NHS
North Lincolnshire
Clinical Commissioning Group
Annual Report
and Accounts
2017/18
Your community, your health

Section	Page
1) Performance Report	
1.1 Overview	2
1.1.1 About This Publication	3
1.1.2 Welcome From The Chair & Chief Officer	5
1.1.3 Who We Are And What We Do	8
1.1.4 A Brief Look Back At 2017/18	10
1.1.5 How We Are Doing	12
1.1.6 What We Want To Achieve	14
1.1.7 The Risks That Could Affect Our Plans	16
1.1.8 Going Concern Declaration	
1.2 Performance Analysis	17
1.2.1 Performance Measures	17
1.2.2 Financial Performance	22
1.2.3 Statutory Duties	22
• Reducing Inequalities	23
• Public Involvement	25
• Equality & Diversity	28
• Improving Quality	31
• Contributing to the delivery of the joint Health And Wellbeing Strategy	36
1.2.4 Sustainable Development	37
1.2.5 Access To Information (FOI)	40
1.2.6 Priorities for 2018/19	41
1.2.7 Use of Earmarked Funds	43
2) Accountability Report	
2.1 Corporate Governance Report	45
2.1.1. Directors & Members Report	45
2.1.1.1 Disclosure Statement	45
2.1.1.2 Governing Body	45
2.1.1.3 North Lincolnshire Practices	54
2.1.1.4 Our Council of Members	55
2.1.1.5 Our Audit Group	56
2.1.1.6 Committee and Subcommittee Membership & Declarations of Interest	57
2.1.2. Additional Disclosures	57
2.1.2.1 Principles For Remedy	57
2.1.2.2 Employee Consultation	58
2.1.2.3 Equality Disclosures	59
2.1.2.4 Emergency Preparedness, Resilience And Response	60
2.1.2.5 Disclosure of “Serious Incidents”/Personal Data Related Incidents	61
2.1.2.6 Statement as To Disclosure To Auditors	62
2.1.2.7 Modern Slavery Act	62
2.1.2.8 Statement of Accountable Officer’s Responsibilities	62
2.1.3. Annual Governance Statement	64

2.1.4. Managing Public Money	97
2.2 Remuneration & Staff Report	98
2.2.1 Remuneration Committee Report	98
2.2.2 Remuneration Committee Membership & Attendance	98
2.2.3 The Remuneration Of Senior & Very Senior Managers	98
2.2.4 Salaries & Allowances	98
2.2.5 Pension Benefits	101
2.2.6 Pay Multiples	104
2.2.7 Staff Report	105
2.2.7.1 Number of Senior Managers	105
2.2.7.2 Staff Numbers And Cost	105
2.2.7.3 Staff Composition	106
2.2.7.4 Sickness Absence Data	106
2.2.7.5 Staff Policies	106
2.2.7.6 Expenditure On Consultancy	106
2.2.7.7 Trades Union Facility Time	107
2.2.7.8 Off Payroll	107
3) Annual Accounts	109
3.1 The Primary Statements	
3.1.1 Statement of Comprehensive Net Expenditure for the Year Ended 31st March ‘18	1
3.2.2 Statement of Financial Position as at 31st March 2018	2
3.2.3 Statement of Changes in Taxpayers' Equity for the Year Ended 31st March ‘18	3
3.2.4 Statement of Cash Flows for the Year Ended 31st March 2018	4
3.2 The Notes to the Accounts	
3.2.1 Accounting Policies	5-6
3.2.2 Other Operating Revenue	9
3.2.3 Revenue	9
3.2.4 Employee Benefits & Staff Numbers	10-12
3.2.5 Operating Expenses	13
3.2.6 Better Payment Practice Code	14
3.2.7 Operating Leases	15
3.2.8 Property, Plant and Equipment	16-17
3.2.9 Trade and Other Receivables	18
3.2.10 Cash & Cash Equivalents	19
3.2.11 Trade & Other Payables	20
3.2.12 Financial Instruments	20-22
3.2.13 Pooled Budgets	23-24
3.2.14 Related Party Transactions	25-26
3.2.15 Losses & Special Payments	27
3.2.16 Continuing Healthcare Retrospective Claims: Accounting Treatment	27
3.2.17 Financial Performance Targets	27
3.2.18 Impact of Practice Merger	27
4) External Audit Opinion & Report	28
5) Glossary of Terms	29

SECTION 1

PERFORMANCE REPORT

1.1 Overview

1.1.1 About this publication

Clinical Commissioning Groups (CCGs) publish their Annual Report and Financial Accounts at the end of each financial year. The first section gives an overview of the CCG and tells the story of the previous 12 months between 1 April 2017 and 31 March 2018, including what we have achieved, the challenges we face and some of the risks that could affect how we move towards achieving our objectives in the coming year.

More detailed information about the our 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 2017-18 are presented at the end.

The Annual Report and Accounts can be downloaded from the CCG website. As sustainability is important to us as an organisation, we do not routinely produce large printed documents but printed 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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Web: www.northlincolnshireccg.nhs.net **Twitter**: **@northlincsccg**

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 public events we hold throughout the year or contact us using the details above.

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1.1.2 Welcome from the Chair and Chief Officer

Firstly, this will be the last Annual Report from myself as Chair as I announced my retirement from 31st May 2018. I have been Chair of the CCG since it was created in 2012 and previously as Chair in the Primary Care Trust (PCT). I have enjoyed watching the changes as the organisation transformed over the last 18 years and am confident my successor Dr Faisel Baig will continue to improve services for local people

The past 12 months have been a story of two halves which saw a change in leadership during November 2017. Since then the CCG is working with partners to improve ways of working and transform local services.

We are embracing this opportunity to understand what is being done well here in North Lincolnshire, what has not worked and why, and to tackle what we and our partners need to do to enable our local communities to make healthier choices and live as active, engaged and independent lives for as long as they can.

2018 sees our much loved NHS celebrate its 70th Birthday. Healthcare has changed considerably over the past seven decades and exciting developments are to continue throughout this anniversary year of the NHS and beyond here in North Lincolnshire.

We will ensure the voices of our patients and their carers and families are heard when we plan or change local services. In June 2017 we established our new Patient and Community Advisory Group (PCAG) to give independent advice to our Governing Body that the right processes and accountabilities are in place to enable local people to be fully involved in our commissioning decisions. The group is made up of members of our Embrace Patient Network with members of the Youth Council, North Lincolnshire Healthwatch, Cloverleaf Advocacy, Humber and Wolds Rural Community Partnership and the Westcliff Drop-In Centre. You can read more about PCAG in the section on public engagement later in this Report.

We have big ambitions and every one of us is determined to bring about improvements our patients and wider communities will be able to see and experience, while making the most of every penny of the money allocated to us by the Government.

Health organisations can no longer work in isolation. The CCG and our colleagues in the local authority are both in the business of wellbeing and we will be working closely together to ensure our population is at the heart of all we do.

We continue to collaborate with different health, care and voluntary organisations from across the Humber area to tackle some of the really big issues facing health and adult social care. As part of this work, the Humber Acute Services Review (HASR) is looking at how to provide the best possible hospital services for people living in our area both now and for future generations and make the most of the money, the caring and highly skilled staff and the buildings available to us. This may

include delivering some aspects of care outside hospital to ensure needs of local people are met.

It is no secret there are real challenges associated with all of our health and care resources, with some areas exceptionally stretched. The HASR is currently exploring the future shape of three services impacted last year due to severe workforce shortages. You can read more about these issues by visiting www.nlg.nhs.uk/about/trust/_service-reconfiguration and follow the progress of the HASR by visiting http://humbercoastandvale.org.uk.

People should be able to receive good local services and our CCG works closely with all of our providers to ensure that patients receive appropriate, quality based care.

The CCG has not been without its own difficulties. It received an “inadequate” rating by NHS England for its performance during 2016/17 and was placed under formal “Legal Directions” by NHS England, as part of the on-going work to bring the health system in North Lincolnshire back into financial balance and to ensure all of the organisations are working as efficiently as possible.

However, we now have a new leadership team in place; with an Interim Accountable Officer and Interim Chief Finance Officer from Hull CCG and a Turnaround Director from NHS England, and we are addressing all concerns to ensure we come out of “Legal Directions” and “Special Measures” during 2018/19.

As a responsible commissioner of health care services, the CCG is looking at areas of opportunity for gaining increased value for money from its financial allocation. The main areas of focus for financial sustainability is through making more cost effective use of the prescribing budget, as well as managing patient need more appropriately between the health care sectors, with the aim of reducing wherever it is clinically appropriate, the use of more expensive acute service activity.

We are delighted to present our Annual Report for 2017/18. On behalf of the CCG Governing Body we would like to place on record our heartfelt thanks to our entire team – including managers, staff, and our health and care partners - for their continued support during the past 12 months.

Emma Latimer joined the CCG as **Accountable Officer for an Interim Period** in November 2017

Dr Margaret Sanderson is to retire from her position as **CCG Chair** in May 2018.

1.1.3 Who we are and what we do

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

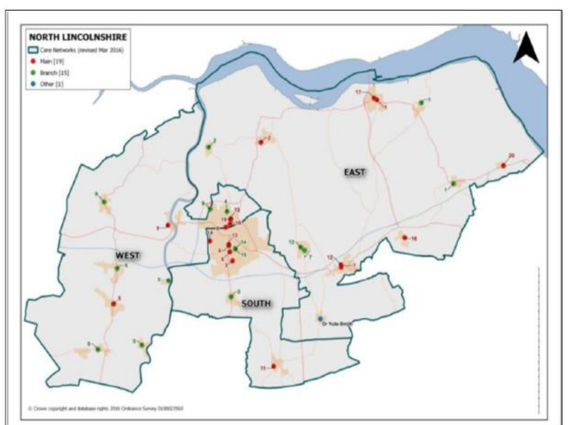
North Lincolnshire CCG is led by GPs representing the 19 North Lincolnshire practices, supported by a small team of non-clinical staff who carry out the day-to-day running of the organisation. We are accountable to our members, patients and our local communities, and overseen by NHS England, the executive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

CCGs are allocated an amount of money to spend on health services each year, for the resident population. This is based on a complex formula which takes into account the overall health and wellbeing needs of the people who live in our area. This money has to be shared across the very wide range of services that local people need. These are services such as life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health 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 planning and buying some preventative (e.g. public health services etc), or some very specialist health services. In addition unlike some CCGs North Lincolnshire does not directly commission most Primary (i.e. GP based) Care, and concentrates on the commissioning of Secondary (i.e. Hospital based care) for the residents of North Lincolnshire.

The money the CCG is allocated by NHS England to undertake its functions, is received in two distinct funding streams. In 2017/18 the CCG was allocated **£224.027m** in total by NHS England (with **£220.196m** to fund commissioned NHS services, and **£3.831m** to pay the costs of running the CCG).

This CCG covers the physical geography of North Lincolnshire which has a similar administrative boundary to the local authority, North Lincolnshire Council, and covers an area of about 328 square miles (850 square kilometres).



The CCG is a GP practice based membership organisation, which is organised into 3 Care networks (West, East & South) comprising the following practices.

	NORTH LINCOLNSHIRE PRACTICES AT OCTOBER 2017	LIST SIZE
1	ANCORA MEDICAL PRACTICE	18,630
2	ASHBY TURN PRIMARY CARE PARTNERS	12,618
3	BARNETBY MEDICAL CENTRE	2,948
4	BRIDGE STREET SURGERY	6,392
5	CAMBRIDGE AVENUE MEDICAL CENTRE	14,299
6	CEDAR MEDICAL PRACTICE	6,923
7	CENTRAL SURGERY BARTON	16,771
8	CHURCH LANE MEDICAL CENTRE	8,908
9	DR RAI N AND PARTNERS	12,735
10	DR WEBSTER P A AND PARTNERS	9,753
11	KIRTON LINDSEY SURGERY	5,709
12	MARKET HILL 8 TO 8 CENTRE	5,750
13	SOUTH AXHOLME PRACTICE	14,808
14	THE BIRCHES MEDICAL PRACTICE	9,054
15	THE KILLINGHOLME SURGERY	1,399
16	THE OSWALD ROAD MEDICAL SURGERY	4,555
17	TRENT VIEW MEDICAL PRACTICE	11,689
18	WEST COMMON LANE TEACHING PRACTICE	7,908
19	WEST TOWN SURGERY	3,077
		173,926

The large urban area of Scunthorpe and Bottesford is the main area where people live, work and shop, and is home to just under half (48%) of our residents. The remaining 52% live in the six main market towns of Barton, Brigg, Crowle, Epworth, Winterton and Kirton Lindsey and in 80 surrounding villages.

Latest population studies indicate that 170,786 *(ONS 2016)* people live in North Lincolnshire. Our population has grown by more than 8% since 2003 which is marginally more than regional and national averages. The population in North Lincolnshire contains people who on average are slightly older than the national average at 41.2 years, with fewer young adults and more people in their 50s and 60s.

Between now and 2037 the CCG's population is expected to grow to more than 184,000 people, with an older profile. The number of children aged 0-4 is projected to fall by 10.3% between 2012 and 2037. More than 32,000 of the CCG's residents are already aged 65 or older, and between 2003 and 2013 the number of residents who have reached the age of 85 grew by more than 46%. It is good news that more people now enjoy longer lives, but it is also one of the challenges faced by the CCG because it also means that more of our residents are living with one or more long-term, and often complex, health conditions.

One in every 9 people living in North Lincolnshire has a caring responsibility. An older population also means there is growing demand on services. The funding the CCG receives to pay for its population's health is not keeping pace with this, and the resources it possesses (i.e. both the money and expert, caring health and care professionals to treat people) need to be stretched further.

However, when the organisations involved in planning or delivering health and care start to work collectively, this allows us to share resources in areas where we are currently stretched, enabling us to continue to provide good services to patients. Additionally, we can look at how support services, such as finance or other back office functions, could be shared to make things more efficient and save money.

The CCG continues to work closely with; our neighbouring CCG in North East Lincolnshire, North Lincolnshire Council, and Northern Lincolnshire and Goole NHS Foundation Trust and our other care providers on the local delivery plan of the Strategic Transformation Partnership (STP) in particular. This work is helping us to understand the local health economy's funding gap and find affordable ways of delivering care which can be sustainable long into the future. Complementing this understanding has been the development of new models of care, particularly for frail and elderly people in our communities, based around care networks.

Public and patient involvement continues to play a vital role in shaping and developing new models of care, both for “in” and “out of” hospital care, and this work will continue throughout 2018/19. 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 the lessons of this report can continue to be learned. This includes adjustments to ensure that the CCG continues to be assured on the quality of the services provided for our local communities.

Who Provides Our Services?

The CCG commissions hospital and the main community services from a number of regional hospital trusts, but predominately from Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Its other main hospital service provider is Hull and East Yorkshire Hospitals NHS Trust (HEYH). Mental health services are mainly provided by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH).

Where appropriate, the CCG also jointly commissions services with partners, such as neighbouring NHS North East Lincolnshire CCG for health care, and North Lincolnshire Council for local authority based social care services.

The CCG also jointly commissions primary care GP services with NHS England and, with decisions reached via 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 the CCG’s vision and commissioning plans.

You can read more about these in the Annual Governance Statement in Section 2.1.3. of this report.

1.1.4 A brief look at progress made during 2017-2018

Vulnerable People

Supporting young people who have experienced trauma

A partnership between the CCG, Barnardo's and North Lincolnshire Council launched in Scunthorpe to provide a therapeutic service for children and young people experiencing trauma as a result of significant harm - including sexual abuse.

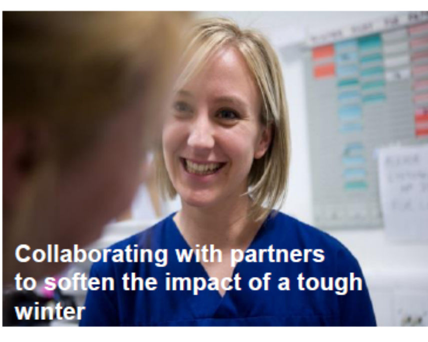
Introduced Care and Treatment Reviews (CTRs) as part of our commitment to transform services for people with learning disabilities, autism or both.

Our **Transforming Care Plan** work saw three out of the five North Lincolnshire in-patients supported to leave hospital.

Twenty-seven North Lincolnshire people began to receive Personal Health Budgets.

Our pilot to improve diagnosis of dementia in Care Homes concluded after delivering 118 direct diagnoses and 146 referrals to memory clinic services, increasing diagnosis rate to 66.5%. The process of dementia diagnosis is now part of the Specialist Assessment for Frail and Elderly, a service focussing on people aged 65+, both residing in Care Homes and the community as a preventative service to provide for social care and health needs in their home.

In and Out of Hospital



In-hours Primary Care Streaming at A&E with extra capacity into Out of Hours service at significantly busy periods ensured patients received primary care response, where appropriate, 24 hours a day.

Achieved improvement trajectory around A&E waiting times in October and November 2017 although this dipped in Q4 as winter pressures impacted on the system.

Our collaborative response to these pressures with main providers supported additional capacity in the system and enabled our local system to cope better than many others of the country. This will be groundwork for a more sustainable solution.

A successful pilot took Multi-Disciplinary Teams (MDTs) into 11 care homes to support holistic care planning and better medicines management. Being developed into a wider service for all care homes and to include frail and elderly people living in their own home.

We upgraded IT in a number of care homes to support access to hospital systems and enable tracking progress of residents who have been admitted, including routine observations and electronic discharge summary. This received positive feedback with funding secured to roll out.

Diabetes

A **good** rating for the quality of diabetes care locally.

353 patients at risk of developing diabetes referred by their GP into Healthier You, the National Diabetes Prevention Programme

Community & Patient Involvement

Established new Patient & Community Advisory Group (PCAG) to ensure the right structures, processes and accountabilities are in place to enable local people to be fully involved in our commissioning decisions.

611 local people took part in our engagement around introducing extended hours GP services to North Lincolnshire

Other Clinical Improvements

- Agreed revised pathways as part of RightCare gastroenterology to manage demand for endoscopy

- Roll-out of the Gold Standard Framework (GSF), to improve the quality of primary care GP based services.

- Led the STP ophthalmology work-stream, developed STP service specifications for HES and CATs. Agreement of new model in NLAG ophthalmology with full clinical engagement)

- To facilitate use of better clinical pathways & better Prescription practice, the Roll-out of DXS and Optimise RX to all 19 practices has now been completed.

- Successful challenge on responsible commissioner basis of a number of high cost, out of area placement, with savings to the CCG

- Reduction in Out of area TCP placements

- Significant reduction in MH Delayed transfers of care

- Successful mobilisation of dermatology which addressed the concerns for British Association of Dermatologists regarding cancer pathways and introduced tele-dermatology with increasing uptake from primary care

1.1.5 How we are doing

The purpose of this section is to provide an overview on how the CCG has performed during 2017/18, against its main formal performance targets. 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.

The CCG is committed to developing positive and constructive relationships with our provider organisations, and the CCG continued to work collaboratively with our provider organisations to support performance improvement during 2017/18.

Quality and safety is a key priority for the CCG, so we ensure that our provider contracts, in addition to other sources of information, contain the relevant standards and targets to provide assurance around the quality of care.

We are pleased to say that we continue to meet many of our constitutional targets; however, the local health system has faced a number of challenges during the year, particularly in relation to the availability of capacity to deliver the NHS Constitution Standards.

A summary of the key challenges identified during 2017/18 is provided below.

NHS Constitution Standards – Performance by Exception

Ambulance Response Times

The current provider for emergency ambulance services is East Midlands Ambulance Service (EMAS). During 2017/18, EMAS failed to meet the required target levels for emergency response times.

The CCG is currently part of a collaborative commissioning arrangement that stretches across the geographic area covered by EMAS, with NHS Hardwick CCG as the lead commissioner. The CCG continues to work in collaboration with NHS Hardwick CCG and pursues recovery actions to secure continuing improvements in response times in North Lincolnshire.

A&E 4 Hour Wait

Achievement of the national four hour waiting time target (95%) continued to be a challenge during 2017/2018.

An improvement trajectory of 90% was agreed for 2017/2018, for which during October and November 2017 the local Acute Trust, Northern Lincolnshire & Goole Hospitals NHS Foundation Trust (NLAG) did achieve. Unfortunately, performance reduced in quarter 4 which led to an overall underachievement of this target.

Cancer Waiting Times

The CCG has identified pressures in delivery of some of the cancer pathways during 2017/2018, these pressures largely related to the cross trust cancer pathways. However, the overall cancer performance position remains strong. The CCG continues to work collaboratively with the cancer network and provider organisations to review this position.

Referral to Treatment Times

The CCG's local providers did not achieve the required levels of performance in relation to referral to treatment waiting times during 2017/2018, with performance falling significantly below required levels in a number of specialties. The total waiting list size and proportion of long waiting patients continued to increase in 2017/18; this was largely due to capacity pressures.

Diagnostic Waiting Times

Waiting times for diagnostic services increased during 2017/18 at the CCG's main acute providers, this is largely due to capacity and staffing challenges across the Humber areas and additional pressures relating to diagnostic equipment failure.

Mixed Sex Accommodation (MSA)

There has been an expediential rise in the number of MSA breaches reported by NLaG during 2017/18, this rise is largely due to the revision of Trust wide policy in relation to the MSA exemption criterion. NLaG continues to work closely with partners to review this position and to ensure that patient's privacy and dignity continue to be maintained.

1.1.6 What we want to achieve

NL CCG 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 Five Year Forward View was published in October 2014 and set out a five-year journey for the NHS. It described a future that should have more focus on prevention and public health; patients with greater control of their own care and a breakdown of barriers in how care is provided. To support this new Models of Care were proposed that describe care delivered in a much more integrated way than currently delivered. 2017/18 forms years three of the Five Year Forward View.

The document sets out three key principles for change relating to gaps in healthcare that the new strategic direction will seek to address. These include:

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

In its Operational Planning (published at the start of the year) the CCG set out its plans and ambitions for the year and responded to the requirements set out in the NHS and Contracting Guidance 2017-2019.

Taking into account the wider strategic plans involving the CCG, the operating plan supplementing the CCG's plans for delivery of the GP Forward View sits alongside the CCG's overall activity and finance plans, the Transforming Care plan, the CAMHs Transformation plan and the Humber, Coast and Vale STP plan.

The NHS has been experiencing growing demand for services and public expectation over recent years, coupled with limited growth in funding and available workforce. This has put the NHS as a whole under great strain – a strain felt equally within social care. Therefore our core ambition for the CCG and its partners has been to develop a sustainable system: able to meet the demands of the changing population, public expectations and an accessible workforce.

In order to respond to these requirements, the NHS is undergoing transformational change which is resulting in new approaches to planning and ways of working. North Lincolnshire CCG set out in its vision for healthcare the strategic aim of the 'shift to the left' (see diagram overleaf) which reflects 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 and health and care teams, which are clustered around GP practices which work in a seamless and integrated way to meet the needs of the population as close to home as possible. Our plans for 2017/18 and beyond will accelerate these developments to achieve sustainability of healthcare for our population.

Over the last year we have developed a much stronger accord within the system with a shared understanding of activity and affordability. There has been a resulting step change in the relationship between the CCG and key providers including the acute trust and the Accountable Care Partnership. This is resulting in improved engagement in solution focussed planning to deliver on shared goals around sustainability.

Our plans for 2018/19 and beyond will consolidate our financial sustainability and accelerate these developments to achieve improved health and healthcare for our population.

Sustainability and Transformation Partnership (STP)

The CCG is an active participant in the STP plan development and committed to aligning local delivery to the STP. The CCG is appropriately represented in all of the STP work-streams and takes an active leadership role in some of the work-streams.

The STP covers the geographical area covered by the following 6 CCGs:

- North Lincolnshire CCG
- North East Lincolnshire CCG
- East Riding of Yorkshire CCG
- Hull CCG
- Scarborough & Ryedale CCG and;

- York CCG.

The Humber, Coast and Vale STP sets out a vision which directly reflects the NL CCG vision. The STP aims to enable people to look after themselves to reduce the risk of them falling ill, have systems in place to avoid crisis through early help and only go to hospital when it is planned and necessary and for the minimum amount of time. The STP sets out a triple aim; achieving our desired outcomes, maintaining quality services and closing our financial gap. The STP plan was published on 21st November 2017.

The STP acts as an umbrella plan with CCG level plans sitting below this. The STP sets out a range of plans to be delivered at scale- across the whole STP footprint whilst also setting out a range of plans which will be delivered at place, i.e. North Lincolnshire. North and North East Lincolnshire CCGs have been working together with the local acute provider, Northern Lincolnshire and Goole NHS Foundation Trust for several years on the Healthy Lives, Healthy Futures programme, and this work has already led to the formulation of the Accountable Care Partnership models currently being implemented in both North and North East Lincolnshire.

The CCG has commenced work with other CCGs across the STP area on the ‘at scale’ agenda, and will continue to contribute to this over the next two years. This work includes development of unified commissioning intentions and contracts to provide consistency of approach, for both commissioners and providers, allowing opportunities to work together to be realised and to improve operational and contract management between CCG’s and providers. These arrangements do not prevent “place level” commissioning where this is appropriate.

The CCG will continue to work with both the STP and the Northern Lincolnshire partner organisations and agencies to ensure a good fit between STP plans and local place-based plans. Current STP-level commissioning plans focus on ophthalmology, weight management, diabetes, outpatients and commissioning of procedures of limited clinical value. Further pathways will be addressed through co-ordinated commissioning plans for dermatology/plastic surgery, musculoskeletal, gastroenterology, respiratory and cardiovascular disease. The co-ordinated commissioning plans reflect that the CCGs are at different stages of commissioning for these and that the underlying needs for CCG populations may be different. In 2017/18, we will utilise the Right-Care approach to redesign gastroenterology, cardiovascular and respiratory services.

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 (NLaG) continue to face significant challenges in delivering sustainable services.

As we reported in our Annual Report for 2016/17, the Trust was placed into both financial and quality “Special Measures” in 2017, so we continue to work with NLaG, supported by the regulators, to tackle the issues that led to this position.

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 a relative decrease in primary care demand has been unable to maintain its Referral to Treatment (RTT) waiting time position and has now confirmed that it will not recover this in 2017/18. The organisation has experienced prolonged difficulties in recruiting both 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.

During 2017/18, the CCG agreed an "Aligned Incentive Contract" with the Trust to maintain the viability of the Trust. However, this also included a requirement to implement a challenging transformation plan which was intended to enable the health economy to take out costs in terms of staffing and infrastructure. Despite working in partnership this has proven difficult to deliver in the context of staffing shortages and increased urgent care demands.

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 to 2019 reflected the ambition to develop of new models of care. North Lincolnshire agreed an Accountable Care Partnership (ACP) model to integrate community provision through a partnership of providers. Whilst the ACP is in place it is (and continues to be) an informal arrangement between the key health and social care agencies, and it has not developed into a more formal alliance, for instance with a draft memo of understanding and a shadow Executive Board to support governance arrangements. Nevertheless, the CCG is working closely with this partnership to realise planned benefits.

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 place-based 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 to managing risk

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:

- As part of the submitted Financial Recovery Plan the CCG also submitted a Medium Term Financial Plan, which returns the CCG to in Year Financial Balance and full NHS Business Rule compliance over the next 3 years.

- With the assistance of the indicative £4m allocation which has been provisionally notified by the Commissioner Support Fund in 2018/19, the CCG is now expected to break even in 2018/19, and return to almost full NHS Business rule compliance sooner than anticipated within the Financial Recovery Plan (e.g. achieving the Mental Health Investment Standard, and re-instating the In-year contingency reserve etc.).

Finally it is important to note, that the prime determinant of "Going Concern" status for public organisations relates to the continuity of service provision, not the continuity of a particular organisation, which so happens to provide the required services at a certain point in time.

1.2. Performance Analysis

1.2.1 Performance Measures

The NHS Constitution sets out a number of pledges to patients on how long they wait to be seen and to receive treatment. The CCG has worked with partners throughout the year to deliver these pledges for the population of North Lincolnshire and we have performed well against many of our constitutional targets.

The following areas of performance achieved the required target levels during 2017/18 (as at 31 March 2018):

- 12 Hour Trolley wait
- Cancer 2 Week Wait
- Cancer 31 Day Subsequent Treatment (Anti-Cancer Drug & Radiotherapy)
- Cancer 31 Day First Definitive Treatment
- Cancelled Operations for a 2nd time
- IAPT Entering Treatment
- IAPT Recovery Rate
- IAPT 6 Week & 18 Week Wait
- Early Intervention 2 Week Wait

However, we recognise that there is still room for improvement in a number of areas; these areas are summarised in the table below (as at 31 March 2018):

Area	RAG	⇩⇧	Comments
18 Week Referral to Treatment Times: Admitted (Target 90%) Non-Admitted (Target 95%) Incomplete (Target 92%) >52 Week Waiters (Zero tolerance)	R	⇩	The CCG's local providers did not achieve the required levels of performance in this area during 2017/18, with performance falling significantly below required levels in a number of specialties at Northern Lincolnshire & Goole NHS Foundation Trust (NL&G) and Hull & East Yorkshire NHS Trust (HEY). There are multiple contributory factors to the decline in performance including shortfalls in capacity across the Humber area, challenges in operational processes and systems and pressures with the flow of patients through the acute services system. Pressures with patient flow are largely due to delays in discharging patients; this continues to have an impact on the overall delivery of 18 week referral to treatment performance.

			The CCG continues to work closely with providers, and NHS Improvement to support delivery of recovery actions. The CCG continues to review the impact that long waiting times have on patient safety of patient experience.
Diagnostic Tests and Waiting Times (Target 1%)	R	↓	Performance against the diagnostic waiting time standard continued to fall under the required levels, during 2017/18. There has been a significant increase in the number of breaches declared by the CCG's main acute providers during 2017/18, compared to 2016/17. The majority of these breaches related to NLaG and were due to capacity and staffing pressures. Recovery plans are in place and the CCG continues to implement joint improvement plans to improve this position.
Accident & Emergency (A&E) 4 Hour Waiting Times (Target 95%) Improvement Trajectory (90%)	R	↓	This target continued to be challenging during 2017-18, with the year-end position not achieving the required 95% within 4 hours. An improvement trajectory of 90% was agreed for 2017/2018, for which during October and November 2017 the local Acute Trust, Northern Lincolnshire & Goole Hospitals NHS Foundation Trust (NLaG) did achieve. Unfortunately, performance reduced in quarter 4 2017/18 which led to an overall underachievement of this target. Recruitment remains a significant issue across the Humber area, particularly in terms of medical staffing, and this is having a direct impact on A&E performance. The A&E Delivery Board continues to implement cross organisational actions to improve delivery of the emergency pathway standards.
62 Day Cancer Referral to Treatment – Total (Target 85%)	R	↓	The CCG continued to experience difficulties with some of the Cancer pathways during 2017/18. These challenges largely related to the clinical complexity of some cases, specific issues around the reliability of equipment and delays in diagnostic services. These areas continue to be reviewed by providers and Commissioners as part of the contract management process, with support from the Yorkshire & Humber Clinical Network for Cancer.
Ambulance Response Programme (ARP)	R	↓	The new Ambulance Response Programme (ARP) standards were introduced on 19th July 17. Reporting under the ARP means that there is no longer a performance 'hit' or 'miss' based on the speed of response. Performance measures are based on the mean and/or 90th

			percentile. The mean time relates to the average time it took the ambulance service to respond to the total number of patients within that category. The 90th percentile gives the time by which 90% of patients received a response. ARP performance data was provided to the CCG from August 2017, however, the output from these new performance standards is not to be formally judged until April 2018; therefore, the information provided in this section is for monitoring purposes only. Category 1 – 3 ambulance response times were not achieved between 1 Aug 17 – 31 March 18 (latest data available).
Treating and caring for people in a safe environment & protecting them from avoidable harm – C Difficile	R	↓	As at 31 March 2018 (latest data available), there have been 42 cases of C Difficile reported (since 1 April 2017), against an annual trajectory of 31. In light of this, the CCG failed to achieve this indicator during 2017/18. Each C Difficile case is subject to a Post Infection Review (PIR) process, in order to identify any potential lapse in care.

In response to some of the challenges described above, during 2017/18 the CCG worked in collaboration with other commissioners and regulators to review performance issues at Northern Lincolnshire & Goole NHS Foundation Trust (NLaG).

As part of this review, specific recommendations were made to NLaG to support recovery and sustain performance; these recommendations have been used to create an improvement plan for delivery in 2018/19. It is anticipated that this plan will support the local health system by improving performance, including reduction of patient waiting times across a range of specialties.

The CCG continues to monitor and review performance across its providers by

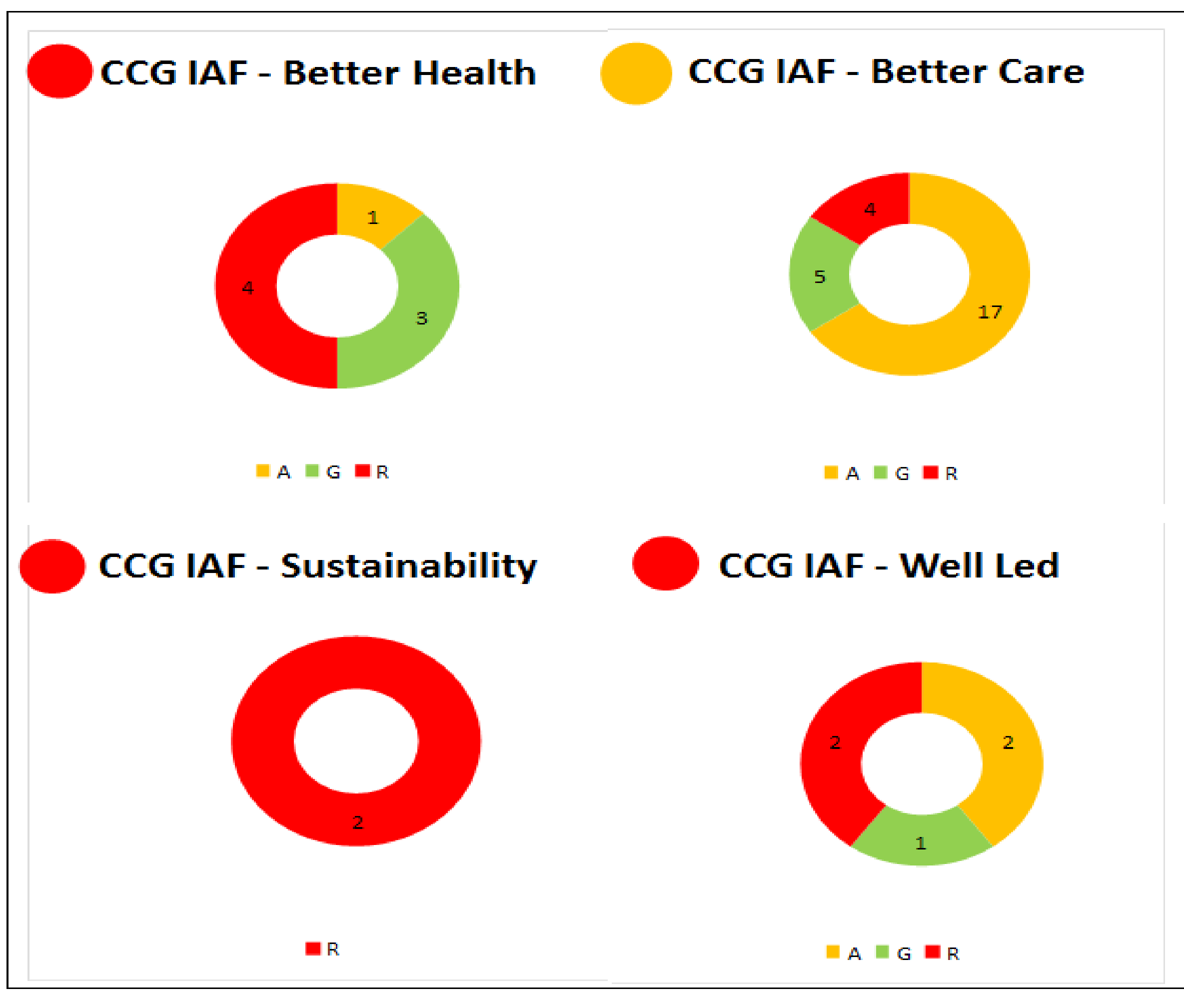
- utilising in-house performance and business intelligence monitoring systems;
- working alongside the Embed performance management team to drive performance improvement;
- working in collaboration with our main providers to strengthen performance through partnership working.

Improvement & Assessment Framework

The CCG's Improvement and Assessment Framework (IAF) provides a greater focus on assisting improvement across the local health system, and sits alongside the CCG's statutory assessment function.

The framework draws together the NHS Constitution, performance and finance metrics and transformational challenges and plays an important part in the delivery of the Five Year Forward View.

The dashboards below provide the latest summary indication of the CCG's current achievements at the end of 2017 (as at 31 March 18).



IAF Indicator Overview

Better Health

The CCG is currently rated red against 4 out of the 8 indicators in this category. These red indicators relate to prescribing; childhood obesity; personal health budgets and unplanned hospitalisation for chronic ambulatory care sensitive conditions.

Better Care

There are 24 indicators in this category, and the CCG is currently rated red against 4 of these indicators. The red indicators relate to Cancer 62 Day waiting times; A&E 4 Hours waiting times; 18 Week Referral to Treatment Times and Maternity smoking at time of delivery.

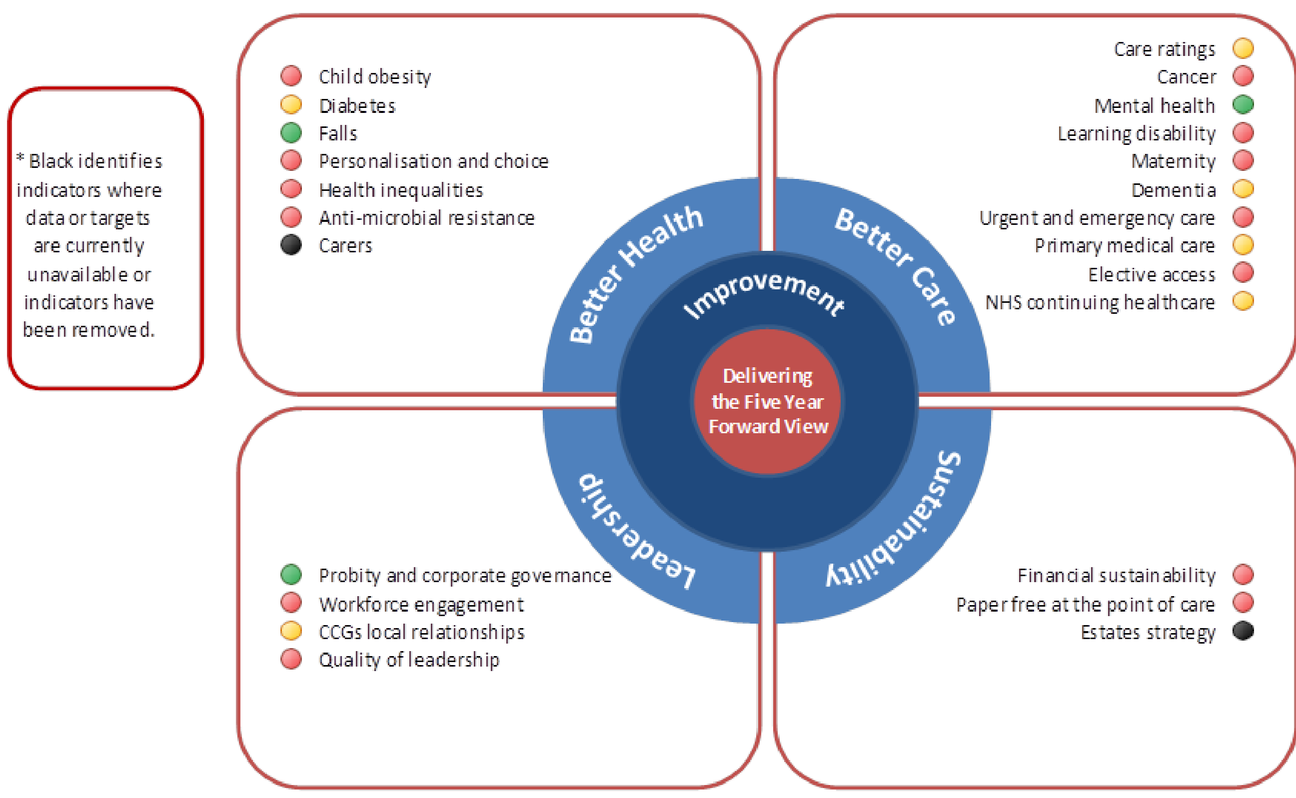
Sustainability

The CCG is currently rated red against each of the 2 indicators in this section. These indicators relate to E-Referral utilisation and the CCG's In Year Financial position.

Well Led

There are 5 indicators within this category and the CCG is currently rated red against 2 of these indicators. These relate to the Staff Engagement Index and quality of the CCG's leadership.

NHS North Lincolnshire CCG - MY NHS IAF Indicators



CCG Assurance

The CCG meets with NHS England on a quarterly basis to review progress against the IAF indicators. As part of these quarterly review meetings, the CCG provides NHS England with details on progress made against the indicators. NHS England uses this information to inform the annual assessment of the CCG's performance.

The CCG achievement against the IAF metrics is published via the MyNHS website. The CCG's 2017/18 year-end assessment will be available via the My NHS website from July 2018.

The MyNHS website can be accessed via the link below

https://www.nhs.uk/service-search/performance/search

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 17 of the Annual Accounts (see page 27) summarises the CCG's performance against these duties and directions.

- In the Financial Year 2017/18 the CCG is reporting an In-Year deficit of £6.025m.
- 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" or management costs do not exceed the agreed "Running Costs" Allocation (RCA)
- 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.

Finally, the CCG also met the Mental Health Investment Standard, due to higher Pooled Budget expenditure in the latter part of the financial year, than was originally anticipated at the start of the financial year.

1.2.3. Statutory Duties

a) Introduction

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.

b) 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 the local population continues to experience 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 we have increased 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 & 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. 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.

- **Tier 4 Obesity Services**

  - From April 2016, the CCG became responsible for commissioning both Tier 3 and Tier 4 severe and complex obesity services; this includes bariatric surgery (Tier 4) (excluding under children/young adults under 18 years of age).
  - From 1st April 2017, the CCG has been be responsible for both T3 and T4 commissioning, reinforcing the need to have access to a quality T3 service locally to support management of referrals into bariatric surgery, given that the costs for T3 services are significantly less that those initial and on-going costs associated with bariatric surgery. The CCG is currently reviewing the optimal ways in which to commission for weight management services with public health and the local authority (who are responsible for commissioning Tiers 1 and 2) to provide an integrated pathway to tier 4 services which provides an appropriate level of support to reduce requirements for bariatric surgery.

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.

c) Engaging people and communities

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, improve services, and build public confidence in the local NHS.

Our Engagement Strategy (ratified by the Governing Body in October 2016) 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.

Ensuring that patients and the public are confident that the strategy provides accessible and meaningful opportunities to contribute to the understanding, design, delivery and on-going review of local health services was identified as a key priority along with an undertaking to explore options for the development of independent assurance of the strategy and our engagement outcomes.

In June 2017 the Governing Body authorised the establishment of a Patient and Community Advisory Group (PCAG) to provide independent feedback to the CCG Governing Body that effective robust structures, processes and accountabilities are in place for engagement with local people to inform the commissioning decisions of the organisation.

Patient representatives were recruited via the CCG's Embrace Patient Network and nomination sought from the Voluntary and Community Sector.

The group is composed of Embrace members, Youth Council members, North Lincolnshire Healthwatch, Cloverleaf Advocacy, Humber and Wolds Rural Community Partnership and Westcliff Drop-In Centre.

The role of PCAG is to:

- To oversee and challenge the CCG to involve local people in their decision making
- To ensure that engagement with the wider community is undertaken using a wide range of methodologies to gather information and views and inform decisions
- To ensure that the CCG puts the patient and patient experience at the heart of quality improvement
- To offer practical support to new projects where community engagement is required
- To listen to, discuss and contribute to proposals/changes that are required; challenging decisions, where appropriate
- To ensure that any proposals and/or decisions regarding services, service change, etc. have had appropriate community involvement in line with best practice

Whilst it is important that the PCAG delivers the assurance the CCG is seeking, this group must be patient-led and we want to avoid being too prescriptive in the early stages with regard to how the group will operate to enable this to evolve as members grow in competency and confidence.

The CCG held a series of development sessions during 2017/18 with members. Formal meetings commence in April 2018 with the Patient & Public Involvement Lay Member chairing the group and reporting outcomes to Governing Body.

An Overview of Engagement and Consultation in North Lincolnshire 2017-18

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 238. Embrace members receive regular e-bulletins communications from the CCG about national, regional and local engagement opportunities in their areas of interest in health and care.

These have included:

- Musculoskeletal (MSK) and Chronic Pain Services workshop
- Sustainable Transformation Partnership workshops – Cancer, Mental Health and Self-Care
- Humber Acute Services Review
- 'Making Time for Everyone - Easier-to-access routine family health services for the future' *(see below for more detail)*
- 'A Clearer View – *(see below for more detail)*
- Progress and feedback reports about previous Health Matters Engagement Events

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

Patient Participation Group (PPG) Chairs Forum

This year the CCG PPI Lay Member continued to facilitate quarterly meetings for PPG Chairs in partnership with Healthwatch North Lincolnshire. The PPI Forum brings representatives from local PPGs together to share information about local and national policy initiatives; discuss proposed developments that may have an impact on patients in general practice settings and work together to promote PPG development. This group has continued to grow in confidence and effectiveness to drive service improvement at a practice level and in contributing to the development of primary care throughout North Lincolnshire.

To support these aims guest presenters have attended meetings to share and discuss key developments including NHS Digital (summary care records), NHSE (GP Five-Year Forward View) and North Yorkshire and Humber Research and Development Services (Research and Development in GP practice).

Health Matters listening sessions

Embrace members, public and stakeholders were invited to meet with CCG leaders and staff informally to discuss their concerns, ask questions and share their experiences.

Stakeholder Groups & Partnerships

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, drop-in centres and support groups. We have also developed links with British Steel for staff engagement and participated in the Crosby International Day event and Healthwatch Wellbeing Fayre over the summer.

The Voluntary, Community & Social Enterprise (VCSE) Event

In July 2017 the CCG in partnership with Voluntary Action North Lincolnshire (VANL) and Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) jointly hosted a cross-sector event 'Transforming Care in North Lincolnshire' - The Role of the Voluntary and Community Sector as a Key Partner in Transforming Health. Around 60 representatives from local organisations came together to share good practice and discussion opportunities for joint working.

Making Time for Everyone - easier-to-access routine family health services for the future

During the summer of 2017 the CCG carried out extensive public and stakeholder engagement to patient views to contribute to the design of a new service specification for a contract to operate extended access to GP practice services.

The engagement sought to look at ways that might make it easier and more flexible to get routine (non-emergency) advice or treatment from a GP practice; specifically:

- What times of day and days of the week for routine appointments
- Whether people are willing to travel to another GP centre for routine appointments outside of normal hours – if so, how long would they be willing to travel?
- Whether people would be willing to see appropriate healthcare professionals other than a GP
- How people feel about using technology – this might be face to face appointments over Skype or using mobile phone apps or online symptom checks to help people feel more confident about making decisions about their family's health:

Significant numbers of local people received the information via presentations or through leaflets, took part in conversations, gave their views verbally and had the opportunity to participate by filling in the survey.

By linking with local organisations, networks, businesses and PPG groups the engagement achieved high levels of participation though our outreach activity. In total 611 people completed the survey either online or in paper form which included patients from all of our North Lincolnshire practices and provided a robust sample size.

The engagement findings report has been published on the CCG website and the CCG will shortly publish a 'You Said: We Did' progress report showing how the views of patients have informed the future reconfiguration of GP services.

A Clearer View – transforming Ophthalmology Services across North And North East Lincolnshire

Between October and December 2017 the CCG working in partnership with North East Lincolnshire Clinical Commissioning Group launched a public engagement to inform plans to improve ophthalmology (eye) services to meet increasing demand for these services.

The CCG's want to design more streamlined services and reduce the amount of hospital based appointments; and look at how eye services are provided when people do need to go onto a ward for treatment, to enable a safe, high quality hospital service to continue to be provided within the available funding for North and North East Lincolnshire patients into the future.

The engagement sought to find out what was important to patients, carers, staff and members about their care specifically:

- Where they access services
- How they access services
- Waiting times
- How appointments and communications between patient and services are managed
- Linking in with GP

Public information about the engagement was available digitally, online and in audio format. There was a survey questionnaire which was available online and hard copy including large print. North East and North Lincolnshire Healthwatch organisations visited local hospital outpatient clinics to promote the engagement. A total of 139 surveys were returned. The CCG's held three public focus groups and visited a number of special interest and community group meetings.

The engagement findings report has been published on the CCG website

The findings from this Report will be used to support the CCGs on-going work around provision of Ophthalmology services. In particular we are working with our providers to ensure they understand what is important to patients using ophthalmology services and that they deliver services in a way which best meets the views expressed by patients

d) Equality and Diversity

The Equality Act 2010 (the Act) legally protects people from discrimination in the workplace and in wider society. The Act replaced previous antidiscrimination laws with a single Act, making the law easier to understand and strengthening protection in some situations.

The intention of the general equality duty is to ensure that a public organisation, like North Lincolnshire CCG, has due regard to the following:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act;
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

At North Lincolnshire CCG, we are committed to promoting equality and fairness for patients, carers and staff, and this is seen through the following.

Equality and Diversity Policy

Our Equality and Diversity Policy 2017-19 sets out the CCG's approach to promoting equality and diversity and explains how we aim to meet the public sector equality duty; this approach is underpinned by the CCG's equality objectives.

In applying this policy, the CCG will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to trade union membership, or any other personal characteristic.

Equality Objectives 2017 - 20

Under the public sector equality duty, the CCG is required to develop and publish equality objectives at least once every four years.

The 2017-2020 Equality Objectives for North Lincolnshire CCG are:

Objective 1:

The CCG will engage and involve, with due regard, local people, communities and stakeholders (representing the Equality Act 2010 Protected Characteristics) when commissioning, designing and evaluating services throughout the year.

Objective 2:

The CCG will demonstrate; and report in the annual report each year; it is a fair and inclusive employer that recognises the value of diversity.

Objective 3:

The CCG will continue to embed equality and diversity principles by developing and supporting all staff and Governing Body members to promote and champion inclusion in all aspects of the CCGs work.

Equality & Inclusion Action Plan

The equality objectives cover commissioning, engagement, workforce and governance. Delivery of these objectives is monitored via the NLCCG Equality & Inclusion action plan, which is overseen by the lead for equality, Heather McSharry, Governing Body Lay member.

The action plan has been developed by members of the Equality and Inclusion Meeting, in collaboration with senior managers, and is refreshed annually.

Progress with the action plan is reported to the CCG Quality, Performance & Finance Committee throughout the year, and twice a year to the Board.

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 & 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 the NLCCG Patient and Community Assurance Group
- membership of Embrace our Patient and Public Engagement Network Embrace
- participation in online and hard copy surveys and questionnaires

Young People

This year the CCG has increased its engagement with young people through the Patient and Community Advisory Group (PCAG). The PCAG includes representation from the Youth Council, schools and local colleges.

Equality Champions

The CCG continues to work with local GP practices to promote equality and inclusion. Each practice has an Equality & Inclusion Champion; these Champions represent the practice at the Equality & Inclusion Champion Forum (the Forum).

The aim of the Forum is to promote a shared understanding of the equality agenda across the North Lincolnshire area. Forum meetings take place on a quarterly basis.

Positive about Disability and Mindful Employer

The CCG is signed up to the Positive about Disability Scheme. The scheme supports organisations in successfully employing and retaining disabled people and those with health problems. The CCG also remains committed to the Mindful Employer scheme which promotes a positive and supportive approach for people with mental health conditions.

Equality Impact Analysis

The CCG routinely analyse existing and new policies to ensure there is no unintended negative or disproportionate impact on groups that are protected by the Equality Act. At the CCG, no policy decision is made without an equality impact analysis being undertaken.

Our Governing Body report cover sheet includes a section specifically about equality impact which prompts managers to carry out an equality analysis of the proposal being presented.

We maintain a log of our equality analyses and we ensure that actions arising from the analyses are implemented and monitored. Our staffs also receive appropriate training and support to complete equality impact analysis.

Equality Delivery System (EDS2)

The CCG adopted EDS2 to manage our equality and diversity performance. We assessed our performance against four EDS2 goals and eighteen outcomes to determine the grades. This has helped us to identify gaps, set priorities and develop action plans.

This year, we have established the Equality and Inclusion Group and the Equality & Inclusion action plan to support our EDS2 work. Our main providers are also implementing EDS2 and we now receive regular assurance updates on compliance against the EDS2 requirements.

Workforce Race Equality Standard (WRES)

The WRES requires NHS organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) board representation.

All providers, as holders of the NHS standard contract started to implement the WRES from April 2015. CCGs are required to seek assurance and receive an annual report from providers. They are not required to apply the WRES to themselves, but pay due regard to it, due to the small size of CCG organisations.

The WRES informs and supports delivery of the CCG's Equality objectives, and action plan.

e) Improving Quality

Introduction

The CCG is fully committed to improving the quality of services provided to the population of North Lincolnshire including those services indirectly commissioned for example, primary care services and care provided in care homes. We have a statutory duty to improve quality under section 14R of the Health and Social Care Act 2012 and during 2017/18 the CCG has discharged these statutory duties in relation to quality improvement in a variety of ways.

Quality Strategy

The development of a revised Quality Strategy sets out our approach to safety and improvement including the CCG's approach to quality in the commissioning and monitoring of services for the coming year. A key aim is to strengthen the collaborative working relationships with our partners and stakeholders in order to improve the quality and provision of services in North Lincolnshire.

The strategy also builds on the recommendations from national reports such as Francis, Keogh, Berwick and Cummings and further outlines the CCG's responsibilities, in relation to quality assurance.

Quality Assurance Framework

In conjunction with the quality strategy, a Quality Assurance Framework has been developed to support delivery of the Strategy. The Framework defines the CCG's approach to meeting its objectives in relation to quality and supports staff in exercising their duty of care to the population of North Lincolnshire.

The Framework provides a comprehensive, systematic and transparent approach to reviewing quality and supports the CCG in applying the right level of rigour and challenge in respect to monitoring the standard of patient safety across our commissioned services.

The Framework has four key stages of data gathering and analysis, triangulation of themes and trends to improve clinical outcomes, review and challenge of standards and practice, and improvement and sharing. Each of these stages is an essential component within the quality assurance process, equipping the CCG with a range of methods, tools and intelligence that, when combined together, enable us to have a full appreciation of the quality of services.

Assuring Quality Across Provider Organisations

The NHS Standard Contract has a number of clauses threaded throughout that serve to focus the provider and commissioner on the achievement of quality improvement, and place

emphasis on avoiding harm. In addition to the standard terms of the contract, specific schedules that relate to quality and performance that both parties review and develop prior to agreement are also included.

These contain national and locally defined quality requirements such as national operational standards, national quality requirements, locally defined quality requirements and the Commissioning for Quality and Innovation (CQUIN) framework.

Quality Risk Profiles have also played a significant part in our assurance process and inspection visits have been made to local provider organisations enabling detailed review and analysis of the quality of services received by patients. These visits have identified where further improvements can be made and supports the commissioning decision making process.

Quality concerns identified across the CCG's main providers in 2017/18

Northern Lincolnshire & Goole NHS Foundation Trust

In April 2017, the Care Quality Commission (CQC) published the outcome report following its comprehensive inspection undertaken across all Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) sites in October, November and December 2016.

The CQC gave NL&G an overall rating of inadequate and placed NL&G in special measures for finance and quality.

Following these inspections, in June 2017 the CQC issued NL&G with a Section 29A warning notice which stated that the quality of health care provided by NL&G required significant improvement.

In response to these concerns, during 2017/18 the CCG worked in collaboration with partners to increase its level of surveillance of some NLaG services from routine to enhanced surveillance. Enhanced surveillance means that some services require a higher level of monitoring, over and above standard contract monitoring arrangements, to ensure that the standard of quality [of the services] remain suitable for patients.

The CCG undertook several quality assurance visits to some NLaG services, completed quality risk profiles of NL&G and escalated concerns identified through these visits and profiles to the Yorkshire & Humber Quality Surveillance Group for in-depth Executive review.

A further CQC inspection is currently underway and we await the outcome of this visit.

The CCG recognises that NL&G has faced several challenges during the year and some of these challenges are described above, the CCG continues to support NLaG in delivering improvement actions via the System Improvement Board.

Thames Ambulance Service Limited (TASL)

In February 2018, the Care Quality Commission (CQC) published the outcome report following its inspection of patient transport services undertaken in September and October 2017. This inspection included patients transport services provided in North Lincolnshire.

The CQC did not provide an overall rating for the service; it regulates independent ambulance services but does not currently have a legal duty to rate them. However, the CQC did provide details on the concerns identified at the time of the visits.

In response to the inspection findings, in October 2017 the CQC issued TASL with a Section 29A warning notice which stated that TASL failed to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In collaboration with other commissioners, the CCG increased its level of quality surveillance of patient transport services provided by TASL to enhanced surveillance, and this instigated several focused quality assurance visits, completion of quality risk profiles and in-depth review of findings at the Yorkshire and Humber Quality Surveillance Group during the year.

The CCG continues to work closely with commissioners, providers and other partners in the local health economy to ensure that sustainable improvements continue to be made across all of our providers, for our population.

Commissioning for Quality & Innovation (CQUIN)

The NHS CQUIN system was introduced nationally in 2009 to incentivise healthcare providers to make improvements in quality and innovation in specified areas of patient care. As part of the 2017/18 contract negotiation process, the CCG agreed CQUIN schemes for each of our main providers.

Several areas of good practice were identified during the year, including the reduction of serious infections in acute settings; increased uptake of flu vaccinations of front line staff and improvements in services provided for people with mental health needs who present to A&E.

Safeguarding Adults & Children

The CCG continues to fulfil its statutory obligations as outlined in Section 11 of the Children Act (2004), and Care Act (2014) and actively demonstrates a commitment to safeguarding children and adults with care and support needs across the community we serve. The CCG also actively works to ensure that the health and wellbeing of looked after children (LAC) is promoted.

We continue to work closely with our partner agencies, and health providers to ensure robust arrangements are in place across all services. There is also a strong commitment to safeguarding arrangements at an executive and Board level. Safeguarding arrangements have been actively monitored via monthly reports to the Quality Group and will continue to do so through the Quality, Performance and Finance Committee for 2018/19.

The CCG is an active member of the North Lincolnshire Safeguarding Children Board (NLSCB) and Safeguarding Adult Board (NLSAB). The CCG Executive Lead for Safeguarding is vice chair of NLSAB, with the Designated Nurse/ Head of Safeguarding leading on, and actively contributing to, the safeguarding boards' statutory functions and priority work streams.

We are committed to integrating safeguarding arrangements with partner agencies where appropriate to achieve improved outcomes, to ensure this is achieved, a Specialist Nurse is co-located full time in the North Lincolnshire Council (NLC) Children's Integrated Multi-Agency Partnership Team, and a Specialist Nurse co-located part-time in NLC's Safeguarding Adult Team.

In June and July 2017 the CCG, contributed to both the OFSTED Inspection of North Lincolnshire Council's services for children in need of help and protection, children looked after and care leavers and the OFSTED Review of North Lincolnshire LSCB's effectiveness.

The report was published in September, and confirmed judgements that both Children's services in North Lincolnshire, and The Local Safeguarding Board received a grading of 'Outstanding'.

A Primary Care Safeguarding Lead Forum, held on a quarterly basis, is facilitated by the Designated & Specialist Nurse and Named GP, and provides safeguarding leads with updates on priorities and emerging themes relevant to practice. This is also a forum where GPs can share good practice and raise concerns, as well as be informed of new developments in safeguarding arrangements.

Changes in the structure of dedicated health services for Looked After Children (LAC) has seen a 20% increase in commissioned nursing capacity in 2017/2018, supplementing a 25% increase in medical capacity in 2016/17.

In addition, NLCCG, in collaboration with NLC, commissions dedicated Child and Adolescent Mental Health Service capacity for North Lincolnshire LAC.

Patient Experience

The CCG is committed to working jointly with the people of North Lincolnshire to listen to patients, carers and their families and to use that information to shape the services that we commission. In 2017/18 we have developed the following areas to assist with this process:

- **NLCCG Patient and Community Assurance Group**

  In January 2018, the CCG launched the Patient and Community Assurance Group (PCAG). The purpose of the PCAG is to seek opinion on service developments and ensure that members of the public have a say on the work of the CCG and to make recommendations for change. These structures and processes are in place to inform the commissioning decisions of the CCG and to ensure that the CCG appropriately and effectively fulfils its statutory duty for public involvement outlined in the Health and Social care Act (2012) and the NHS Constitution (2013).

- **Patient Stories to CCG Governing Body**

  During 2017/18, a patient story was discussed during the public section of each Governing Body meeting. These stories included a patient's experience of managing pain whilst on a waiting list for surgery; a patient's experience of living with Motor Neurone Disease, and a carer's experience of Congenital Myotonic Dystrophy (CMD), in North Lincolnshire. The purpose of sharing these stories is to demonstrate the impact that our services have on the local population, from the perspective of our patients and their families enabling us to identify areas that may require further development and informs the CCG's planning and decision making process.

  Patient stories can be accessed via the Governing Body page on the CCG's website

  http://www.northlincolnshireccg.nhs.uk/the-board/our-meetings/

Management of complaints, comments and concerns

We understand that complaints, comments, concerns and compliments provide valuable insights into services, care and the compassion that is received by patients and their relatives; we use this feedback to continually drive improvements. All feedback received by the CCG,

including the outcome of formal investigations, forms part of the CCG's continuous quality improvement process and is managed with the relevant service provider via the contract management process.

During 2017/18, the CCG updated its Complaints Policy to reflect emerging national and local best practice. In addition to this, staff received bespoke complaints training from a legal firm that specialises in health law; the learning from this training also supports the CCG in further enhancing our processes.

Reducing avoidable harm from Healthcare Acquired Infections (HCAI's)

- The CCG's Infection Prevention and Control (IPC) Specialist Nurse has continued to work with all providers including Primary Care and Care Home services to reduce the numbers of Clostridium Difficile [C Difficilie] and MRSA cases. Significant work is done with the providers to promote best practice and provide training as requested/required.

- Post infection Reviews (PIR) are undertaken with the GP practices and other community staff when a C Difficile case arises. This assists with learning and sharing of practice and also helps to address wider infection and prevention issues ensuring that all members of the Primary Healthcare teams learn from reported incidents and outbreaks.

- Liaison with link workers within both primary care and care homes occurs on a quarterly basis by way of Forums; these sessions provide updates in relation to relevant subjects nationally, regionally and locally which can be disseminated across the health community.

- Proactive work has also been undertaken throughout this financial year in relation to conducting Infection Prevention & Control audits and the creation of action plans within both care homes and GP practices. Whilst these audits are ordinarily planned with the provider, unannounced audits are also undertaken and again, assist with the development and improvement of services.

Reducing harm from Serious Incidents

Patient safety is of paramount importance to NLCCG and this is prioritised in our focus on Risk Management. The Serious Incident and Patient Safety Groups review the data provided through any clinical patient harm incidents that have occurred within the provider organisations. The data is analysed and, where appropriate, challenged to ensure that themes and trends are addressed and lessons learnt are acted upon to ensure that risk is mitigated and reduced.

Recent changes include a more collaborative approach where we, as commissioners, have been invited to participate in Root Cause Analysis (RCA) meetings with providers; it is anticipated this will assist with the wider learning and identification of themes and trends at an earlier stage thus assisting with the reduction of such incidents.

Continuing Healthcare

NHS Continuing Healthcare (CHC) is defined as care for adults aged 18 or over which is procured and funded solely by the NHS, therefore free at the point of delivery to those

individuals who are eligible. NHS CHC can be delivered in a care setting or as a package of care within an individual's own home.

To be eligible, individuals are required to be assessed and identified as having a 'primary healthcare need' as set out in the National Framework for NHS Continuing Healthcare and NHS–funded Nursing Care (2012). This is identified by looking at four key characteristics - Nature, Intensity, Unpredictability & Complexity of the care.

A rigorous quality review of the CHC service has been undertaken over this financial year to ensure maximum efficiency and effectiveness within this complex service. This included a review of workforce, documentation and policy and processes, including patient experience data. The review of workforce brought about the creation of two new roles within the team to further improve efficiency and effectiveness; a Procurement Officer and a Personal Health Budget Business Co-ordinator. The review of skill mix identified further training needs to the nursing team which has resulted in improvements to the decision making of recommendations for eligibility for CHC funding.

A focus on Personal Health Budgets (PHBs) has resulted in a significant increase in the number of individuals in receipt of a PHB. A PHB is an amount of money to support an individual's health and wellbeing needs which is planned and agreed with the individual and which allows them to manage their healthcare and control the support they require such as treatment, equipment and personal care in a way which suits them.

f) 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

Introduction

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 2017/18 we have maintained our initiatives from 16/17 to reduce our carbon footprint, these include

- Installing recycling bins for staff to use
- Cutting down on printing, especially agendas and papers for meetings
- Asking staff to turn off all computer monitors when not in use by implementing a screensaver reminder

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 organisation's corporate templates that support decision making functions.

Travel

To support our ambition to reduce our carbon footprint, we continue to use unified communications tools as an alternative to face to face meetings; these include video conferencing and teleconferencing.

We continue to promote cycling to work for staff for whom this is a possibility and have offered staff a Return to Cycling workshop and bike service sessions. We have recently had the showers in the building repaired to help encourage cycling to work.

Facilities Management

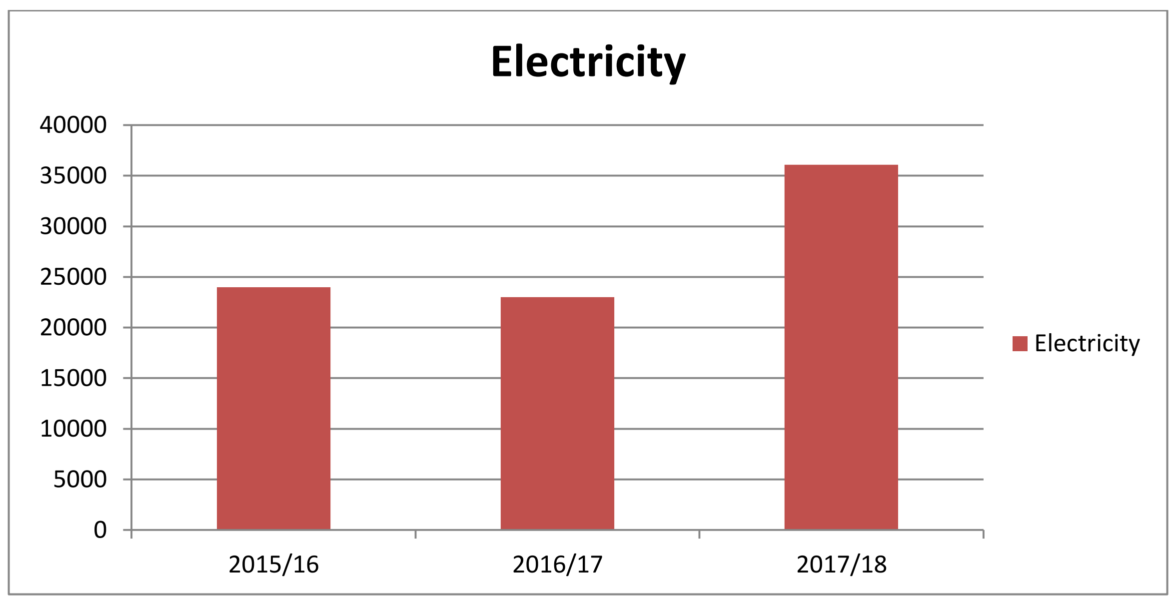
NHS Property Services (NHSPS) manage the building from which the CCG operates. The CCG has a lease/rental agreement with NHSPS and all utility bills go directly to them as 'landlord'.

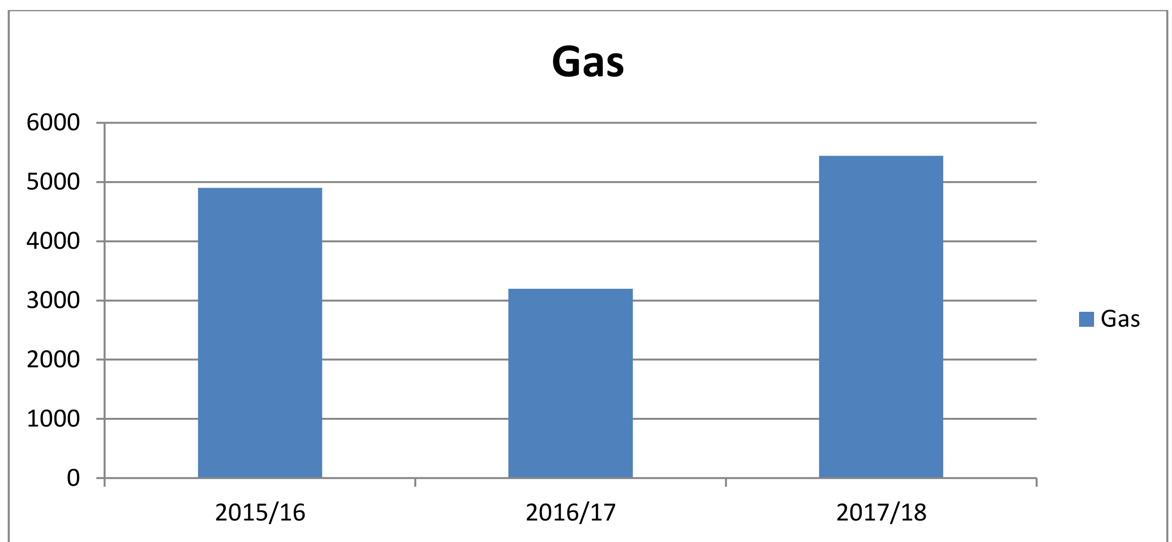
The following tables highlight our carbon footprint for gas, electricity and water (as at 28 February 18). We have seen an increase in cost for electricity, gas and water over the past year. The reason for the increase in energy usage over the reporting period can be accredited

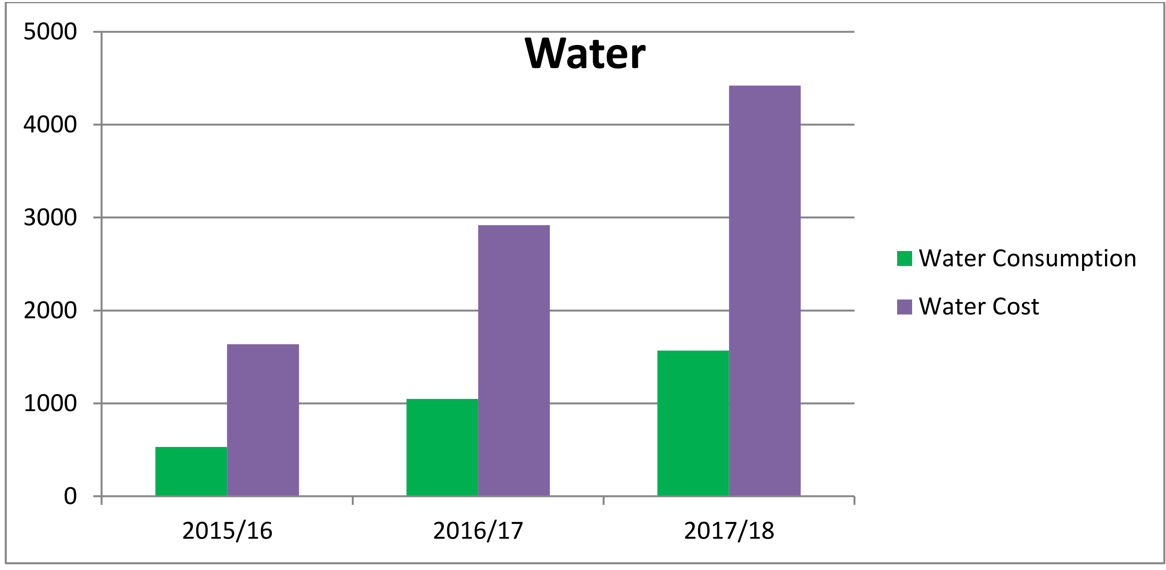
to the increase of eMBED Health Consortium staff who now occupy and frequent the building on a daily/weekly basis.

Since April 2017, the number of eMBED staff has tripled in size as Health Place has become the central location for their staff looking after the Yorkshire and Humber area.

The 3 Graphs overleaf indicate the CCG's usage of Electricity, Gas and Water over the last 3 financial years.







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.

In 2016/17, 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.

Key actions from 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 identified for improvement include to:

- Develop water reduction targets
- Reduce business miles expended by CCG employees
- Develop Active Travel/Green Travel plan
- Contract 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)

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

	2017/18
Number of FOI requests processed	240
Percentage of requests responded to within 20 working days	99.2%
Average time taken to respond to an FOI request	15 days

Two requests took longer to comply with, one delay was due to the complex nature of the request and/or response, one delay was due to unforeseen and exceptional circumstances around national cyber-attacks on the NHS.

The CCG did not provide the information requested in 37 cases because one or more exemptions applied either to part of, or to the whole request e.g. information was accessible by other means, the cost of providing the information exceeded the limits set by the FOIA, 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 where a ‘repeated request’ was received

The CCG did not provide information in 32 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

Strategic Intentions 2018/19 to 2020/21

The CCG's strategic intentions and subsequent operational plan refresh for 2018/19 has been developed in response to a range of information sources including the Joint Strategic Assessment and associated public health observatory data, Burden of Disease analysis, and benchmarking information including RightCare and Dr Foster analytical tools.

The Burden of Disease describes the differences in life expectancy locally compared to England and identifies the causes of this.

North Lincolnshire has high levels of premature mortality, ranked 244 highest out of 324 Districts with a higher proportion of cancers and respiratory disease reflecting its industrial heritage.

The UK Global Burdon of Disease Study has demonstrated that, while life expectancy has improved and years of life lost (YLL) reduced substantially over the last decade there has been no corresponding reduction in the years of life with illness and disability (YLD) and no substantial narrowing of the gap in health inequalities. Local analysis shows that the greatest variation in is those areas of highest deprivation and relate mainly to respiratory conditions in women and external factors (accidents and self-harm) and circulatory conditions in men.

The CCG has used this information along with the other sources described to help prioritise actions to address specific population needs. The CCG refreshed strategic intentions are:

Prevention:	**Out of Hospital:**

The CCG in partnership with the NL Council by 2020 aims to:
• promote a healthy start in life
• increase the number of Healthy Life Years people have by;
  – increasing health awareness, and
  – promoting healthier life choices to prevent ill health;
  –
• reduce inequalities to improve the wider determinants of health
	The CCG aims by 2020 to:
	• deliver a new community service model where care is closer to home.
	• ensure that general practice is fit for the future, able to work at scale and make the best use of resources and technologies as described in the GP Five Year Forward View.

Acute Commissioning:	**Vulnerable People:**

Prevention:	Out of Hospital:
The CCG by 2020 aims to reduce the reliance and dependence on acute services to ensure patients are only admitted: • for investigation and/or a procedure that involves a hospital stay of greater than one day or access to specialist equipment /profession which for safety or economies of scale suit hospital; • if medically unstable and/or need continuous monitoring and care; • because of emergency and/or trauma	By 2020 the CCG aims to secure sustainable: • improvement in adults, children & young people's emotional wellbeing & mental health. • comprehensive local mental health services which are responsive, high quality and which promote recovery & well- being, and which are provided as close to home as possible • improvements in relation to dementia including increased awareness, prompt diagnosis and tailored, good quality post-diagnostic treatment and support • services that promote the four key principles of Rights, Independence, Choice, & Inclusion for people with learning disabilities & provide support services which are community based & person centred

In agreeing these strategic intentions, the CCG has identified a number of priorities for 2018/19, which are listed below:

Priority
1 **Prevention –** To develop social prescribing in NL to promote self-care/self-management
2 **Out of Hospital –** To define a new community service model where care is closer to home, which requires: • Reconfiguring existing community services into more coherent groupings of care • Ensuring newly created groupings cover the key areas of care (prevention, detection/diagnosis management & rehabilitation • Ensuring groupings can deal with physical, mental and social well-being • Moving activity out of hospital which does not need to be there • Commissioning for outcomes not process
3 **Acute Commissioning** – The CCG needs to implement systems/processes to manage demand and offer alternatives in the community
4 **Primary Care** – By 2020, the CCG aims to ensure that general practice is fit for the future, able to work at scale and make the best use of resources for technologies as described in the GP 5 year forward view through the following priority areas: • Investment • Recruitment and Retention • Primary Care Networks (includes sustainability, extended access for example) • Infrastructure (Premises and IM&T)

Priority
There are also 2 cross cutting themes, these are: • Communications and Engagement • Quality
5 Vulnerable People – Focus on optimum levels of social functioning and joint commissioning
6 Medicines Management – - ensure high quality and safe prescribing in primary care that takes into account existing national and local guidance - Implement plans to look at safe "de-prescribing" of medicines to improve quality of life of our patients.

In order to deliver these priorities, the CCG will continue its work on a number of enablers. These include Estates and IT strategies, workforce, communications and engagement, quality, contracting and business support.

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

1.2.7. Use of Earmarked Funds 2017/18

The CCG was obligated to spend 100% of Practice Transformation Funding over two years. In 2017/18 there was nil expenditure, so the full £558k has been provided within the CCG’s Draft Financial Plan for 2018/19.

SECTION 2
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 2017/18 up to the signing of the Annual Report & Accounts.

Name	Designation
Emma Latimer	Chief Officer - November 2017 to present
Liane Langdon	Chief Officer - to November 2017
Dr Margaret Sanderson	Clinical Chair

2.1.1.2. Governing Body

Our Governing Body ensures that 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.

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/

The shaded sections show members who left the CCG during 2017/2018.

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

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

Emma Latimer, Chief Officer

Emma joined NHS North Lincolnshire Clinical Commissioning Group as its Chief Officer for an interim period on November 6 2017. She continues her role as Chief Officer for NHS Hull CCG which she has led since its establishment in 2013.

Emma’s 27 year career in the NHS spans senior management in the ambulance service, hospital and community and health care commissioning.

Her track record for inspirational leadership across organisational boundaries and region-wide transformation programmes saw her appointed as Leader of the Humber Coast and Vale Sustainability and Transformation Plan (STP) in 2016. The STP brings together 20 organisations including CCGs, local authorities and providers serving an estimated 1.4 million people.

Liane Langdon, Chief Officer (January 2016-October 2017) & Project Director (October 2017 to March 2018)

Liane joined the NHS in 1998 as a graduate trainee and has worked in and around health and social care since. 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. Shortly after the CCG was placed under Legal Directions in August 2017 Liane made the decision to stand down from the Chief Officer role to enable the completion of the directions from NHS England feeling that this was a natural pause in the CCG's improvement journey and the time was exactly right for a new pair of hands to take the wheel for the challenging road to recovery.

Liane went on to work with NHS England for a fixed period to take the lead on key elements of the plan to transform care for people with complex learning disabilities across Yorkshire and the Humber.

Immediately prior to joining the CCG as Chief Officer, Liane was Director of Commissioning and Strategic Development at NHS Leeds North CCG.

Emma Sayner, Chief Finance Officer

Emma Sayner joined the CCG in January 2018, she also continues her role as Chief Finance Officer with NHS Hull Clinical Commissioning Group. Emma has spent more than ten years in senior finance leadership roles and four years as Chief Finance Officer (as well as being Deputy Chief Officer) for Hull CCG.

Emma entered the NHS at the beginning of her career after completing the NHS Graduate Financial Management Training Scheme in 2000. In 2014 she undertook a six-month secondment covering the Yorkshire and Humber Director of Finance post at NHS England. She currently fulfils a key role in the Humber, Coast and Vale Sustainability and Transformation Plan (STP). Emma's skills, drive and motivation has brought together financial leads across the STP 'footprint' to reach agreement around the scale of the financial challenge and programme of work. She is well respected as a valuable source of knowledge and a mentor to many people in and out of the NHS.

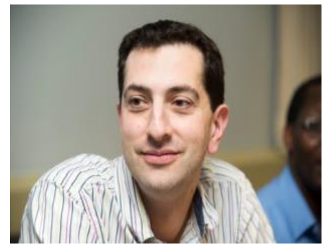
She is an Associate Member of the Chartered Institute of Management Accountants (ACMA) and holds a Bachelor of Arts Honours Degree.

Ian Holborn, Chief Finance Officer (July 2016-December 2017)

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).

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 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.

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.

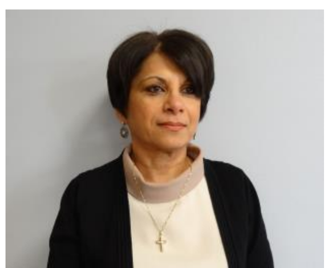
Dr Salim Modan, GP Member

Dr Salim Modan is a clinical lead for primary care, ophthalmology and MSK. He also provides input into the primary care commissioning committee, quality and performance committee and remuneration committee.

Dr Modan is a trained surgeon and worked as an assistant professor in a medical school in India. He trained in a general practise in the United Kingdom and has been a practicing GP since 2006 at Riverside Surgery in Brigg. Dr Modan had taught medical students and he currently trains GP registrars. He is also a GP representative on the North Lincolnshire Local Medical Committee.

Dr Modan has a passion for NHS and is great advocate for innovation in general practice, with a view to work on scale and the integrated commissioning model.

Dr Neveen Samuel, GP Member



Dr Samuel has been a GP partner at Winterton practice since 2001. She is a trainer, tutor and examiner for Hull and York Medical School (HYMS) and a member of the Royal College of General Practitioners (RCGP)

Dr Samuel has diplomas in elderly care, Obstetrics and Gynaecology, Child Health and family planning. She has a special interest in stroke and geriatric medicine and is her practice lead for clinical governance, dispensary/staffing lead and training and education. She established community geriatric and fall services. Dr Samuel who is married with three grown up children came from Sudan in 1991.

Ian Reekie, Lay Member, Joint Commissioning

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

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 and worked in Lincolnshire for almost all of her career and takes a very active role in community activity

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Heather McSharry, Lay Member, Equality and Inclusion

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.

Erika Stoddart, Lay Member, Governance

Erika Stoddart is currently Director of Resources for Ongo the main Housing Association in North Lincolnshire. She is a qualified management accountant and has a particular interest in risk and governance. Erika has worked in the Private, Public and the Charitable Sectors in her career to date. She is the Lay member for Governance and the Chair of the Audit Committee.

Non-Voting Members

Richard Young, Director of Commissioning

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 more than 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.

Penny Spring, Director of Public Health

Penny joined North Lincolnshire Council as Director of Public Health (a joint role with the CCG) in May 2017. She was previously Director of Public Health at Northumberland County Council.

Prior to Penny’s appointment, Chris Nield, Interim Public Health Consultant sat on the Governing Body as a non voting member.

Julie Warren, Turnaround Director

Julie was appointed as Turnaround Director jointly by the CCG and NHS England in October 2017. She has twenty five years’ experience in the NHS across Yorkshire holding Executive roles for the last ten years. She has held a variety of roles in health, including public health, commissioning, strategy, service redesign, governance and organisational development.

Prior to this role she was the Locality Director for NHS England across the North Yorkshire and Humber, overseeing the assurance and delivery of 8 CCG’s and directly commissioning GP services/military health.

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.

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.

North Lincolnshire Practices
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 Town Surgery, Barton on Humber
Winterton Medical Practice, Winterton

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 was chaired by **Dr Margaret Sanderson** from 1 April 2017 to 31 December 2017; **Dr Faisel Baig** took over as chair of the meeting from 1 January 2018.

Practice	Representative
Ancora Medical Practice	**Dr Mubarak Jajja**
Ashby Turn Primary Care Partners	**Dr Nadeem Akhtar**
Bridge Street Surgery	**Dr Andrew Whitaker**
Cambridge Avenue Medical Centre	**Dr Thennavan 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 Manish Khandelwal**
South Axholme Practice	**Dr Gary Armstrong**
The Birches Medical Practice	**Dr Pratik Basu**
The Killingholme Surgery	**Angela Elsom, Nurse Practitioner**
The Medical Centre, Barnetby	**Dr Sami 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**
Winterton Surgery	**Dr Andrew Clark**

2.1.1.5. Integrated Audit & Governance Committee

Members of the CCG's Audit Group (01 April 2017 to 31 December 2017) and the CCG's Integrated Audit & Governance Committee (01 January 2018 to 31 March 2018) during the financial year were as follows:

Audit Group – (01 April 2017 to 31 December 2017)

Member	Appointment
Ian Reekie - Chair	Lay Member – Joint Commissioning
Erika Stoddart	Lay Member – Governance
Dr Toby Blumenthal	GP
Janice Keilthy	Lay Member – Patient & Public Involvement
Dr Hardik Gandhi	New GP member
Dr Sami Ahmed	GP

Integrated Audit & Governance Committee (01 January 2018 to 31 March 2018)

Member	Appointment
Erika Stoddart	Lay Member Governance – Chair
Ian Reekie	Lay Member Joint Commissioning – Vice Chair
Heather McSharry	Lay Member Equality & Diversity
Toby Blumenthal	GP

Ian Holborn, Chief Finance Officer & Business Support, (01.04.17 – 31.12.17), Emma Sayner, Chief Finance Officer from 01.01.18, and Bill Lovell, Deputy Chief Finance Officer attended meetings to advise the group as required.

Catherine Wylie, Director of Nursing & Quality and John Pougher, Head of Governance, 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 attended meetings to provide support as required:

Benita Boyes	East Coast Audit Consortium
Robert Bassham	East Coast Audit Consortium
Shaun Fleming	East Coast Audit Consortium
Jackie Rae	KPMG
John Prentice	KPMG
Sue Kendall	AuditOne
Ian Wallace	AuditOne
Rob Walker	Mazars
Mark Kirkham	Mazars

2.1.1.6. Committee / 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.

The CCG also utilises information on complaints, to facilitate its quest for continuous improvement, and the latest complaints information for 2017/18 is summarised below:

Number of complaints brought forward from 2016/2017	Number of new complaints received in 2017/2018				Number of complaints withdrawn or passed to Provider for further response in 2017/2018	Number of complaints Upheld	Number of Complaints Partially Upheld	Number of Complaints Not Upheld	Number of Complaints On-going *(carried forward to 2018/2019)*
	Qtr 1	Qtr 2	Qtr 3	Qtr 4					
	6	*2*	*7*	*2*					
5	17				5	6	2	5	4

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 or policies that have been updated during 2017/18, with support of staff consultation include:

- Flexible Working
- Absence Management
- Redeployment
- Disciplinary
- Career Break Policy
- Petty Cash
- Lease Car
- Capital Investment/Fixed Asset Register
- Redress
- Budget Virement
- Salary Advances and Recovery of Salary Arrears
- Purchasing Card
- Non-Pay Expenditure
- Accounting & Provisions
- Losses and Special Payments
- Writing off a bad debt
- Lone Working
- Induction & Probationary Period
- Fire Safety – **New**
- Management of Complaints, Comments and Concerns
- Conflict of Interests
- Acceptable Computer Use
- Data Protection & Confidentiality
- Mobile Working
- Confidentiality Audit
- Safe Haven
- Information Security
- Code of Confidentiality
- Records Management
- Email policy
- Primary Care Rebate Scheme
- Starting Salaries
- Anti-Fraud, Bribery & Corruption
- Health & Safety - **New**

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 & 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 (EPRR) 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 2017 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 core standards including deep dive questions in the CCG Governance arrangements for EPRR. Following the self-assessment the CCG declared itself as obtaining substantial compliance. An action plan for 2018/19 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 which will be moving to a Humber wide on call rota from April 2018, also being reviewed and up-dated this year are the NL CCG Pandemic Influenza Plan, the EPRR policy, Infectious Disease Outbreak Plan and Fuel Shortage plan.

In January 2018, the CCG took part in training on Resilience Direct, the emergency response community in the UK have access to a new, fully accredited and secure information-sharing platform called Resilience Direct™ with Resilience Direct, real time information can be shared across all organisational and geographic boundaries. For the first time, organisations can work collaboratively during an incident. It brings location context to our data and can integrate with other live third party datasets making us better informed and able to make more accurate decisions, directly from a desktop or mobile device.

In February 2018 the CCG took part in a large scale multi-agency flooding exercise to 'test' the North Lincolnshire CCGs Major Incident Plan. The CCG also ensured all on call Directors had completed the Strategic Leadership in Crisis training'

Going forward into 2018/19 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 as well as on call cascade numbers.

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 2017/18, 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 that would be relevant for the purposes of their audit report

- 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.

Emma Latimer

Emma Latimer
Accountable Officer

Date: 25/05/2018

2.1.2.7. Modern Slavery Act

North Lincolnshire Clinical Commissioning Group fully supports the Government's objectives to eradicate modern slavery and human trafficking, but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement, as set out in the Modern Slavery Act 2015.

2.1.2.8. Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Emma Latimer to be the Accountable Officer of North Lincolnshire Clinical Commissioning Group. This role was filled by Liane Langdon up to November 5th 2017.

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

They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,

- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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

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

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

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

Emma Latimer

Emma Latimer
Chief / Accountable Officer

Date : 25/05/2018

2.1.3 Annual Governance Statement

2.1.3.1 Introduction and Context

The CCG and the Imposition of Legal Directions

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

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of 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.

With effect from 14 August 2017, the clinical commissioning group was subject to directions from NHS England issued under Section 14Z21 of the National Health service Act 2006.
Full details of the Legal Directions are available at:
https://www.england.nhs.uk/publication/directions-for-nhs-north-lincolnshire-clinical-commissioning-group/

The main provisions of the "Legal Directions" are as follows:

- The full disclosure to NHS England of the Capability and Capacity Review (CCR) that the CCG has commissioned together with the production of an Improvement Plan to deliver the recommendations of the CCR;
- The development of a credible financial recovery plan for Board approval that ensures that the CCG operates within its annual budget in 2017/18 remaining recurrent in subsequent years, financial analysis and reasons for deterioration; delivers efficiency initiatives and allocates resources, with a clear risk assessment;
- To commission and complete the Governance Review and implement recommendations;
- That NHS England will be involved in the process to make any new appointments to the Executive Team and the next tier of management.

In response to the "Legal Directions" the CCG has developed an Improvement Plan and the Governing Body continues to work closely with NHS England to deliver against the agreed actions.

General Context

North Lincolnshire CCG comprises 19 practices covering a population of about 174,352 (February 2018). 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 2017/18 it had a total budget of £224.027 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.

2.1.3.2 Overview on how the CCG's functions are governed

Led by the Accountable Officer

The CCG is led by the CCG's Chief Officer, who is also the CCG's Accountable Officer. The responsibilities of the CCG's Accountable Officer in terms of Governance, are set out in the Clinical Commissioning Group's Accountable Officer Appointment Letter.

Briefly include:

- responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives,
- the safeguarding of public funds and assets in accordance with the responsibilities assigned in HM Treasury's "Managing Public Money" guidance.
- ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.
- responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.
- ensuring that the CCG has made appropriate arrangement, through the main function of the Governing body, for ensuring that it exercises its functions effectively efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it, in accordance with the National Health Service Act 2006 (as amended), at paragraph 14L(2)(b).

For fuller details of the Accountable Officer's personal responsibilities please refer to section 2.1.2.8.

Through the Operation of the CCG's Constitution

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 provisions which regulate:

- Its membership and geographical area of coverage.
- 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.

2.1.3 The Governing Body and Committee Structure

a) Introduction

The Governing Body has its functions identified as set out in the Constitution which has been agreed by member practices.

The CCG maintains a Constitution and associated Standing Orders, Prime Financial Policies and Scheme of Delegation, all of which have been approved by the CCG membership and certified as compliant with the requirements of NHS England. Taken together these documents enable the maintenance of a robust system of internal control. The Scheme of Delegation defines those decisions that are reserved to the Council of Members and those that are the responsibility of its Governing Body (and its committees), CCG committees, individual officers and other employees. The Council of Members comprises representatives of the 19 member practices and has overall authority on the CCG's business.

The Governing Body has responsibility for leading the development of the CCG's vision and strategy, as well as providing assurance to the Council of Members with regards to the achievement of the CCG's objectives. It has established committees to assist in the delivery of the statutory functions and key strategic objectives.

The CCG's Improvement Plan produced in response to legal directions included a review of existing committee structures. Following extensive consultation it was agreed in January 2018 that the following committees would support the Governing Body:

- Integrated Audit & Governance Committee
- Quality Performance & Finance Committee
- Planning & Commissioning Committee
- Primary Care Commissioning Committee
- Remuneration Committee
- Senior Leadership Team

b) The Governing Body

During 2017-18 The Governing Body met 8 times in public and was quorate at each meeting. The Governing Body also held 7 workshop sessions. Attendance figures for the Governing Body and other committees are attached at **Appendix 1.**

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.
- Regular reviews of the CCG Strategic Risk Register.
- Full and active participation in the Humber, Coast & Vale Strategic Transformation Partnership (STP).
- Participation in the CCG Improvement and Assessment Framework review for NHS England.
- A self – assessment exercise using the Good Governance Matrix.
- Approval of the CCG's strategic intentions for 2018/2021 and agreement of the 6 key priority areas for 2018/19 with each area aligned to a clinical lead and CCG committee.
- Consideration and approval of the improvement plan in response to the legal directions; including the medium term financial recovery plan.

The Governing Body is supported by a number of the strategic committees, which are set out below.

c) The Integrated Audit & Governance Committee

As part of the Governance review the Group was re-formed as an Integrated Audit & Commissioning Committee in January 2018.

Chaired by the CCG Lay Member for Governance, and including GP Governing Body and additional lay representation, the committee met as an Audit Group 4 times during the year and was quorate at each meeting. It has met twice as an Integrated Audit & Governance Committee and was quorate at both meetings.

The Committee is responsible for providing assurance to the Governing Body on processes operating within the organisation for risk, control and governance. It has delegated responsibility for oversight of risk management and internal control, internal audit, external audit, value for money whilst reviewing the findings of other significant assurance functions including counter fraud.
Highlights of its work include:

- Review of draft annual report and annual accounts
- Tackling compliance issues e.g. taxation, legal and constitutional issues (e.g. tender waivers) and gaining relevant assurances.
- Regular reviews of Counter Fraud and security work
- Monitoring the implementation of audit recommendations
- Regular updates on detailed financial policies and procedures, scheme of delegation and progress against the financial recovery plan
- Working with Internal Audit on the development of assurance mapping to record internal, semi-independent assurance to the CCG linking with the Strategic Risk Register

d) Planning & Commissioning Committee

As part of the CCG Governance review the CCG's Engine Room Group was re-formed as a Planning & Commissioning Committee in January 2018.
This Engine Room met 20 times during the year and was quorate at each meeting. The Planning & Commissioning Committee met 3 times and was quorate at each meeting. The Planning & Commissioning Committee is chaired by a GP Board Member with delegated authority from the Council of Members. Its remit is to ensure the planning, commissioning and procurement of commissioning related business is in line with the commissioning strategy and organisational objectives.

Highlights of its work include:

- Review of the progress and delivery of main work programmes
- Development of the 2017/18 Operational Plan and 2018/19 refresh
- Support of the Care Home Action Team Service and re-design
- Development of vision for local urgent care provision and re-design of local services to reflect the national integrated urgent care specification
- Liaison with and support of Clinical Alliance
- Overview and selection of clinical pathway redesign
- Overseeing contracting and delivery of operations and strategy
- Community services reconfiguration
- Invitation of a range of speakers to inform and provide information on specific work areas, including the consideration of service offers
- It holds eMBED Health Consortium (eMBED) and other relevant organisations to account for operational, financial and performance issues.

e)The Quality Performance & Finance Committee

The Quality Group was re-formed as a Quality Performance & Finance Committee as a part of the CCG Governance review in January 2018.

The Quality Performance & Finance Committee is chaired by a CCG Lay member for Patient & Public Involvement. The Quality Group has met 7 times during the year and all meetings were quorate. It has met three times as a Quality Performance & Finance Committee and all meetings were quorate. The remit of the Committee is to ensure the continuing development, monitoring and reporting of performance outcome metrics in relation to the Clinical Commissioning Group's quality improvement, financial performance and management plans.

Highlights of the work undertaken by the Committee:

- A review of crisis care response at Rotherham Doncaster & South Humber Foundation Trust (RDaSH)
- Undertaking formal Service Provider visits, including those to North Lincolnshire & Goole Foundation Trust (NLaG) and Thames Ambulance Services Limited (TASL)

- The development of an integrated quality performance and finance report to ensure the Committee and Governing Body are clearly and accurately informed about the financial and performance issues along with patient safety concerns within each provider and data is appropriately analysed and considered.
- 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 through the primary care dashboard.
- 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 local care homes
- Collaborated with North East Lincolnshire CCG in the development of Quality risk profiles for NLaG, East Midlands Ambulance Service (EMAS) and Thames Ambulance Service Ltd to support the escalation of issues to the Regional Quality Surveillance Group

f) Primary Care Commissioning Committee

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, include:

- Enhanced General Practice extended hours
- Estates Technology & Transformation Fund
- Reviewing planned referrals to secondary care and arrangements for the management of practice prescribing budgets
- Review and approval of practice mergers, closure of lists and the Primary Care Transformation Fund bids.

g) The Remuneration Committee

The Remuneration Committee is chaired by the Lay Member for Patient & 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 4 times during the year and was quorate at each meeting, and its main performance role in 2017/18 was to undertake a

- Review of Very Senior Managers terms and conditions

h) The CCG's use of the UK Corporate Governance Code

To ensure compliance with best Governance practice, the CCG also refers to the UK Corporate Governance code.

Though the CCG is not formally required to comply with the UK Corporate Governance Code provisions, it has used the principles of the Corporate Governance Code as a guide to improving corporate governance, including those aspects of the Code that are considered most 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 Strategic Risk Register public meetings of the Governing Body
- Reviewed Very Senior Managers (VSM) roles, responsibilities, remuneration and performance
- Reviewed Governing Body appointments and clinical leads

i) The CCG's discharge of statutory functions and corporate governance

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.

j) Risk management arrangements and effectiveness

Arrangements for the identification, mitigation and management of risk play an integral role with in the overall corporate CCG's governance functions.

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.

In addition, 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 Senior Leadership 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. Finally, the CCG is also committed to eliminating avoidable risks relating to either staff, patients, clients or other stakeholders.

In particular, 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.

In addition, North Lincolnshire CCG actively engages with public stakeholders for example:

- Partnership working with the Local Authority through the Health and Wellbeing Board and liaison with the Health Scrutiny Panel
- Establishment of a Patient & Community Assurance Group
- 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

k) The CCG's capacity to handle risk

The Risk Management Strategy, updated in 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 Integrated Audit & Governance Committee 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 AuditOne 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 Integrated Audit & Governance Committee. The Local Counter Fraud Specialist is directly responsible to the Chief Financial Officer and all fraud work is reported to the CCG Integrated Audit & Governance Committee.

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 Performance & Finance Committee provides assurance (and Integrated Audit & Governance Committee independent assurance) that the risk registers 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 CCG.

- That the Accountable 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 Strategic Risk Register identifies the risks to the delivery of the organisations strategic objectives whilst the Corporate 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 Electronic Staff Record(ESR) Information Governance training. Any data security incidents are reported through the CCGs incident reporting system and notified to the Information Governance Manager for investigation.

l) 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 Strategic Risk Register 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.

An Assurance Framework based upon Department of Health and "best practice" guidance was adopted by the CCG in July 2017.

A key element of the framework is the Strategic Risk Register that provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives.

The Strategic Risk register maps out the key controls to mitigate the risks and provides 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 public meetings of the Governing Body and regularly by the Quality Performance & Finance Committee. The Integrated Audit & Governance Committee provides independent assurance. The Strategic Risk Register 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 2018 are highlighted in the table below:

Risk Description	Current Risk Rating
If the CCG fails to improve health inequalities and promote population health it will face increases in preventable illness.	20
If the CCG fails to deliver a new community service model where it is closer to home there will not be the capacity or resources to fund an acute model	20
If the CCG fails to implement robust demand management and offer alternatives in the community the acute sector does not have a workforce or resources to deliver the forecast demand.	20
If the CCG fails to have sustainable local mental health services we will not have people functioning at optimal levels.	20
If the CCG fails to ensure high quality and safe prescribing in primary care that considers national and local guidance it could have detrimental effects on patients and CCG resources.	20
If the CCG fails to ensure that General Practice is fit for purpose, able to work at scale and make best use of resources as described in the 5 year forward plan, we do not have the resources or capacity to continue the current model.	20
The CCG is under legal directions with NHS England and need to fulfil a number of requirements to have them removed the risk being that the CCG fails to have systems and processes in place to fulfil these requirements	20
If the CCG fails to deliver a financial plan recovery plan there will be no resources to support investment and the CCG could lose ability to self – direct from NHS England or be required to submit to regional NHSE reorganisation and review	20
If the CCG fails to deliver the recommendations outlined in the external governance review, which was a requirement of NHS England legal directions	15
The CCG does not have the correct capacity and capability to deliver all its constitutional requirements	25
The CCG is not assured that the local acute provider (NLaG) is improving against the special measures imposed by NHS Improvement following the CQC inspection	25

Each ‘strategic’ risk is owned by a lead director and is reviewed and updated on a regular basis. The Quality Performance & Finance Committee review the Corporate Risk Register and Strategic Risk Register. The Corporate Risk Register identifies the highest rated operational risks faced by the CCG. The Governing Body review the Strategic Risk Register bi-monthly. The Integrated Audit & Governance Committee reviews the Strategic Risk Register at every meeting providing independent assurance to the Governing Body. This gives significant assurance that systems are in place and that there is a clear audit trail. A Heads of Service Meeting, with representatives from each directorate, reviews the CCG’s Corporate and Directorate Risk Registers. This meeting determines if risks are appropriately assigned, key risks are identified and escalated if appropriate.

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 the effectiveness of risk mitigation plans both at a strategic and operational level.
- Ongoing work to promote embedding risk management in CCG activities and as a key tool in the strategic leadership of the CCG.
- 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.
- A Risk Appetite Workshop, to facilitate improved management and mitigation of appropriately identified risks.

m) Other sources of assurance

Internal Control Framework

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

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

- Identify and prioritise risks to the achievement of the CCG's objectives;
- Evaluate the likelihood of those risks being realised;
- The impact should they be realised;
- Manage them effectively.

The CCG's system of internal control has been in place for the year up to 31st March 2018 and up to the date of the approval of the Annual Report and Accounts.

The Strategic Risk Register is reviewed regularly by the Governing Body and the Integrated Audit & Governance Committee to ensure that risks have been identified and appropriate mitigating actions are in place. The corporate risk register and directorate registers are reviewed by the Quality Performance & Finance Committee.

Underpinning the prime financial policies, the CCG had detailed financial policies and a supporting scheme of delegation. However due to the failure of the CCG to meet financial requirements and governance concerns NHS England imposed legal directions on the CCG on the 14th of August 2017. The CCG has since been working with NHS England to comply with all the legal direction requirements. This work has included:

- Production and implementation of an Improvement Plan that will ensure the capacity, capability and governance of the CCG is fit for purpose.
- A Financial Recovery Plan.
- Implementation of an action plan based on recommendations from an external review of CCG governance arrangements.

Annual Audit of Conflicts of Interest Management

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

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.

A link to the CCG's Register of Interests for the reader is provided here:

http://www.northlincolnshireccg.nhs.uk/data/uploads/publications/declarations-of-interest/nlccg-coi-register-as-at-may-2018-2.xlsx-decision-makers.pdf

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 was 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 Primary Care Commissioning Committee also reviewed the range and quality of data regarding primary care and identified further improvements, and the CCG Board received regular quality and corporate performance reports during the year, which were refined following user 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 Information Technology 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 Performance & Finance Committee. 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 members undertake annual information governance training and have implemented a number of measures to ensure they 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 fulfil 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 local general practices 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 Integrated Governance dashboard to summarise its performance.

The dashboard summarises performance against mandatory information governance requirements. It is reviewed on a regular basis by the CCG Quality Performance & Finance Committee.

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 Internal Audit & Integrated Governance Committee/Information Governance section of this statement. North Lincolnshire CCG had no lapses of data security during 2017/18.

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
- Review of executive leads and work portfolios
- 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 their 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, Procurement services, and SBS Financial Accounting, and from NHS Digital and for NHS Electronic Staff Records (ESR).

eMBED also provide a range of services including Information Management Technology, 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 2017/18 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 2017/18.

The CCG has also received the service auditor report for payroll services from Northumbria Healthcare NHS Foundation Trust.

The CCG further has an Assurance Map which is monitored by the Integrated Audit & Governance 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.

n) Control Issues

Introduction

Identification and mitigation / management of control issues is a key feature of sound risk management systems.

During 2016/17 the CCG informed NHS England that it was unable to meet its statutory financial duties, and as a result was promptly placed under Special

Measures and subsequently issued with formal “Legal Directions” on 14th August 2017.

In addition during 2017/18 when it was clear that the CCG was not going to achieve its Planned £90K surplus for 2017/18, the External Auditors issued a report to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014. This report informed the Secretary of State for Health & Social Care that the CCG was now forecasting that it will not meet the requirement, under section 223H (1) of the NHS Act 2006 (as amended), to ensure expenditure in this financial year does not exceed income.
As a result, the CCG was subjected to an independent Governance Review and received a new Interim Accountable Officer and Chief Financial Officer to guide the CCG to Financial Recovery. A formal Improvement Plan to assist the CCG in this task was subsequently submitted to NHS England in January 2018.

The Review identified a number of control areas that needed to be explicitly addressed by an Improvement Plan, which is monitored on a regular basis by the Governing Body, and has focussed on the following areas:

Control issues identified by the Governance Review

Capability – The requirement to strengthen the capability of the senior leadership team with specialist skills required to deliver the improvements.
Actions to date have included:

- The appointment of an Interim Accountable Officer from a CCG rated as an ‘outstanding CCG’.
- The Secondment of a Turnaround Director from NHS England.
- A review of clinical leadership to support new ways of working.

Capacity – The requirement to review the CCG structures that have been a limiting factor to deliver sustainable wide improvement and provide effective commissioning and clinical leadership
Actions to date have included:

- A Review of Executive portfolio’s & structures to identify gaps.
- The newly appointed Turnaround Director has focused on supporting and strengthening: governance, leadership and financial recovery.
- Interim scoping work undertaken by the NHSE Deputy Director of Nursing to strengthen vulnerable people commissioning.
- A Review of clinical leadership roles and portfolios.

Financial Leadership – The requirement to improve financial leadership in order to support financial recovery.
Actions to date have included:

- NHSE Yorkshire & Humber support to shape the initial CCG financial recovery plan.
- Establishment of a combined Quality Performance & Finance Committee to enable greater focus on overall service improvement.
- Accountable Officer commitment and focus to prioritise the plan to stabilise the financial position.

- The appointment of an Interim Chief Finance Officer from a CCG rated as an ‘outstanding CCG’.

Governance – The requirement for the Governing Body to be more effective and improve decision making through the committee structure
Actions to date have included:

- Complete review of committees reporting directly to the Governing Body, including terms of reference, membership and frequency and implemented in January 2018.
- Instigated new templates for reporting to standardise the format and information required to aid decision making.
- Governing Body self-evaluation against the Good Governance Matrix.

Financial Recovery – The requirement is for the Governing Body to undertake causal analysis of descent into financial deficit in 2016/17, and to develop an appropriate Financial Recovery Plan
Actions to date have included:

- Root cause analysis of the CCG’s financial position has been undertaken and subjected to NHS England and third party scrutiny.
- Quality Improvement Productivity Plans have been developed with input from National NHS QIPP Team and local NHS Team and peer review exercises.
- The financial position has been stabilised, as evidenced by the CCG’s final Deficit for 2017/18 being in line with the CCG’s reported Forecast Out-turn for 2017/18, which was agreed with NHS England at the end of 2017.

The CCG Governance Review

In addition to the Improvement Plan the CCG developed an Action Plan in response to an external governance review that was required under the Directions. The Action Plan is reviewed quarterly by the Governing Body and has focussed the following main areas:

Board Development Programme

Actions to date include:

- Use of a “Board Maturity Matrix” to review Governing Body performance.
- Review of all Committees reporting to the Governing Body.
- Adoption of an integrated reporting system (i.e. bringing Quality, Performance & Finance monitoring together in one report).
- The Governing Body actively taking decisions in the public domain.
- Weekly Executive Team to Executive Team meetings with North Lincolnshire Council to promote greater integration.

Commissioning

The main action to date involves the development of joint working arrangements with NE Lincolnshire and Hull CCG.

Culture

The main action to date centred on exploring Organisational Development opportunities in partnership with North Lincolnshire Council.

Wider partnerships

Actions to date include:

- The introduction of a Project Management Office (PMO) Team working across the STP to align CCG and STP work streams.
- Extending invites to Health Watch to a range of meetings regarding service development / improvement, along with the Council for Voluntary Services.

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

Introduction

Sound corporate governance has played a key role within the CCG's overall pursuit of improved economy, efficiency and effectiveness.

2017/18 Performance

As a result of the Financial Recovery (aka Improvement Plan) the CCG has an accepted planned control deficit for 2017/18 of £6.3m and has achieved this target (subject to audit), inclusive of a further adjustment down of circa £300k due to a reduction in Category M centrally negotiated prescription charges.

Medium Term Financial Strategy

As part of the submitted Financial Recovery Plan the CCG also submitted a Medium Term Financial Plan, which returns the CCG to in Year Financial Balance and full NHS Business Rule compliance over the next 3 years.

However, with the assistance of the indicative £4m allocation which has been provisionally notified by the Commissioner Support Fund in 2018/19, the CCG is now expected to break even in 2018/19, and return to almost full NHS Business rule compliance sooner than anticipated within the Financial Recovery Plan (e.g. via achieving the Mental Health Investment Standard, and re-instating the In-year contingency reserve, etc.).

Finally, for 2018/19 the CCG has significantly reduced the Quality, Innovation. Productivity & Prevention (QIPP) risk down from over 7% in 2017/18 of the CCG's income, utilising "bottom up" manager based plans rather than "top down" unplanned savings.

Governance arrangements to promote improvements in economy, efficiency and effectiveness

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 Integrated Audit & Governance Committee and requires that it undertakes functions as set out in its Terms of Reference as agreed by the Governing Body.

The Internal Audit & Integrated Governance Committee 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 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;
- 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.

The year-end results for the Quality of Leadership Indicator will be available from July 2018 at https://www.nhs.uk/service-search/performance/search, following publication of the CCG Annual Report and Accounts.

The latest published CCG results (Q3 2017/18) are available now on the above website.

p) The duty for managing public money and the 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 Information Governance toolkit) was identified through the IG sub Group and corrective action taken to ensure compliance.

Finally, the Annual Governance draws to a close by summarising external viewpoints on the CCGs governance arrangements, before ending with the Accountable Officer's personal review of the CCG's governance, Risk Management & Internal control arrangements.

q) Counter Fraud Arrangements

The Integrated Audit and Governance Committee has assured itself that the organisation has adequate arrangements in place for countering fraud and regularly reviews the outcomes of counter fraud work. The CCG has an accredited Local Counter Fraud Specialist (LCFS) in place to undertake work against NHS Counter Fraud Authority Standards; the LCFS resource is contracted in from AuditOne and is part of a wider Fraud Team resource with additional LCFS resource available as and when required. The Chief Finance Officer is accountable for fraud work undertaken and a Counter Fraud Annual Report (detailing counter fraud work undertaken against each standard) is reported to the Integrated Audit & Governance Committee (IAGC) annually.

There is an approved and proportionate risk-based counter-fraud workplan in place which is monitored at each IAGC meeting. In line with NHS Counter Fraud Authority 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 2018 to assess the work completed around anti-fraud, bribery and corruption work and assessed itself as an 'Amber' rating. This self-assessment (SRT) detailing our scoring was approved by Chief Finance Officer prior to submission. Should a NHS Counter Fraud Authority quality assurance inspection be undertaken then any recommendations would be acted upon – to date the CCG has not been subject to an NHS Counter Fraud Authority quality inspection.

r) 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:

From my review of your systems of internal control, I am providing reasonable assurance that the system of internal control has been effectively designed to meet the organisation's objectives, as compliance with the control framework was not found to be taking place in a consistent manner and some moderate remedial action is required.

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

Audit Area	Audit Rating	CCG Response
Board Assurance Framework	Substantial	
Committee Arrangements	No assurance level provided	
Conflicts of Interest	Good	
Risk Management Arrangements	Reasonable	CCG implementing recommendation in Q1 of 2018/19. Oversight by Integrated Audit and Governance Committee
NHS Directions	Reasonable	CCG implementing recommendation in Q1 of 2018/19. Oversight by Integrated Audit and Governance Committee
Information Governance	No assurance level provided	
Strategic Planning	Limited	CCG implementing recommendation in Q1 of 2018/19. Oversight by Integrated Audit and Governance Committee. Interim Chief Operating Officer monitoring progress on a monthly basis.

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

As Accountable Officer, I have specific responsibility for reviewing the effectiveness of the system of internal control. In addition, 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.

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.

Drawing on the 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 Integrated Audit & Governance Committee and Quality, Performance & Finance Committee, and where appropriate a plan is in place to address weaknesses and ensure continuous improvement of the system.

In particular, my review is also informed by:

- External Audit providing progress reports to the Integrated Audit & Governance Committee and the Annual Completion Report within the CCG.
- Internal Audit review of systems of internal control and progress reports to the Integrated Audit & Governance Committee, especially the Head of Internal Audit Opinion.
- Assurance reports on risk and governance received from the Integrated Audit & Governance Committee.
- Performance management systems.
- Internal committee structure with delegated responsibility for risk identification, evaluation, control, review and assurance.
- Review of the Strategic Risk Register 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 Registers.
- The Corporate Risk Register

In addition to myself, the following committees and officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2017/18 and have managed risks assigned to them.

The 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 Integrated Audit & Governance Committee and delegates' responsibility for operational and clinical risk management to the Quality, Performance & Finance Committee.

The Integrated Audit & Governance Committee: 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.

The Quality Performance & Finance Committee: 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 Committee is underpinned by various sub groups covering areas including health & safety, emergency planning, information governance, infection control, quality in contracts and incident management.

Chief Finance Officer: 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.

The NHS England Local Area Team: The CCG has quarterly Assurance Reviews with the Local Area Team of NHS England.

Reviews in the first half of 2017/18 focussed on the deteriorating financial position and the leadership of the CCG in August 2017. However, the second half of the year, commenced with the NHS England facilitated appointment of key interim Directors to strategic positions within the senior management team, (i.e. myself as Chief / Accountable Officer, a new Interim Chief Finance Officer and a NHSE seconded Turnaround Director from November 2017).
The quarterly reviews since these appointments were made have been more positive, following an external governance review, and focused efforts to stabilise the CCG's financial position, working with partners including NHS England. These reviews have covered authorisation domains and the national CCG assurance framework.

The CCG is also fully committed to deliver the action plan resulting from the reviews necessitated by the CCG's descent into Special Measures / Legal Directions, in order to "get out of" Special Measures / Legal Directions as soon as practical in 2018/19.

t) Conclusion

Whilst the CCG is under Legal Directions significant progress has been made in year against the directions with the implementation of an Improvement Plan and actions arising from an external governance review.

The CCG has achieved a revised control planned deficit of £6.025m (subject to audit) and we expect to break even during 2018/19.

With the exception of the internal control issues I have outlined in my statement , my review confirms that the CCG has a system of internal controls that supports the achievement of its policies, aims and objectives that is “fit for purpose” and that these control issues either have been, or are being, mitigated and addressed.

Emma Latimer
Accountable Officer
May 2018

Annual Governance Statement Appendix:

Main meeting attendances during 2017/18

Governing Body

Date of meetings	Dr Margaret Sanderson Chair	Liane Langdon Chief Officer left 30.09.17	Emma Latimer Interim Chief Officer wef	Catherine Wylie Dir of Nursing & Quality	Ian Holborn Director of Finance - left 31.12.17	Emma Sayner Chief Finance Officer wef	Dr Robert Jaggs Fowler GP Member	Dr Faisal Baig GP Member	Dr Andrew Lee GP Member	Dr Neveen Samuel GP Member	Dr Salim Modan GP Member wef 01.01.17	Dr Satpal Shekhawat GP Member	Ian Reekie, Lay Member, Joint Commissioning	Janice Keilthy, Lay Member, Patient & Public Involvement	Heather McSharry, Lay Member, Equality, Diversity & Inclusion	Erika Stoddart, Lay Member Governance	Julie Warren Yurrarlund Director	Dr Richard Shenderey, Secondary Care Doctor	Christine Wield Consultant in Public Health	Penny Spring Director of Public Health	*Richard Young Director of Commissioning Co-opted Member
13.04.17	✓	x		x	✓		✓	✓	x	x		✓	✓	✓	✓	✓		✓	✓		✓
05.17 Private Extraordinary Meeti	✓	x		✓	✓		✓	✓	✓			✓	✓	✓				x			✓
05.17 Private Extraordinary Meeti	✓	✓		✓	✓		✓	✓	✓	✓		✓	✓	✓	✓						✓
12.05.17 Workshop	✓	✓		✓	✓		✓	✓	✓	✓		x	✓	✓		x		✓	x		✓
08.06.17	✓	✓		✓	✓		✓	✓	x	x		x	✓	✓	✓	✓			✓	✓	x
13.07.17 *Workshop*	x	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	x	x	✓
10.08.17	✓	✓		✓	✓		✓	✓	x	✓	x	✓	✓	✓	✓	✓		x		✓	✓
14.09.17 *Workshop*	✓	✓		✓	✓			x	✓	✓	✓	✓	✓	✓	✓	✓		✓		x	x
12.10.17	x	✓		✓	✓			✓	✓	✓	✓	x	✓	✓	✓	✓		✓		✓	
09.11.17 *Workshop*	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
14.12.17	✓		✓	x	✓		x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	✓
11.01.18 *Workshop*	✓		✓	✓		✓	✓	✓	✓	x	x	✓	✓	✓	✓	✓	✓	✓	✓		✓
08.02.18	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	x
08.03.17 *Workshop - Cancelled*																					
29.03.18 *Workshop*	✓		✓	x		✓	x	✓	✓	✓	✓	✓	x	✓	x	✓	✓	x		✓	✓

Engine Room from 01.04.17 until 31.12.17

Date of meetings	Dr Margaret Sanderson *(Chair)*	*Liane Langdon *(Chief Officer) - left 30.09.17*	*Emma Latimer *(Interim Chief Officer) wef 6.10.17*	Julie Warren *Turnaround Director*	Richard Young *(Director of Commissioning)*	Catherine Wylie *(Dir of Risk & QA)*	**Ian Holborn *(Dir of Fin)*	Dr Faisal Baig	Dr Mbugua - left 30.06.17	Dr Salim Modan wef 01.07.17	Dr Neveen Samuel	Dr Robert Jaggs-Fowler	Dr Andrew Lee	Dr Satpal Shekawat	*Penny Spring Director of Public Health	*Christine Nield *(Cons in Public Health)*	*Cheryl George *Consultant in Public Health*
06.04.17	✓	×			✓	✓	✓	✓	×		✓	×	✓	✓		✓	
20.04.17	✓	×			✓	✓	✓	✓	×		✓	✓	✓	✓		✓	
04.05.17	✓	×			✓	✓	×	✓	×		✓	✓	✓	✓		✓	
18.05.17	✓	✓			✓	✓	✓	✓	×		✓	×	✓	✓	×	✓	
01.06.17	✓	×			✓	✓	✓	✓	×		✓	✓	✓	×	✓	×	
15.06.17	×	✓			×	✓	✓	✓	×		×	×	✓	✓	×	✓	
06.07.17	✓	✓			✓	×	×	✓		✓	✓	✓	✓	✓	×	×	
20.07.17	✓	✓			✓	✓	✓	✓		×	✓	✓	✓	✓	×	×	
03.08.17	✓	✓			✓	✓	×	✓		✓	✓	✓	×	✓	×	✓	
17.08.17	✓	✓			✓	✓	✓	✓		✓	✓	✓	✓	×	✓	×	
07.09.17	✓	✓			✓	✓	×	✓		✓	×	×	✓	✓	✓		
21.09.17	✓	×			✓	✓	×	×		✓	✓	×	✓	✓	✓		
05.10.17	✓	×			✓	✓	✓	✓		✓	×	×	✓	✓	×	✓	
19.10.17	✓	×			✓	✓	✓	✓		×	✓	×	×	×	✓		
02.11.17	×		×	✓	✓	×	✓	×		✓	✓	✓	✓	✓	✓		
16.11.17	✓		×	×	✓	✓	✓	✓		✓	✓	✓	✓	✓		✓	
30.11.17 Workshop	×		×	✓	✓	✓	✓	✓		✓	✓	✓	✓	×			✓
07.12.17 Cancelled																	
21.12.17	✓		✓	✓	✓	✓	✓	×		✓	×	✓	✓	✓		✓	

Became Planning & Commissioning Committee with effect from 01.01.18

Date of meetings	Dr Satpal Shekhawat *(Chair)*	*Emma Latimer *(Interim Chief Officer) wef 6.10.17*	Julie Warren *Turnaround Director*	Richard Young *(Director of Commissioning)*	Catherine Wylie *(Dir of Nirsing & Quality)*	Emma Sayner Interim Chief Finance Officer wef 01.01.18	Dr Faisal Baig	Dr Salim Modan wef 01.07.17	Dr Neveen Samuel	Dr Robert Jaggs-Fowler	Dr Andrew Lee	Dr Margaret Sanderson	Jane Ellerton Head of Strategic Commissioning	Bill Lovell Deputy Chief Finance Officer	Chloe Nicholson Quality Manager	Ian Reekie - Lay Member Joint Commissioning	Janice Keiltity Patient 7 Public Involvement	*Penny Spring Director of Public Health	Victoria Gibbs Head of Integerated Commissioning & Prevention
18 .01.18	✓	✓	✓	✓	×	×	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
15.02.18	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	
15.03.18	✓	×	✓	✓	✓	×	✓	✓	✓	×	✓	✓	✓	×	✓	×	✓		✓

Joint Commissioning Committee from 01.04.17 until 31.12.17
Became Primary Care Commissioning Committee from 01.01.18 - 31.03.18

Date of meetings	Ian Reekie Lay Member Joint Commissioning	Ian Holborn - Director of Finance - 01.04.17 - 31.12.17	Emma Sayner Interim Chief Officer - wef 01.01.18	Dr Andrew Lee	Dr Margaret Sanderson	Catherine Wylie Director of Risk and Quality Assurance/Nurse Member	Richard Young Director of Commissioning	Dr Robert Jaggs-Fowler Medical Director	Liane Langdon Chief Officer	Emma Latimer Interim Chief Officer	Janice Keilthy Lay member Patient and Public Involvement	Erika Stoddart Lay Member Governance	Heather McSharry Lay Member Equality & Inclusion	Carol Lightburn - Director Healthwatch	Amalia Booker - Humberside LMC	Geoff Day Head of Co-Commissioning	Dr Wendy Barker NHSE
20.04.17	✓	✓		✓	x	✓	✓	✓	x		✓	✓	✓	✓	✓	✓	x
15.06.17	✓	✓		✓	x	✓	x	x	✓		✓	✓	✓	✓	x	✓	✓
17.08.17	✓	✓		✓	✓	✓	✓	✓	✓		✓	x	✓	✓	✓	✓	✓
19.10.17	✓	✓		x	✓	✓	✓	x	✓		✓	✓	x		x	✓	✓
21.12.17	✓	✓		✓	✓	✓	✓	✓		x	✓	✓				✓	✓
22.02.18	✓		x	x	x	✓	✓	✓		x	✓	x	✓	✓	✓	✓	x

Quality Group from 01.04.17 until 31.03.18
Became Quality, Performance & Finance Committee with effect from 01.01.18 (see following page)

Date of meetings	Catherine Wylie Director of Quality and Risk (Chair 01.01.17 - 30.06.17)	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	Sarah Glossop Designated Nurse Safeguarding Children	Jane Ellerton Senior Manager Commissioning Support and Service Change	Hazel Moore Head of Nursing	Heather McSharry Lay Member Equality & Inclusion (Chair wef 01.07.17)
26.04.17 - CANCELLED										
02.05.17	✓	✓	x	✓	✓	✓	✓	x	✓	
24.05.17	✓	✓	✓	✓	x	✓	✓		✓	
28.06.17	✓	x	✓	✓	✓	✓	✓	✓	✓	
26.07.17	x	✓	x	✓	✓	✓	✓		✓	✓
23.08.17	✓	✓	✓	x	✓	✓	x	✓	✓	✓
27.09.17	x	x	✓	✓	x	✓	✓	✓	✓	✓
25.10.17	x	x	✓	✓	✓	✓	x	✓	x	x
22.11.17	✓	✓	✓	✓	x	x	✓	x	✓	✓
27.12.17	✓	x	✓	✓	✓	✓	✓	✓	✓	✓

Finance & Performance Group from 01.04.17 until 31.12.17

Date of meetings	Liane Langdon Chief Officer	Emma Latimer Interim Chief Officer	Ian Holbom Chief Finance Officer	Catherine Wylie Director of Nursing & Quality	Richard Young Director of Commissioning	Dr Margaret Sanderson CCG Chair	Bill Lovell Deputy Director of Finance	Jane Ellerton Head of Strategic Commissioning	Alicia Gray Performance & Information manager	Ian Reekie Lay Member Governance	Janice Keilthy Lay Member PPI - Chair	Erika Stoddart Lay Member Governance	Heather McSharry Lay Member Equality & Diversity	Dr Robert Jaggs-Fowler Medical Director	Dr Faisal Baig	Dr Shekhawat	Dr Andrew Lee	Dr Salim Modin	Julie Warren Turnaround Director	John Pougher Head of Governance
30.03.17	✓		✓		✓	✗	✓	✓	✗	✗	✓	✗		✗	✗	✗	✗			
23.05.17			✓	✗	✓		✗	✗	✓	✗	✓			✓		✗	✗			
30.05.17			✓				✓				✓	✓								✓
01.08.17	✗		✓	✗	✓						✓	✓	✓	✗		✗	✗			
05.10.17			✓	✓	✓		✓	✓	✓		✓	✓	✓	✗		✗	✓	✓		
07.12.17		✗	✓	✓	✗		✗				✓		✓			✗	✗	✓	✓	

Became Quality, Performance & Finance Committee with effect from 01.01.18

Date of meetings	Janice Keilthy Lay Member Patient & Public Involvement (Chair)	Heather McSharry Lay Member Equality & Inclusion Vice Chair	Catherine Wylie Director of Quality and Risk (Chair 01.01.17 - 30.06.17)	Ian Holborn Chief Finance Officer	Emma Sayner Chief Finance Officer	Dr Faisel Baig Clinical Lead for QIPP	Dr SalimModain - GP	Jane Ellerton Senior Manager Commissioning Support and Service Change	Hazel Moore Head of Nursing	Dr Robert Jaggs-Fowler Medical Director	John Pougher Head of Governance	Chloe Nicholson Quality Manager	Bill Lovell Deputy Director of Finance	Sarah Glossop Designated Nurse Safeguarding Children
24.01.18	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
01.03.18 Cancelled														
08.03.18	✓	✓	✓		✗	✓	✗	✓	✓	✓	✓	✓	✓	✓

Audit Group from 01.04.17 until 31.12.17

Date of meetings	Ian Reekie Lay Member - Joint Commissioning - Chair	Erika Stoddart Lay Member Governance	Janice Keilthy Lay Member PPI	Dr Hardik Gandhi	Dr Sami Ahmed	Dr Toby Blumenthal
19.04.17	✓	✓	✓	✓	✓	✓
24.05.17	x	✓	✓	✓	x	✓
12.07.17	✓	✓		x	x	✓
08.11.17	✓	✓		x	x	✓

Became Integrated Audit & Governance Committee with effect from 01.01.18

Date of meetings	Erika Stoddart Lay Member Governance - Chair	Ian Reekie Lay Member - Joint Commissioning - Vice Chair	Heather MsSharry Lay Member Equality 7 Diversity	Dr Toby Blumenthal
01.03.18 Cancelled				
08.03.18	✓	✓	✓	x

Remuneration Committee 01.04.17-31.03.18

Date of meetings	Janice Keilthy Lay Member PPI - Chair	Dr Salim Modan - Vice Chair	Erika Stoddart - Lay Member Governance	Dr Satpal Shekhewat
03.11.17	✓	✓	✓	✓
09.11.17	✓	✓	x	x
08.12.17	✓	✓	x	x
08.02.18	✓	✓	x	x
21.03.18	✓	✓	✓	x

Council of Members - 01.04.17-31.03.18

Date of meetings	Ancora	Ashby Turn	Barnetby	Bridge St	Cambridge Avenue	Cedars	Central	Church Lane	Market Hill	Oswald Rd	Riverside	South Axholme	Sth Killingholme	The Birches	Traingate	Trent View	West Common Lane	West Town	Winterton
27.04.17	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
25.05.17	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
22.06.17 AGM	✓	✓	✗	✗	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓
29 June 17 - ER Workshop	✓	✓	✓	✗	✓	✓	✓	✓	✗	✓	✓	✓	✗	✗	✗	✗	✓	✗	✗
27.07.17 Cancelled																			
24.08.17	✓	✓	✓	✗	✓	✓	✗	✓	✗	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓
28.09.17	✓	✓	✓	✓	✓	✓	✓	✓	✗	✗	✗	✓	✗	✓	✓	✓	✓	✓	✓
26.10.17	✗	✓	✓	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓	✓
23.11.17	✓	✓	✓	✓	✓	✓	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓
25.01.18	✓	✓	✗	✓	✗	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
22.02.18	✓	✓	✗	✓	✗	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
22.03.18	✓	✓	✓	✗	✓	✓	✗	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓

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 1.2.3. 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 2016/17 the national Agenda for Change pay award resulted in all CCG staff on Agenda for Change being awarded a 1% consolidated (i.e. pensionable) pay award, and as result of the CCG entering Special Measures / Legal Directions VSMs did not receive any pay award for 2017/18.

2.2.4. Salaries and Allowances (Subject To Audit)

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

Table 1a) *contains details the details for 2017/18 with comparative figures for 2016/17 shown in* ***Table 1b)****.*

TABLE 1A: SALARIES & ALLOWANCES 2017/18

NAME		POSITION TITLE	PERIOD IN OFFICE	(A) SALARY (Bands of £5,000)	(B) EXPENSE PAYMENTS £ (Taxable - rounded to the Nearest £100)	(C) PERFORMANCE PAY & BONUSES (Bands of £5,000)	(D) LONG TERM PERFORMANCE PAY & BONUSES (Bands of £5,000)	(E) ALL PENSION RELATED BENEFITS (Bands of £2,500)	(F) TOTAL SALARY & ALLOWANCES (Bands of £5,000)
Dr Margaret	Sanderson	Chair	1/04/2017 to 31/03/2018	75 to 80	-	-	-	-	75 to 80
Dr Faisel	Baig	GP Member	1/04/2017 to 31/03/2018	50 to 55	-	-	-	22.5 - 25	70 to 75
Dr Andrew	Lee	GP Member	1/04/2017 to 31/03/2018	40 to 45	-	-	-	-	40 to 45
Dr Salim	Modan	GP Member	1/07/2017 to 31/03/2018	20 to 25	-	-	-	82.5 to 85.0	140 to 145
Dr Neeven	Samuel	GP Member	1/04/2017 to 31/03/2018	30 to 35	-	-	-	177.5 - 180	205 to 210
Dr Satpal Singh	Shekawat	GP Member	1/04/2017 to 31/03/2018	30 to 35	-	-	-	10 - 12.5	40 to 45
Dr Richard	Shenderey **	Secondary Care Consultant	1/04/2017 to 31/03/2018	5 to 10	-	-	-	-	5 to 10
Liane	Langdon	Chief Officer	Chief Officer until 31/10/2017, Project Director until 31/03/2018.	90 to 95	-	-	-	42.5 - 45	135 to 140
Emma	Latimer	Chief Officer	11/11/2017 to 31/03/2018	10 to 15	-	-	-	0 to 2.5	10 to 15
Ian	Holborn	Chief Finance Officer	1/04/2017 to 31/12/2018	70 to75	-	-	-	-	70 to75
Emma	Sayner	Chief Finance Officer	11/11/2017 to 31/03/2018	15 to 20	-	-	-	5 to 7.5	15 to 20
Julie	Warren	Turnaround Director	1/11/2017 to 31/03/2018	5 to 10	-	-	-	-	5 to 10
Dr Robert	Jaggs -Fowler *	Director of Primary Care etc	1/04/2017 to 31/03/2018	90 to 95	-	-	-	-	90 to 95
Catherine	Wylie	Director of Risk & Quality Assurance (& GB Nurse)	1/04/2017 to 31/03/2018	80 to 85	-	-	-	12.5 - 15	95 to 100
Richard	Young	Director of Commissioning	1/04/2017 to 31/03/2018	80 to 85	7,000	-	-	-	85 to 90
Caroline	Briggs ***	Transformation Programme Director	1/04/2017 to 31/03/2018	80 to 85	-	-	-	22.5 - 25	100 to 105
Janice	Keilthy	Lay Member NLCCG	1/04/2017 to 31/03/2018	5 to 10	-	-	-	-	5 to 10
Heather	McSharry	Lay Member NLCCG	1/04/2017 to 31/03/2018	5 to 10	-	-	-	-	5 to 10
Ian	Reekie	Lay Member NLCCG	1/04/2017 to 31/03/2018	5 to 10	-	-	-	-	5 to 10
Erika	Stoddart	Lay Member NLCCG	1/04/2017 to 31/03/2018	5 to 10	-	-	-	-	5 to 10

* Dr Robert Jaggs-Fowler's salary covers both his roles as Primary Care Director, Safeguarding GP & Medical Director

** Dr Richard Shenderey is remunerated via Airedale NHS Foundation

*** Caroline Briggs works jointly across both North Lincolnshire & North east Lincolnshire CCGs.

Three Senior Postholders are not paid directly by North Lincolnshire CCG:

1) Emma Latimer (Chief Officer) is on the payroll of Hull CCG. Total Salary £135k - £140k
2) Emma Sayner (Chief Finance Officer) is on the payroll of Hull CCG. Total Salary £105k - £110k
3) Julie Warren (Turnaround Director) is the substantitive Locality Director for North Yorkshire & The Humber, and is paid via the payroll of NHS England. Total Salary £120k - £125k

TABLE 1B: SALARIES & ALLOWANCES 2016/17

NAME		POSITION TITLE	PERIOD IN OFFICE	(A) SALARY (Bands of £5,000)	(B) EXPENSE PAYMENTS £ (Taxable - rounded to the Nearest £100)	(C) PERFORMANCE PAY & BONUSES (Bands of £5,000)	(D) LONG TERM PERFORMANCE PAY & BONUSES (Bands of £5,000)	(E) ALL PENSION RELATED BENEFITS (Bands of £2,500)	(F) TOTAL SALARY & ALLOWANCES (Bands of £5,000)
Dr Margaret	Sanderson	Chair	1 April 2016 to 31st March 2017	75 to 80	-	-	-	-	75 to 80
Dr Faisel	Baig	GP Member	1 April 2016 to 31st March 2017	45 to 50	-	-	-	7.5 to 10	55 to 60
Dr Andrew	Lee	GP Member	1 April 2016 to 31st March 2017	40 to 45	-	-	-	-	40 to 45
Dr James	Mbugua	GP Member	1 April 2016 to 31st March 2017	30 to 35	-	-	-	5 to 7.5	35 to 40
Dr Nicholas	Stewart	GP Member	1 April 2016 to 31st 1st October 2016	15 to 20	-	-	-	-	15 to 20
Dr Satpal Singh	Shekawat	GP Member	1 October 2016 to 31st March 2017	15 to 20	-	-	-	42.5 to 45	55 to 60
Professor John	Mayberry	Secondary Care Consultant	1 April 2016 to 10th June 2016	0 to 5	-	-	-	-	0 to 5
Dr Richard	Shenderey **	Secondary Care Consultant	1 October 2016 to 31st March 2017	-	-	-	-	-	0
Liane	Langdon	Chief Officer	1 April 2016 to 31st March 2017	105 to 110	-	-	-	127.5 to 130	230 to 235
Ian	Holborn	Chief Finance Officer	1 April 2016 to 31st March 2017	70 to 75	-	-	-	10 to 15	80 to 85
Dr Robert	Jaggs -Fowler *	Director of Primary Care	1 April 2016 to 31st March 2017	140 to 145	-	-	-	-	140 to 145
Catherine	Wylie	Director of Risk & Quality Assurance (& GB Nurse)	1 April 2016 to 31st March 2017	80 to 85	-	-	-	65 to 67.5	145 to 150
Richard	Young ****	Interim Director of Commissioning	4th June 2016 to 31st March 2017	-	-	-	-	-	0
Caroline	Briggs ***	Transformation Programme Director	1 April 2016 to 30th June 2016	80 to 85	-	-	-	-	80 to 85
Paul	Evans	Lay Member NLCCG	1 April 2016 to 31st March 2017	5 to 10	-	-	-	-	5 to 10
Janice	Keilthy	Lay Member NLCCG	1 April 2016 to 31st March 2017	0 to 5	-	-	-	0 to 2.5	0 to 5
Heather	McSharry	Lay Member NLCCG	1 November 2016 to 31st March 2017	0 to 5	-	-	-	0 to 2.5	0 to 5
Ian	Reekie	Lay Member NLCCG	1 April 2016 to 31st March 2017	5 to 10	-	-	-	-	5 to 10

* Dr Robert Jaggs-Fowler's salary covers both his clinical & non clinical roles (i.e. across his roles as GP Governing Body member / Safeguarding GP & Medical Director

** Dr Richard Shenderey is remunerated via Airedale NHS Foundation

*** Caroline Briggs Salary reflects her full salary for 2016/17, although she was only in the Director of Commissioning role for 3 months.

**** Richard Young - no values were disclosed in 2016/17 here as this post was reported under the off payroll sections of the annual report.

2.2.5. Pension Benefits (Subject to Audit)

Details of Pension benefits are shown in **Table 2** over leaf.

Table 2a*) contains details the details for 2017/18 with comparative figures for 2016/17 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 2017/18

NAME		POSITION TITLE	PERIOD IN OFFICE	(A) REAL INCREASE IN PENSION - AT PENSION AGE (Bands of £2,500)	(B) REAL INCREASE IN PENSION LUMP SUM AT PENSION AGE (Bands of £2,500)	(C) TOTAL ACCRUED PENSION AT PENSION AGE - AT 31st MARCH 2018 (Bands of £5,000)	(D) LUMP SUM AT PENSION AGE RELATED TO ACCRUED PENSION AT 31st MARCH 2018 (Bands of £5,000)	(E) CASH EQUIVALENT TRANSFER VALUE - AT 1st APRIL 2017 £000	(F) REAL INCREASE IN CASH EQUIVALENT TRANSFER VALUE £000	(G) CASH EQUIVALENT TRANSFER VALUE - AT 31st MARCH 2018 £000	(H) EMPLOYER'S CONTRIBUTION TO STAKEHOLDER PENSION £000
Dr Margaret	Sanderson *	Chair	1/04/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Dr Faisel	Baig	GP Member	1/04/2017 to 31/03/2018	0 to.2-5	0 to.2-5	10 to 15	25 to 30	132	12	144	0
Dr Andrew	Lee *	GP Member	1/04/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Dr Salin	Modan **	GP Member	1/07/2017 to 31/03/2018	2.5 to 5.0	10 to 12.5	5 to 10	10 to 15	21	62	82	0
Dr Neeven	Samuel **	GP Member	1/04/2017 to 31/03/2018	7.5 to10.0	22.5 to 25.0	5 to 10	20 to 25	0	158	158	0
Dr Satpal Singh	Shekawat	GP Member	1/04/2017 to 31/03/2018	0 to.2-5	0 to.2-5	5 to 10	10 to 15	65	7	71	0
Dr Richard	Shenderey ***	Secondary Care Consultant	1/04/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Liane	Langdon	Chief Officer	Chief Officer until 31/10/2017, Project Director until 31/03/2018.	0 to.2-5	0 to Minus 2.5	20 to 25	50 to 55	276	37	312	0
Emma	Latimer +	Chief Officer	11/11/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Ian	Holborn ++	Chief Finance Officer	1/04/2017 to 31/12/2018	-	-	-	-	-	-	-	-
Emma	Sayner +	Chief Finance Officer	11/11/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Julie	Warren ***	Turnaround Director	1/11/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Dr Robert	Jaggs -Fowler *	Director of Primary Care	1/04/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Catherine	Wylie	Director of Risk & Quality Assurance (& GB Nurse)	1/04/2017 to 31/03/2018	0 to.2-5	0 to.2-5	35 to 40	115 to 120	746	54	800	0
Richard	Young	Director of Commissioning	1/04/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Caroline	Briggs	Transformation Programme Director	1/04/2017 to 31/03/2018	0 to.2-5	0 to Minus 2.5	35 to 40	95 to 100	628	48	676	0
Janice	Keilthy +++	Lay Member NLCCG	1/04/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Heather	McSharry +++	Lay Member NLCCG	1/04/2017 to 31/03/2018	-	-	-	-	-	-	-	-
Ian	Reekie	Lay Member NLCCG	1/04/2017 to 31/03/2018	-	-	-	-	-	-	-	-

NOTES

*	These members have left the NHS pension scheme.
**	Postholders joining the NHS officer pension scheme in 2017/18: Dr Samuel joined on 1st April 2017 and opted out of the scheme on the 31st December 2017. Dr Modan joined the NHS Officer Pension scheme on 1/7/2017, and is still a member.
***	No pension details are available to the CCG for these individuals as they are not paid through the CCG's payroll.
+	For pension details related to these individuals please see Hull CCG's Annual Report & Accounts 2017/18
++	This individual left the NHS Pension scheme with less than 2 years' eligible membership, so there are no figures to disclose.
+++	These lay members were drawn into the NHS pension scheme in error in 2016/17, and arrangements are in place to refund all contributions paid and cancel all benefits accrued.

TABLE 2B) PENSION BENEFITS 2016/17

NAME	POSITION TITLE	PERIOD IN OFFICE	(A) REAL INCREASE IN PENSION - AT PENSION AGE (Bands of £2,500)	(B) REAL INCREASE IN PENSION LUMP SUM AT PENSION AGE (Bands of £2,500)	(C) TOTAL ACCRUED PENSION AT PENSION AGE - AT 31st MARCH 2018 (Bands of £5,000)	(D) LUMP SUM AT PENSION AGE RELATED TO ACCRUED PENSION AT 31st MARCH 2018 (Bands of £5,000)	(E) CASH EQUIVALENT TRANSFER VALUE - AT 1st APRIL 2017 £000	(F) REAL INCREASE IN CASH EQUIVALENT TRANSFER VALUE £000	(G) CASH EQUIVALENT TRANSFER VALUE - AT 31st MARCH 2018 £000	(H) EMPLOYER'S CONTRIBUTION TO STAKEHOLDER PENSION £000
Dr Margaret Sanderson	Chair	1 April 2016- 31 March 2017	-	-	-	-	257	-	-	-
Dr Faisel Baig	CCG GP Member	1 April 2016- 31 March 2017	0 to 2.5	-	10 to 15	10 to 15	126	18	144	-
Dr Robert Jaggs-Fowler *	Director of Primary Care	1 April 2016- 31 March 2017	-	-	-	-	-	-	-	-
Dr Andrew Lee	CCG GP Member	1 April 2016- 31 March 2017	-	-	-	-	-	-	-	-
Dr James Mbugua	CCG GP Member	1 April 2016- 31 March 2017	0 to 2.5	-	5 to 10	25 to 30	144	19	163	-
Dr Nicholas Stewart	CCG GP Member	1 April 2016- 1 Oct 2016	0 to 2.5	0 to 2.5	5 to 10	15 to 20	93	0	0	-
Dr Satpal Shekawat	CCG GP Member	1 Oct 2016- 31 March 2017	0 to 2.5	5.0 to 7.5	0 to 5	5 to 10	7	25	32	-
Paul Evans	Lay Member NLCCG	1 April 2016- 31 March 2017	-	-	-	-	-	-	-	-
Ian Reekie	Lay Member NLCCG	1 April 2016- 31 March 2017	-	-	-	-	-	-	-	-
Janice Keilthy	Lay Member NLCCG	1 Oct 2016- 31 March 2017	0 to 2.5	-	0 to 5	-	-	1	1	-
Heather McSharry	Lay Member NLCCG	1 Nov 2016 - 31 March 2017	0 to 2.5	-	0 to 5	-	-	-	-	-
Professor John Mayberry	Secondary Care Consultant	1 April 2016- 10 June 2016	-	-	-	-	-	-	-	-
Dr Richard Shenderey **	Secondary Care Consultant	1 Oct 2016- 31 March 2017	-	-	-	-	-	-	-	-
Liane Langdon	Chief Officer	1 April 2016- 31 March 2017	5.0 to 7.5	2.5 to 5.0	20 to 25	50 to 55	184	89	273	-
Ian Holborn	Chief Finance Officer	1 July 2016 - 31 March 2017	0 to 2.5	-	0 to 5	-	-	-	-	-
Kieran Lappin ***	Interim Chief Finance Officer & Business Support	1 April 2016 - 11 July 2016	-	-	-	-	-	-	-	-
Catherine Wylie	Director of Nursing and Quality	1 April 2016- 31 March 2017	2.5 to 5.0	10 to 12.5	35 to 40	110 to 115	653	86	739	-
Caroline Briggs ****	Director of Commissioning	1 April 2016 - 30 June 2016	0 to 2.5	-	5 to 10	15 to 20	102	10	155	-
Richard Young ***	Interim Director of Commissioning	4 June 2016 - 31 March 2017	-	-	-	-	-	-	-	-

*	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.

2.2.6 Fair Pay Disclosure - 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 of the organisation's workforce.

The banded remuneration of the highest paid director/Member in NHS North Lincolnshire CCG in the financial year 2017-18 was £165-170k (2016-17, £195-200k). This was 4.59 times the median remuneration of the workforce, which was £36.6k (2016-17 figures were 5.61 times the median remuneration of £35.2k).

In 2017-18 and 2016-17 no employees received annualised remuneration in excess of the highest-paid director/member. Annualised remuneration ranged from £16k to £168k (2016-17 £16k to £168k)

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.

The pay multiple has fallen from 5.61 in 2016/17 to 4.58 in 2017/18. This reduction reflects the CCG's movement away from high cost agency staff in 2017/18, and the impact of the CCG's movement into special measures / legal direction and its ability to draw on experienced staff from a high quality local CCG and NHS England itself, at reasonable cost levels. Furthermore, in 2017/18 it has become possible to analyse recharged staff costs in greater detail, and to include them in the Median pay calculation.

2.2.7 Staff Report (Subject to audit)

2.2.7.1 Number of Senior Managers

As at 31st March 2018 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 2017-18 for North Lincolnshire CCG.

4. Employee benefits and staff numbers

4.1.1 Employee benefits	2017-18	Total		Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	2,924	2,632	293	1,774	1,488	286	1,150	1,143	7
Social security costs	279	279	0	162	162	0	117	117	0
Employer contributions to the NHS Pension Scheme	323	323	0	182	182	0	141	141	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	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	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**3,526**	**3,233**	**293**	**2,118**	**1,832**	**286**	**1,408**	**1,401**	**7**
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	**3,526**	**3,233**	**293**	**2,118**	**1,832**	**286**	**1,408**	**1,401**	**7**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,526**	**3,233**	**293**	**2,118**	**1,832**	**286**	**1,408**	**1,401**	**7**

The table below details the average number of people NHS North Lincolnshire CCG employed during 2017-18

Staff Group	Permanent Employees (Number)	Other Staff (Number)	Total Staff (Number)
Total CCG	66.14	2.43	68.57

2.2.7.3 Staff Composition

As at 31st March 2018 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	**8**	**9**
Employees	**14**	**59**

2.2.7.4 Sickness absence Data

North Lincolnshire CCG's sickness data for the calendar year (January – December 2017) is as follows:

Absence	Total
Average sickness %	3.6%
Total number of FTE days lost	695.9

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.

In 2017/18 the CCG remains signed up to Disability Confident Committed and Mindful Employer.

2.2.7.6 Expenditure on Consultancy

The CCG had £1,592 expenditure on consultancy in 2017/18, relating to a governance review.

2.2.7.7 Trade Union Facility Time

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

2.2.7.8 OTHER PAYMENTS DURING 2017/18 (Subject To Audit)

OFF PAYROLL & OTHER SPECIAL SALARY RELATED PAYMENTS

The CCG can confirm that during 2017-18 there were no:

- Senior manager service contracts
- Exit packages
- Severance packages
- Compensation for early retirement or loss of office
- Payment made to past directors

The CCG has reported 1 loss, which is reported in Note 15 of the Annual Accounts
The table below provides details of any new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and March 2018, for more than £245 per day.

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	5
Of which….	
No. assessed as caught by IR35	5
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the entity's payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

During 2017-18 there have been 4 off-payroll engagements for board and senior officials, as follows:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	4

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 must include both on and off-payroll engagements.	19

Details:

Emma Latimer - Chief Officer from 6 November 2017
This appointment was made on an interim basis with support from NHS England, following North Lincolnshire CCG being placed in Legal Directions in August 2017. Emma Latimer is on the payroll of an NHS organisation via Hull CCG.

Emma Sayner - Chief Finance Officer from 1 December 2017
This appointment was made on an interim basis with support from NHS England, following North Lincolnshire CCG being placed in Legal Directions in August 2017. Emma Sayner is on the payroll of an NHS organisation via Hull CCG.

Julie Warren - Turnaround Director from 1 November 2017
This appointment was made on an interim basis with support from NHS England, following North Lincolnshire CCG being placed in Legal Directions in August 2017. Julie Warren is on the payroll of an NHS organisation via NHS England.

Dr Richard Shenderey - Secondary Care Consultant from 1 October 2016
This role requires the individual to remain independent of the CCG, so that impartial advice can be given. Dr Richard Shenderey is on the payroll of an NHS organisation via Airedale NHS Foundation Trust.

AUDIT COSTS (Subject to Audit)

Our external auditor is Mazars, Mazars House, Gelderd Road, Goldersome, Leeds LS27 7JN. Auditors remuneration in relation to April 2017 to March 2018 totalled £43,000 for statutory audit services. This covered audit services required under the Audit Commission's Code of Audit Practice (giving opinion on the Annual Accounts and work to examine our use of resources and financial aspects of corporate governance).

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

BETTER PAYMENT PRACTICE CODE (Subject to Audit)

The CCG has signed up to the Better Payments Practice Code and aims to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. During 2017-18 North Lincolnshire CCG paid 99.42% of non NHS trade invoices within target and 99.73% of NHS trade invoices within target. Further details are in Note 6.1 of the Annual Accounts.

SECTION 3
ANNUAL ACCOUNTS

North Lincolnshire CCG - Annual Accounts 2017-18

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

	Note	**2017-18 £'000**	2016-17 £'000
Income from sale of goods and services	2	(655)	(3,120)
Other operating income	2	(727)	(2,510)
Total operating income		**(1,382)**	**(5,630)**
Staff costs	4	3,526	3,354
Purchase of goods and services	5	227,494	230,282
Depreciation and impairment charges	5	9	5
Provision expense	5	0	0
Other Operating Expenditure	5	405	500
Total operating expenditure		**231,434**	**234,141**
Net Operating Expenditure		**230,052**	**228,511**
Finance income			
Finance expense		0	0
Net expenditure for the year		**230,052**	**228,511**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**230,052**	**228,511**
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 2018		**230,052**	**228,511**

Please note that throughout the accounts the figures are presented in £000s.
This rounding process has in places resulted in issues with the totals not reflecting the rounded figures.

The notes on pages 5 to 27 form part of this statement

North Lincolnshire CCG- Annual Accounts 2017-18

Statement of Financial Position as at
31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	8	0	9
Intangible assets		0	0
Investment property		0	0
Trade and other receivables		0	0
Other financial assets		0	0
Total non-current assets		0	9
Current assets:			
Inventories		0	0
Trade and other receivables	9	1,212	3,939
Other financial assets		0	0
Other current assets		0	0
Cashandcashequ~a~n~	10	66	70
Total current assets		1,278	4,009
Non-current assets held for sale		0	0
Total current assets		1,278	4,009
Total assets		1,278	4,018
Current liabilities			
Trade and other payables	11	(16,1 00)	(16,348)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions		0	0
Total current liabilities		(16,100)	(16,348)
Non-Current Assets plus/less Net Current Assets/liabilities		(14,822)	(12,330)
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		(14,822)	(12,330)
Financed by Taxpayers'Equity			
General fund		(14,822)	(12,330)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers'equity:		{14,822}	(12,330)

The notes on pages 5 to 27 form part of this statement

The financial statements on pages 1 to 4 were approved by the Audit Group on behalf of the Governing Body on 23rd May 2018 and signed on its behalf by:

Chief Accountable Officer

North Lincolnshire CCG - Annual Accounts 2017-18

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

Changes in taxpayers' equity for 2017-18	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2017	(12,330)	0	0	**(12,330)**
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 2018	**(12,330)**	**0**	**0**	**(12,330)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(230,052)			(230,052)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		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 Yea	**(230,052)**	**0**	**0**	**(230,052)**
Net funding	227,560	0	0	227,560
Balance at 31 March 2018	**(14,822)**	**0**	**0**	**(14,822)**

Changes in taxpayers' equity for 2016-17	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Balance at 01 April 2016	**(9,476)**	**0**	**0**	**(9,476)**
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 2017	**(9,476)**	**0**	**0**	**(9,476)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(228,511)			(228,511)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		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 Yea	**(228,511)**	**0**	**0**	**(228,511)**
Net funding	225,657	0	0	225,657
Balance at 31 March 2017	**(12,330)**	**0**	**0**	**(12,330)**

The notes on pages 5 to 27 form part of this statement

North Lincolnshire CCG - Annual Accounts 2017-18

Statement of Cash Flows for the year ended 31 March 2018

	Note	**2017-18 £'000**	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(230,052)	(228,511)
Depreciation and amortisation	5	9	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	2,727	(1,118)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	(248)	3,966
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		**(227,564)**	(225,658)
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		**(227,564)**	(225,658)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		227,560	225,657
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		**227,560**	225,657
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(4)**	(1)
Cash & Cash Equivalents at the Beginning of the Financial Year		**70**	71
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		**66**	70

The notes on pages 5 to 27 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 and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to 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 and the CCG being subject to Legal Directions with effect from 14th August 2017.*
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.

1.4 **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.

1.6 **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 IAS 1.122. The clinical commissioning group occupies property owned and managed by NHS Property Services Ltd. While our arrangements with NHS Property Services 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:

Vulnerable People Packages of Care

The primary basis for estimating the forecast level of expenditure not yet invoiced is recorded package costs in the Broadcare patient database.
Analysis during 2017-18 (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%)

For Continuing Healthcare Packages, the following adjustments are also made:
* Pre panel packages are recorded on Broadcare at a nominal package value to reflect that on average only 1 in 5 will be found eligible.
*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.

Notes to the financial statements

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 February and 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 invoiced spend and activity recorded on the Secondary Uses Service (SUS).

1.8 **Revenue**
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 **Employee Benefits**

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

1.9.2 **Retirement Benefit Costs**
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the 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.
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.

1.17 **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.

1.20 **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 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the 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.

1.26 **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.

1.27.4 **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.

Notes to the financial statements

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 and Social Care, 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.

1.32 **Losses & Special Payments**

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

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 DH Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2 Other Operating Revenue

		2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
	Recoveries in respect of employee benefits	0	0	0	0
	Patient transport services	0	0	0	0
	Prescription fees and charges	70	0	70	33
	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
1*	Non-patient care services to other bodies	655	0	655	3,120
	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
	Non cash apprenticeship training grants revenue	0	0	0	0
2*	Other revenue	656	21	635	2,477
	Total other operating revenue	**1,381**	**21**	**1,360**	**5,630**

Explanatory Notes

1* The value of Pooled Budget Income included within Non-patient care services to other bodies for 2017-18 is nil (2016-17: £2,567k). This is as a result of a change in the transactional arrangements of the pool for 2017-18 where each party has accounted for only their own in year transactions. The final position for the pool budgets has been reflected by a single transaction at year end, resulting in a net accounting treatment.

2* The value of Better Care Fund Income (Risk Income) included within Other Revenue for 2017-18 is nil (2016-17: £2,404k)

3 Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
From rendering of services	1,381	21	1,360	5,630
From sale of goods	0	0	0	0
Total	**1,381**	**21**	**1,360**	**5,630**

North Lincolnshire CCG - Annual Accounts 2017-18

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2017-18	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	2,924	2,631	293
Social security costs	279	279	0
Employer Contributions to NHS Pension scheme	323	323	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**3,526**	**3,233**	**293**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**3,526**	**3,233**	**293**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,526**	**3,233**	**293**

4.1.1 Employee benefits

2016-17	Total £'000	Permanent Employees £'000	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
Apprenticeship Levy	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**

4.2 Average number of people employed

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**68**	**66**	**2**	**63**
Of the above: **Number of whole time equivalent people engaged on capital projects**	**0**	**0**	**0**	**0**

4.3 Exit packages agreed in the financial year

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	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	**0**	**0**	**0**	**0**	**0**	**0**

	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**

* 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 may have been recognised in part or in full in a previous period.

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.

4.4 Pension costs

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

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

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

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

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

For 2017-18, employers' contributions of £323,006 (Excluding Chair and Non Exec) were payable to the NHS Pensions Scheme (2016-17: £293,080 Excluding Chair and Non Exec) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.

5. Operating expenses

		2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
	Gross employee benefits				
	Employee benefits excluding governing body members	2,982	1,626	1,356	2,913
	Executive governing body members	544	492	52	441
	Total gross employee benefits	**3,526**	**2,118**	**1,408**	**3,354**
	Other costs				
	Services from other CCGs and NHS England	95	3	92	244
	Purchase of healthcare from foundation trusts	128,763	0	128,763	131,879
	Purchase of healthcare from other NHS trusts	20,538	0	20,538	20,031
	Sustainability Transformation Fund	0	0	0	0
	Services from other WGA bodies	0	0	0	0
	Purchase of healthcare from non-NHS bodies	31,182	0	31,182	30,947
	Purchase of social care	6,430	0	6,430	6,224
	Chair and Non Executive Members	403	403	0	500
	Supplies and services – clinical	83	0	83	76
1*	Supplies and services – general	2,473	25	2,448	4,673
	Consultancy services	2	2	0	0
2*	Establishment	704	120	584	232
3*	Transport	1,762	1	1,761	3
4*	Premises	319	97	222	353
	Impairments and reversals of receivables	0	0	0	0
	Inventories written down and consumed	0	0	0	0
	Depreciation	9	9	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	43	43	0	54
	Other non statutory audit expenditure				
·	Internal audit services	31	31	0	30
·	Other services	0	0	0	0
	General dental services and personal dental services	0	0	0	0
	Prescribing costs	32,930	0	32,930	32,921
	Pharmaceutical services	0	0	0	0
	General ophthalmic services	0	0	0	0
	GPMS/APMS and PCTMS	792	0	792	728
	Other professional fees	1,222	382	839	1,304
	Legal fees	52	14	38	0
	Grants to Other bodies	0	0	0	0
	Clinical negligence	0	0	0	0
	Research and development (excluding staff costs)	0	0	0	0
	Education and training	74	12	62	30
	Change in discount rate	0	0	0	0
	Provisions	0	0	0	0
	Funding to group bodies	0	0	0	0
5*	CHC Risk Pool contributions	0	0	0	554
	Non cash apprenticeship training grants	0	0	0	0
	Other expenditure	2	0	2	0
	Total other costs	**227,908**	**1,142**	**226,766**	**230,787**
	Total operating expenses	**231,434**	**3,260**	**228,174**	**234,141**

Explanatory Notes

1* Supplies and services – general programme expenditure includes £1,062k of Pooled Budget costs (2016-17: £3,151k). This is as a result of a change in the transactional arrangements of the pool for 2017-18 where each party has accounted for only their own in year transactions. The final position for the pool budgets has been reflected by a single transaction at year end, resulting in a net accounting treatment.

2* Establishment programme expenditure has increased during 2017-18 as follows:

a) 2017-18 includes spend of £303k for Data Lines (2016-17: £17k). In 2017-18 the responsibility for the Primary Care costs was transferred to CCG's from NHS England, along with the funding.

b) 2017-18 includes £86k of expenditure for General Practice Forward View Online Consultations (2016-17: nil)

c) 2017-18 includes £38k of costs for Optimise RX (2016-17: nil)

3* Transport programme expenditure of £1,761k includes costs for Patient Transport of £1,759k. In 2016-17 these costs were included as part of Purchase of Healthcare from Non-NHS Bodies (£1,659k).

4* Premises expenditure includes £314k of operating lease costs (2016-17: £343k)

5* From 2017-18 onwards CCG's are no longer required to contribute to the CHC Risk Pool. The value for 2017-18 is therefore nil (2016-17: £554k).

6.1 Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 **Number**	2016-17 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	10,582	53,218	9,720	48,091
Total Non-NHS Trade Invoices paid within target	10,521	52,893	9,551	47,502
Percentage of Non-NHS Trade invoices paid within target	**99.42%**	**99.39%**	**98.26%**	**98.78%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,225	149,822	2,295	151,068
Total NHS Trade Invoices Paid within target	2,219	149,820	2,279	150,957
Percentage of NHS Trade Invoices paid within target	**99.73%**	**100.00%**	**99.30%**	**99.93%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2017-18 £'000**	2016-17 £'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				2017-18				2016-17
	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	314	0	**314**	0	343	0	**343**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**314**	**0**	**314**	**0**	**343**	**0**	**343**

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.

7.2 As lessor

North Lincolnshire Clinical Commissioning Group holds no leases as a lessor (2016-17: None)

North Lincolnshire CCG - Annual Accounts 2017-18

8 Property, plant and equipment

2017-18	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 2017	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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**25**	**0**	**25**
Depreciation 01 April 2017	0	0	0	0	0	0	16	0	16
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	9	0	9
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**25**	**0**	**25**
Net Book Value at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Purchased	0	0	0	0	0	0	0	0	0
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Asset financing:									
Owned	0	0	0	0	0	0	0	0	0
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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 2017	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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

8 Property, plant and equipment cont'd

8.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2017-18 **£'000**	2016-17 £'000
Land	0	0
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	25	0
Furniture & fittings	0	0
Total	**25**	**0**

8.2 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

North Lincolnshire CCG - Annual Accounts 2017-18

9 Trade and other receivables

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
1* NHS receivables: Revenue	23	0	2,801	0
NHS receivables: Capital	0	0	0	0
2* NHS prepayments	549	0	604	0
NHS accrued income	60	0	0	0
Non-NHS and Other WGA receivables: Revenue	76	0	150	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	241	0	0	0
Non-NHS and Other WGA accrued income	248	0	367	0
Provision for the impairment of receivables	0	0	0	0
VAT	15	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	**1,212**	**0**	**3,939**	**0**
Total current and non current	**1,212**		**3,939**	
Included above:				
Prepaid pensions contributions	0		0	

9.1 Receivables past their due date but not impaired

	2017-18 £'000 DH Group Bodies	2017-18 £'000 Group Bodies	2016-17 £'000 All receivables prior years
1* By up to three months	0	54	2,419
By three to six months	0	4	0
By more than six months	0	18	37
Total	**0**	**76**	**2,456**

£30k of the amount above has subsequently been recovered post the statement of financial position date.

North Lincolnshire CCG did not hold any collateral against receivables outstanding at 31 March 2018

Explanatory Notes

1* 2016-17 included a balance of £2,404k with Northern Lincolnshire and Goole Hospitals NHS FT in relation to Better Care Fund Income.

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

10 Cash and cash equivalents

	2017-18	2016-17
	£'000	£'000
Balance at 01 April 2017	70	71
Net change in year	(4)	(1)
Balance at 31 March 2018	**66**	**70**
Made up of:		
Cash with the Government Banking Service	66	70
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	**66**	**70**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**66**	**70**
Patients' money held by the clinical commissioning group, not included above	0	0

	11 Trade and other payables	**Current 2017-18 £'000**	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
	Interest payable	0	0	0	0
	NHS payables: revenue	1,234	0	1,032	0
	NHS payables: capital	0	0	0	0
	NHS accruals	1,659	0	1,334	0
	NHS deferred income	0	0	0	0
1*	Non-NHS and Other WGA payables: Revenue	984	0	4,054	0
	Non-NHS and Other WGA payables: Capital	0	0	0	0
	Non-NHS and Other WGA accruals	12,035	0	9,463	0
	Non-NHS and Other WGA deferred income	0	0	0	0
	Social security costs	37	0	41	0
	VAT	0	0	0	0
	Tax	31	0	37	0
	Payments received on account	0	0	0	0
2*	Other payables and accruals	120	0	387	0
	Total Trade & Other Payables	**16,100**	**0**	**16,348**	**0**
	Total current and non-current	**16,100**		**16,348**	

Explanatory Notes

1* Non-NHS and Other WGA payables: Revenue for 2016-17 included £2,107k payable to North Lincolnshire Council for Better Care Fund.

2* Other payables include £38.75k outstanding pension contributions at 31 March 2018 (31 March 2017: £48.74k).

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

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

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

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.

North Lincolnshire CCG - Annual Accounts 2017-18

12 Financial instruments cont'd

12.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £'000	Loans and Receivables 2017-18 £'000	Available for Sale 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	83	0	83
· Non-NHS	0	324	0	324
Cash at bank and in hand	0	66	0	66
Other financial assets	0	0	0	0
Total at 31 March 2018	**0**	**473**	**0**	**473**

	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 2018	**0**	**3,388**	**0**	**3,389**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	Other 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,893	2,894
· Non-NHS	0	13,139	13,139
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 2018	**0**	**16,032**	**16,032**

	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	13,905
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 2018	**0**	**16,270**	**16,271**

13 Pooled budgets

The NHS clinical commissioning group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2017-18	2016-17
	£'000	£'000
Income	0	2,404
Expenditure	(24,322)	(26,457)

Breakdown of Expenditure is as follows:

	North Lincolnshire CCG Share			
	2017 - 18			2016-17
Analysis of Pool Budget Expenditure	**Total Pool Expenditure**	**%**	**£'000**	**£'000**
Mental Health Pool	(14,697)	86.9%	(12,772)	(12,750)
Learning Disability Pool	(9,023)	4.7%	(425)	(373)
Better Care Fund	(11,125)	100.0%	(11,125)	(13,334)
Total	**(34,845)**		**(24,322)**	**(26,457)**

During 2017-18 there has been a change in the transaction arrangements of the Mental Health and Learning Disability Pooled Budgets. Each organisation has accounted for only their own in year transactions and the final position of the pools has been reported by making a single adjustment at year end. This has resulted in a net accounting treatment for 2017-18.

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 2017 to 31 March 2018

	2017/18	2016/17
	£'000	£'000
Gross Funding		
NHS North Lincolnshire CCG	**11,675**	12,018
North Lincolnshire Council	**1,760**	1,944
	13,435	13,962
Expenditure		
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	**11,396**	11,744
North Lincolnshire Council Adult Mental Health Services	**3,022**	2,794
Contribution to North Lincolnshire Council Social Care Services (Sandfield)	**119**	119
Challenge Fund	**83**	83
MIND	**77**	72
Total Expenditure	**14,697**	14,812
Net Underspend/(Overspend)	**(1,262)**	(850)
Risk Share Arrangements		
NHS North Lincolnshire CCG	**(1,097)**	(732)
North Lincolnshire Council	**(165)**	(118)
	(1,262)	(850)
North Lincolnshire Total Contribution		
Gross Funding	**11,675**	12,018
Risk Share	**1,097**	732
	12,772	12,750

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.

13 Pooled budgets cont'd

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 2017 to 31 March 2018

	2017/18 £'000	2016/17 £'000
Gross Funding		
NHS North Lincolnshire CCG	**412**	372
North Lincolnshire Council	**8,325**	7,781
	8,737	8,153
Expenditure		
Registered Services: Local Authority	**515**	234
Agency/Externally Procured Services	**7,570**	7,034
Professional Services	**322**	334
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	**616**	574
	9,023	8,176
Net Underspend/(Overspend)	**(286)**	(23)
Risk Share Arrangements		
NHS North Lincolnshire CCG	**(13)**	(1)
North Lincolnshire Council	**(272)**	(22)
	(286)	(23)
North Lincolnshire Total Contribution		
Gross Funding	**412**	372
Risk Share	**13**	1
	425	373

Better Care Fund

The Better Care Fund is a government plan to integrate health and social care across the country by 2020.

Locally, North Lincolnshire Clinical Commissioning Group have implemented the Better Care Fund via a Section 75 Pooled Budget agreement with North Lincolnshire Council.

Memorandum Account for the Better Care Fund Pooled Budget for the Period 1 April 2017 to 31 March 2018

	2017/18 £'000	2016/17 £'000
Income *		
Northern Lincolnshire & Goole NHS Foundation Trust	**0**	2,404
Expenditure		
Health Services	3,475	3,123
Social Care	6,430	6,224
Expenditure on Non Elective Activity	1,220	3,987
Total Revenue Expenditure	**11,125**	13,334
Net Expenditure	**11,125**	10,930
Financial target	**11,125**	10,930
Under / (Overspend)	**0**	0

* Risk income paid by NLAG in compensation for Non Elective Activity savings which were not made by the BCF schemes in 2016-17.

North Lincolnshire CCG - Annual Accounts 2017-18

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 Margaret L Sanderson				
CCG Chair				
Partner in Trent View Medical Practice	56	2	0	0
Husband is a Consultant employed by Northern Lincolnshire and Goole Hospitals NHS FT	106,881	0	662	0
A Member of Safecare, North Lincs GP Federation	230	0	10	0
Emma Latimer				
Interim Chief Officer from Oct 17				
Chief Officer - Hull CCG	71	0	0	0
Emma Sayner				
Interim Chief Finance Officer from Dec 17				
Chief Finance Officer - Hull CCG	71	0	0	0
Julie Warren				
Turnaround Director from Oct 17				
Locality Director (North) Yorkshire & Humber NHS England	41	742	0	0
Catherine Wylie				
Director of Quality & Risk Assurance and Nurse Member				
Partner Governor for Rotherham, Doncaster & South Humber Foundation Trust	14,119	0	241	0
Dr Robert M Jaggs-Fowler				
Medical Director				
President of St John Ambulance & Priory of the Order of St John (Humber)	2	0	0	0
Richard Young				
Director of Commissioning				
Partner Governor for Northern Lincolnshire & Goole NHS Foundation Trust	106,881	0	662	0
Dr Richard Shenderey				
Secondary Care Consultant to Governing Body				
Consultant at Airedale General Hospital	7	0	0	0
Dr Andrew Lee				
GP Member				
Partner of West Common Lane Teaching Practice, Scunthorpe	65	1	0	0
A Member of Safecare, North Lincs GP Federation	230	0	10	0
Dr Satpal Singh Shekhawat				
GP Member				
Partner at Kirton Lindsey Surgery	29	1	0	0
A Member of Safecare, North Lincs GP Federation	230	0	10	0
Dr Faisel Baig				
GP Member				
A Member of Safecare, North Lincs GP Federation	230	0	10	0
Management Committee Board Member and Director of Humberside Group of LMC's	1		1	
Dr Naveen Samuel				
GP Member				
Partner Winterton Medical Practice	52	1	0	0
A Member of Safecare, North Lincs GP Federation	230	0	10	0
Dr Salim Modan				
GP Member				
Partner at Riverside Surgery	62	1	0	0
A Member of Safecare, North Lincs GP Federation	230	0	10	0
Ian Reekie - Vice Chair				
Lay Member - Joint Commissioning				
Spouse employed by Spire Healthcare Ltd, Hull	1,552	0	0	0
Erika Stoddart				
Lay Member - Governance				
Director of Resources Ongo Ltd	3	0	0	0
Chair of Audit Group and Governor at The Grimsby Institute	2	0	0	0

Explanatory Note

The transactions noted above are between North Lincolnshire CCG and the stated organisation and have been conducted during the normal course of trading, no guarantees or provisions for irrecoverable balances have been made.

Only relationships with a financial transaction are disclosed.

14 Related party transactions cont'd

The Department of Health and Social Care 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
- 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
  - Lincolnshire Community Health Services NHS Trust
  - Yorkshire Ambulance Service 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
  - Northumberland, Tyne & Wear 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 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	0	0	0	0
Fruitless payments	1	2	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**1**	**2**	**0**	**0**

16 Continuing Healthcare Retrospective Claims: Accounting Treatment

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare Claims accounted for by NHS England on behalf of this CCG is as follows:

	2017-18 £000's	2016-17 £000's
Accrual	162	230
Provision	0	0
Contingent Liability	0	120
	162	350

17 Financial performance targets

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

North Lincolnshire Clinical Commissioning Group performance against those duties was as follows:

	2017-18 Target £000's	**2017-18 Performance £000's**	2016-17 Target £000's	2016-17 Performance £000's
Expenditure not to exceed income	225,408	231,433	230,198	234,296
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	224,027	230,052	224,413	228,511
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	3,831	3,238	3,821	3,231

North Lincolnshire CCG's expenditure has exceeded the targets set by £6,025k in 2017-18 (2016-17: £4,098k)

18 Impact of Practice Merger

From1 March 2018 North Lincolnshire CCG became responsible for the patients of the former Hawthorne Practice, which merged with Kirton Lindsey Practice.
As a result North Lincolnshire CCG has included a matching income and expenditure accrual for £466k to cover its financial commitment for the final month of the financial year.
As a result there has been a net nil impact within the CCG's financial statements.

SECTION 4

AUDIT OPINION

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

Opinion

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

In our opinion the financial statements:

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

Opinion on regularity

Except for the incurrence of expenditure in excess of the specified targets, in our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

As disclosed in note 16 of its financial statements, the CCG failed to meet its statutory duties under:

- section 223H(1) of the NHS Act 2006 (as amended) to ensure expenditure did not exceed income in 2017/18; and
- section 223I(3) of the NHS Act 2006 (as amended) to ensure revenue resource use does not exceed the amount specified in the Direction.

Basis for opinion

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

Use of the audit report

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

Conclusions relating to going concern

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

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

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.
We have nothing to report in this regard.

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

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

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

Matters on which we are required to report by exception

Referral to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014
Auditor's responsibilities

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 26 February 2018, we issued a report to the Secretary of State for Health under section 30(b) of the Local Audit and Accountability Act 2014, for the breach of financial duties under

- section 223H(1) of the NHS Act 2006 (as amended) to ensure expenditure did not exceed income in 2015/16; and
- section 223I(3) of the NHS Act 2006 (as amended) to ensure revenue resource use does not exceed the amount specified in the Direction.

Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources
We report to you if we are not satisfied that the CCG has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Qualified conclusion
On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, we are not satisfied that, in all significant respects, NHS North Lincolnshire CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion
The CCG reported a deficit of £6.0 million in its financial statements for the year ending 31 March 2018, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraphs 223I (2) and (3) of Section 27 of the Health and Social Care Act 2012, to break even on its commissioning budget. The CCG has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of £4 million for 2018-19. However, under the new Commissioner Sustainability Fund, this £4m deficit will be funded if the CCG meets the control total agreed with NHS England. The CCG is in special measures and operating under legal directions. NHS England's inspection and assessment framework has identified that the CCG is inadequate.

These issues are evidence of weaknesses in proper arrangements for understanding and using appropriate and reliable financial and performance information (including, where relevant, information from regulatory/monitoring bodies) to support informed decision making and performance management, managing risks effectively and maintaining a sound system of internal control, planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions and working with third parties effectively to deliver strategic priorities.

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

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we issue a report in the public interest under schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under schedule 7(2) of the Local Audit and Accountability Act 2014.

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

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

Auditor's responsibilities for the audit of the financial statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in

accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

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

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

We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Certificate

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

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

Section 5 - Glossary of the terms used in this report

Term	Definition
NLaG	Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) operates from three hospital sites: Scunthorpe General Hospital, Diana Princess of Wales Hospital and Goole and District Hospital. The Trust provide acute hospital services and community services across North and North East Lincolnshire
HEY	Hull and East Yorkshire Hospitals NHS Trust (HEY) operates from two hospitals: Hull Royal Infirmary and Castle Hill Hospital. The Trust provide a range of acute services to the people of Hull and East Yorkshire
RDaSH	Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) operates from Doncaster, Rotherham and Scunthorpe. The Trust specialises in delivering Adult and Older Adults Inpatient and Community Mental Health services; Children and Adolescent Mental Health services; Learning Disabilities services; Substance Misuse services; Psychological Therapies, Forensic and Community Services
EMAS	East Midlands Ambulance Service NHS Trust (EMAS) provides emergency 999 and urgent care to the population of North Lincolnshire
MSA	In December 2010, the collection of monthly Mixed-Sex Accommodation (MSA) breaches was introduced by NHS England. The requirement covers sleeping accommodation, bathroom/toilet accommodation and (in mental health and learning disability providers) day rooms/lounges. Provider organisations are required to report breaches relating to sleeping accommodation to NHS England every month via the Unify2 data collection system
CAMHs	Child and Adolescent Mental Health Services (CAMHS) are the NHS services that assesses and treat young people with emotional, behavioural or mental health difficulties. CAMHS support covers depression, problems with food, self-harm, abuse, violence or anger, bipolar, schizophrenia and anxiety
RTT	The Referral To Treatment (RTT) rules aims to set out clearly and succinctly the rules and definitions for referral to treatment consultant-led waiting times to ensure that each patient's waiting time clock starts and stops fairly and consistently
IAPT	The Improving Access to Psychological Therapies (IAPT) programme commenced in 2008. The objective of the programme is to transform treatment of adult anxiety disorders and depression in England
A&E	Accident & Emergency (A&E) services are provided at Scunthorpe General Hospital
STP	The Humber, Coast and Vale Sustainability and Transformation Partnership (STP) is a collaboration of nearly 30 different organisations across a geographical area of more than 1500 square miles. The aim of the STP is to work collectively to plan for the future of health and care services in the Humber area and to find new ways to tackle the challenges that we face locally
GSF	The Gold Standards Framework (GSF) is a systematic, evidence based approach to optimising care for all patients approaching the end of life, delivered by generalist frontline care providers
HES	Hospital Eye Service
CATs	Cataract service
DXS	DXS Point-of-Care™ is a clinical decision support system that enables health care data such as care pathways, medicines, referrals, patient education and support groups to be filtered and presented to healthcare providers
Optimise RX	OptimiseRx is a medicines optimisation system used in primary care across the UK
TCP	Transforming Care Partnership (TCP)
IG toolkit	The Information Governance (IG) Toolkit is an online system which allows organisations to assess themselves or be assessed against Information Governance policies and standards.