice	1,892	1	0	0
Husband is a Consultant employed by Northern Lincolnshire & Goole Hospitals NHS Foundation Trust.	110,277	2,412	214	2,436
A Member of Safe Care, North Lincs GP Federation	365	0	0	0
Mrs C Wylie				
Director of Quality & Risk Assurance and Nurse Member				
Partner Governor for Rotherham, Doncaster & South Humber Foundation Trust	14,319	20	134	20
Dr R M Jaggs-Fowler				
GP Member/Medical Director				
A Member of Safe Care, North Lincs GP Federation	365	0	0	0
Dr A Lee				
GP Member				
A Partner of West Common Lane Teaching Practice, Scunthorpe	62	0	0	0
A Member of Safe Care, North Lincs GP Federation	365	0	0	0
Dr S Shekhawat				
GP Member				
A Member of SafeCare, North Lincs GP Federation	365	0	0	0
Dr F Baig				
GP Member				
A Member of Safe Care, North Lincs GP Federation	365	0	0	0
Dr J Mbugua				
GP Member				
A Partner in Trent View Medical Practice, Scunthorpe	1,892	0	0	0
Work in Dermatology at Northern Lincolnshire & Goole NHS Foundation Trust	110,277	2,412	214	2,436
Wife works at Northern Lincolnshire & Goole NHS Foundation Trust	110,277	2,412	214	2,436
A Member of Safe Care, North Lincs GP Federation	365	0	0	0
Mr I Reekie - Vice Chair				
Lay Member - Joint Commissioning				
Wife works as a receptionist at the private Spire - Hull & East Riding Hospital.	1,352	0	2	0
Mr Richard Young				
Interim Director of Commissioning				
Partner Governor for Northern Lincolnshire & Goole NHS Foundation Trust	110,277	2,412	214	2,436
	462,817	9,669	992	9,764

The payments to related parties listed above are the total value of expenditure between the CCG and the named organisation rather than transactions attributable to the listed individual. The purpose is to report total expenditure that could be influenced with the identified supplier.

14 Related party transactions (contd)

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

NHS England (including NHS Yorkshire and Humber Commissioning Support Units)	
	NHS Commissioning Board
	NHS North East Lincolnshire CCG
NHS Trusts	Hull & East Yorkshire Hospitals NHS Trust
	East Midlands Ambulance Service NHS Trust
	Leeds Teaching Hospitals NHS Trust
	United Lincolnshire Hospitals NHS Trust
	Yorkshire Ambulance Service NHS Trust
	Nottingham University Hospitals NHS Trust
	Mid Yorkshire Hospitals NHS Trust
	Lincolnshire Community Health Services NHS Trust
NHS Foundation Trusts	Northern Lincolnshire & Goole NHS Foundation Trust
	Rotherham Doncaster & South Humber NHS Foundation Trust
	Doncaster & Bassetlaw Hospitals NHS Foundation Trust
	Sheffield Teaching Hospitals NHS Foundation Trust
	Sheffield Children's NHS Foundation Trust
	York Teaching Hospital NHS Foundation Trust
	Humber NHS Foundation Trust
	Derby Hospitals NHS Foundation Trust
	University College London Hospitals NHS Foundation Trust
	Harrogate & District NHS Foundation Trust
NHS Litigation Authority; and,	
NHS Business Services Authority.	
NHS Property Services	

In addition, the clinical commissioning group 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 Lincolnshire Council
HM Revenue and Customs
National Insurance Fund

15 Events after the end of the reporting period

From 1 April 2017 North Lincolnshire CCG has been placed under a capped expenditure regime along with Northern Lincolnshire and Goole Hospitals NHS Foundation Trust. This arrangement will require both organisations to work together to meet a capped expenditure total in 2017-18. In effect this will mean that the CCG will have to meet its revenue control total agreed with NHS Engalnd in 2017-18.

From 1 April 2017 the Mental Health and Learning Disability Pooled Budgets with North Lincolnshire Council have been suspended awaiting renegotiation of 2017-18 joint agreements.

16 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

	2016-17 Target	**2016-17 Performance**	2015-16 Target	2015-16 Performance
Expenditure not to exceed income	230,198	234,296	227,563	225,354
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	224,413	228,511	220,942	218,733
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	3,821	3,231	4,083	3,754

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

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS North Lincolnshire CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £2.171m. This additional surplus has been offset against other cost pressures from the current financial year.

Taking into account the Risk Reserve (as mentioned above) this resulted in North Lincolnshire CCG posting a final deficit of £4.098m. rather than a surplus of £2.230m as planned at the start of the financial Year. This position resulted primarily from: a £2.992m partial settlement of a contract dispute with our main secondary care service provider, which was finally resolved in December 2016, and the remaining overspend was due to higher than anticipated patient demand, which resulted in overspends across a number of budget areas including: Prescribing, Out of Area MH & LD, and Continuing Healthcare, and our minor Acute healthcare contracts in particular.

As a result of forecasting a Deficit early in 2016/17 the CCG were able to benefit from a capacity and capability review by PWC which assisted the CCG to minimise its deficit down to the reported value.

However, as a result of posting a Deficit in 2016/17 the CCG is now expected to cap its expenditure to its available revenue resources, through collaborative working with its main secondary care service provider , and may be placed under Directions from NHSE in order to access the appropriate support which is required to return the CCG to a position of recurrent financial balance.

17 Continuing Healthcare Retrospective Claims: Accounting Treatment

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS Engalnd is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to

	31-Mar-17 £000's	**31-Mar-16 £000's**
Accrual	230	0
Provision	0	724
Contingent Liability	120	0
	350	724

4.0 AUDIT OPINION ON THE ACCOUNTS

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

We have audited the financial statements of NHS North Lincolnshire CCG for the year ended 31 March 2017 on pages 106 to 134 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 56, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

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

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

Scope of the audit of the financial statements

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

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

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

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

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on regularity

Basis for qualified opinion on regularity

The CCG reported a deficit of £4.098 million in its financial statements for the year ending 31 March 2017, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223I of Section 27 of the Health and Social Care Act 2012, to ensure that its revenue resource use in a financial year does not exceed the amount specified by NHS England.

Qualified Opinion on regularity

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity paragraph, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements conform to the authorities which govern them.

Opinion on other matters

In our opinion:

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

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

Other matters on which we report by exception - Adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

In considering the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources we identified that the CCG, despite having set a balanced budget for the year ended 31 March 2017, reported a deficit of £4.098 million. This issue is evidence of the need to improve arrangements for managing finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions. The CCG has provided further explanation in Note 16 of its Annual Accounts 2016/17.

Except for the matters referred to above we are satisfied that the CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Other matters on which we are required to report by exception - Referral to Secretary of State

We have a duty under the Local Audit and Accountability Act 2014 to refer the matter to the Secretary of State if we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 10 May 2017 we wrote to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to a breach of revenue resource limit of £4.098 million for the year ended 31 March 2017, which we have reason to believe exceeded the CCG's statutory powers.

Certificate

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

John Graham Prentice FCCA MBA
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
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30 May 2017