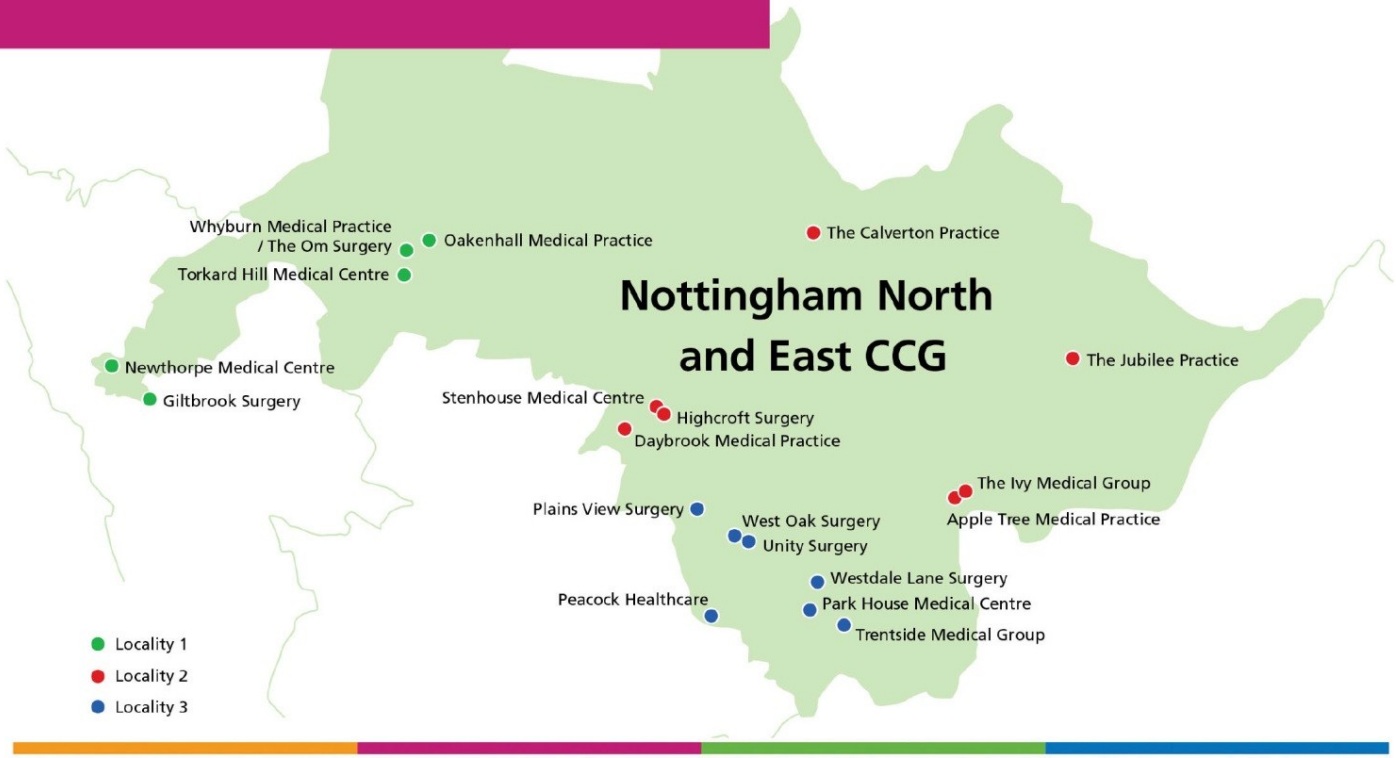
Putting good health *into practice*

NHS
Nottingham North and East Clinical Commissioning Group




Our Annual Report and Accounts 2016/17



NHS Nottingham North and East Clinical Commissioning Group Annual Report 2016/17

This is the Annual Report and Accounts for NHS Nottingham North and East Clinical Commissioning Group 2016/17. It includes information about the organisation and its activities during 2016/17.

This document can be made available in large print and other formats, including translations, upon request.

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Performance report

This document fulfils our duty to produce an annual report on how we have discharged our functions in 2016/17. It also highlights our achievements, as well as the challenges faced during 2016/17.

The form and content of this report has been agreed with the CCG's Audit and Governance Committee and the Governing Body before being published.

The Annual Report has been presented alongside our annual financial accounts, which have been prepared under a direction issued by NHS England under the Health and Social Care Act 2012 c.7 Schedule 2 s.17.

Chief officer's statement

I am delighted to present Nottingham North East Clinical Commissioning Group's (NNE CCG's) annual accounts and report, which cover the period 1 April 2016 to 31 March 2017.

2016/17 has been a year of significant financial challenge for the CCG but due to the unquestionable dedication, determination and committed of staff, member practices, patients and partners I am extremely pleased to be able to report that we have met all our financial duties for the fourth year running.

During 2016/17 the CCG has maintained a focus on improving the health and well-being of the local population and improving the services and quality of care our patients receive. In this respect the CCG has much to be proud of. However, with resources stretched, the benefits of working collaboratively with our local health and care partners have become increasingly more apparent. The CCG has played a key role in leading the ongoing transformation of the local health and care system through the development and implementation of the Nottinghamshire Sustainability and Transformation which sets out the vision for transformation of the health and care system over the next five years.

The CCG has performed well against most of the national quality, performance and improvement targets and I am proud of what we have delivered in 2016/17.

In addition this year has seen positive changes to the Governing Body with the appointment of Dr James Hopkinson as the new Clinical Lead and Chair of the CCG. James has wasted no time and has implemented a number of measures to strengthen the CCG's governance arrangements; the benefits of these are already apparent. Specifically James has appointed an additional GP and third lay member to the Governing Body thereby ensuring that clinical leadership and patient involvement continue to be at the heart of the CCG's decision-making.

2017/18 is set to be another financially challenging year for the CCG. We have ambitious plans to deliver financial turnaround and we are working closely with other local CCGs to ensure that we are able to meet our financial responsibilities in 2017/18 as we have done in previous years. With support from patients and the public and with the strength and commitment of the CCG's leadership, I am confident that we will be successful.

There is no doubt that the NHS is continually evolving to improve care and local services and 2017/18 will see the CCG continuing to focus on commissioning cost-effective and efficient services that are also high quality. I am delighted that NNE together with our partner organisation in Greater Nottingham have been named as one of nine potential first-wave new 'accountable care organisations' and I am convinced that working at scale and across organisations will deliver real improvements in patient care.

Finally I would like to express my sincere thanks to the residents and patients of NNE CCG. Without the help of those who use our local services, and those residents who support us directly with their own time and through their own personal determination and pride in their local NHS, it would not have been possible for us to deliver what we have in 2016/17. This support is greatly appreciated.

Sam Walters
Accountable Officer

May 2017

Overview

The purpose of this overview is to give a brief summary of the CCG, its purpose and activities, demographic profile, how we work in the local health system, and with whom we have contracts. It also summaries our performance against key targets, risks to achieving our strategic objectives and what our main challenges have been this year. We have provided more detail on all of these areas later in the report.

Purpose and activities of the organisation

About us

We are an NHS commissioning organisation with 20 GP member practices covering a population of approximately 150,000. We are passionate about the provision of health services for the people around Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield, and Newthorpe.

Our business

Our purpose is to ensure high quality, efficient and cost effective healthcare services for our geographical area. We are responsible for buying and contracting healthcare services which includes hospital care as well as services received in a community setting. We have a Clinical Chair, Dr James Hopkinson, who provides overall clinical leadership. Our Accountable Officer Sam Walters has overall responsibility for managing the work of the CCG. The work of the CCG is overseen by a governing body comprised of GPs, a secondary care consultant, lay representatives, a registered nurse and director of nursing and quality, chief finance officer, and chief officer. Other directors of the CCG are in attendance.

In order to ensure that we are working efficiently and effectively as part of the wider system, we work collaboratively with our neighbouring CCGs and the local authorities at both a county and district level.

With our neighbouring CCGs, working collaboratively allows us to share resources and commission jointly alongside reducing complexities within the system. More specifically, collaborating in this way enables the CCGs to:

- maximise management and clinical capacity and capability, whilst remaining within the allocated running costs allowance
- integrate commissioning and provision across primary care, community services and acute care
- share, spread and sustain good practice and influence clinical behaviours using sound evidence

- scale commissioning control appropriately, e.g. at a local level for specific local needs and at a broader scale when commissioning as a group of CCGs

2016/17 has seen NHS organisations come together with local government partners to develop a Sustainability and Transformation Plan (STP) which is a local blueprint for delivering the ambitions of a transformed health service. Our local area 'footprint,' covers Nottingham and Nottinghamshire (apart from Bassetlaw, which is covered by the South Yorkshire and Bassetlaw STP). The plan was published in December and covers the next five years. We also work as part of the Greater Nottingham Health and Care Partners (GNHCP), a group which aims to deliver the ambitions of the STP locally.

Our aims

The CCG has 5 aims that we plan to achieve when commissioning health services to our local population:

- Reduce health inequalities in the local population by targeting those people with the greatest health needs
- Drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation
- Direct available resources to where they will deliver the greatest benefit to the local population
- Commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect
- Ensure that patients are able to make choices about the care they receive and are seen in the right place at the right time by the right person

NNE CCG's vision is:

"Putting Good Health into Practice"

This vision will be delivered through:

- improving the health of the community and reducing health inequalities
- securing the provision of safe, high quality services
- achieving financial balance and value for money.

Our population

The Nottingham North East (NNE) CCG area has a population of 151,353 (NHS Digital, 2016). Statistically, our population has a higher proportion of working age and older adults, with the 25-64 year old population and over 65 year old populations representing 52.6% and 19.1% of the population respectively. The proportion of the over 65 year old population for example, is 8.5% greater than that of England average of 17.6%. The 25-64 year old population is significantly greater (1.15% higher) than England's average of 52%. Conversely to these populations, the

proportion of 0-15 year olds and 16-24 year olds is significantly lower (ONS, 2014). See figure 1 for a representation of the age structure of the NNE population:

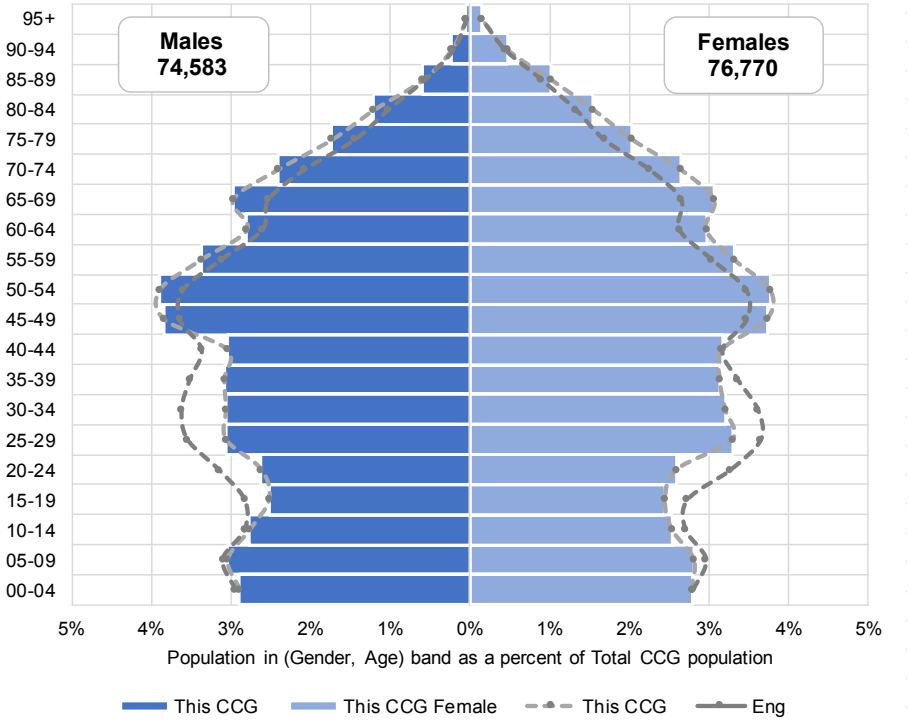


Figure 1: Population pyramid for NNE (NHS Digital, 2016)

The proportion of BME individuals in NNE is 6.2%, less than half the England average of 14.6% (ONS Census 2011). NNE has a relatively older population to that of England which presents different challenges to health and social care services as older people use services more. Due to challenges in data collection by CCG area, specific population growth estimates are unavailable. The CCG area includes the Gedling district, where it is estimated that the population will grow 6.8% between 2017 -2027. For the same period, England is estimated to expect a population increase of 6.9%.

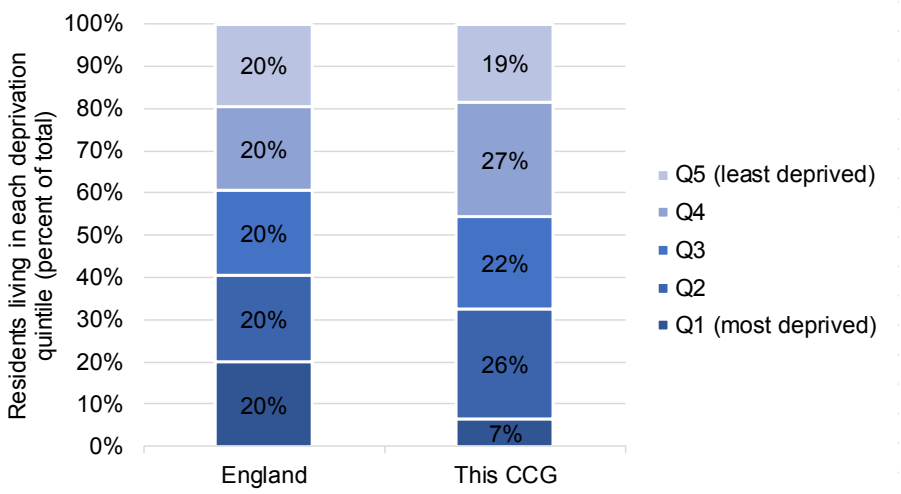
Health inequalities

Deprivation and health inequalities

The NNE CCG area is ranked 143rd of all 209 CCGs in England according to the Index of Multiple Deprivation of all England CCGs. NNE is 117 of 209 for health deprivation and disability by the ranked average (Dept. for Communities and Local Government, 2015). Only 3.9% of NNE residents live in overcrowded housing which is lower that the England average of 8.7% (ONS Census, 2011).

Child poverty stands at 17.2%, lower than England's average of 18.6% (PHE, 2013). When NNE is ranked by average score for income deprivation affecting children, it ranks at 122 of 209 CCGs (Dept. for Communities and Local government, 2015). GCSE sitting children in NNE are 4.8% more likely to achieve 4 A*-C grades than the

average child in England. Numbers of children reaching a good development at age 5 are also higher than England at 62% vs. 60.4% (PHE/ONS 2013-14). Figure 2 highlights the differences in inequality between NNE and England on average:



Source: DCLG Indices of Multiple Deprivation (2015), CCG spatial boundary

Figure 2: Population living in national deprivation quintiles

Life expectancy is 8.1 years lower for men and 6.7 years lower for women in the most deprived areas of Gedling than in the least deprived areas. Figure 3 below show life expectancy for men and women in this local authority for 2012-2014. Each chart is divided into deciles (tenths) by deprivation (IMD 2010), from the most deprived decile on the left of the chart to the least deprived decile on the right. The steepness of the slope represents the inequality in life expectancy that is related to deprivation in this local area. If there was no inequality in life expectancy as a result of deprivation, the line would be horizontal.

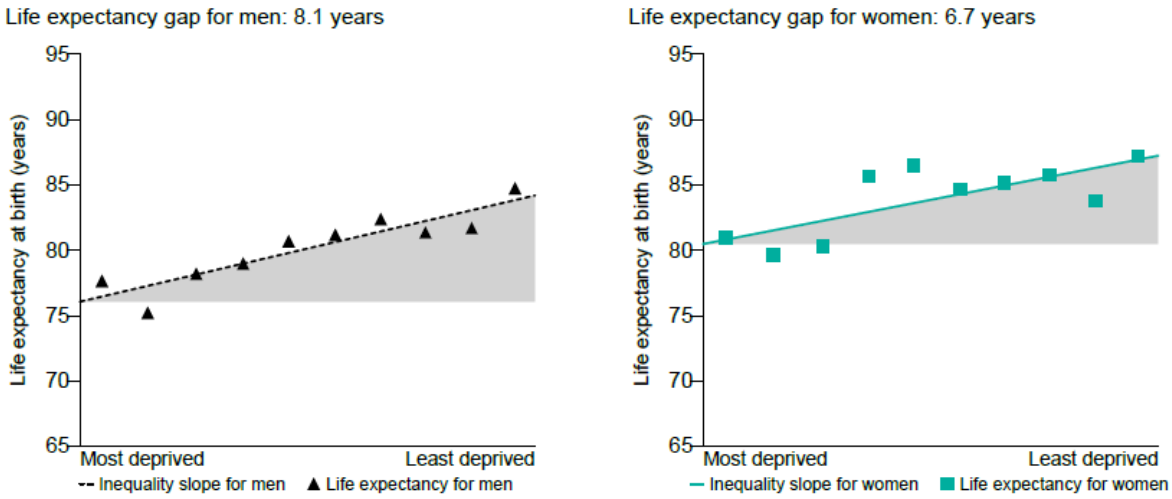


Figure 3: Life expectancy versus deprivation

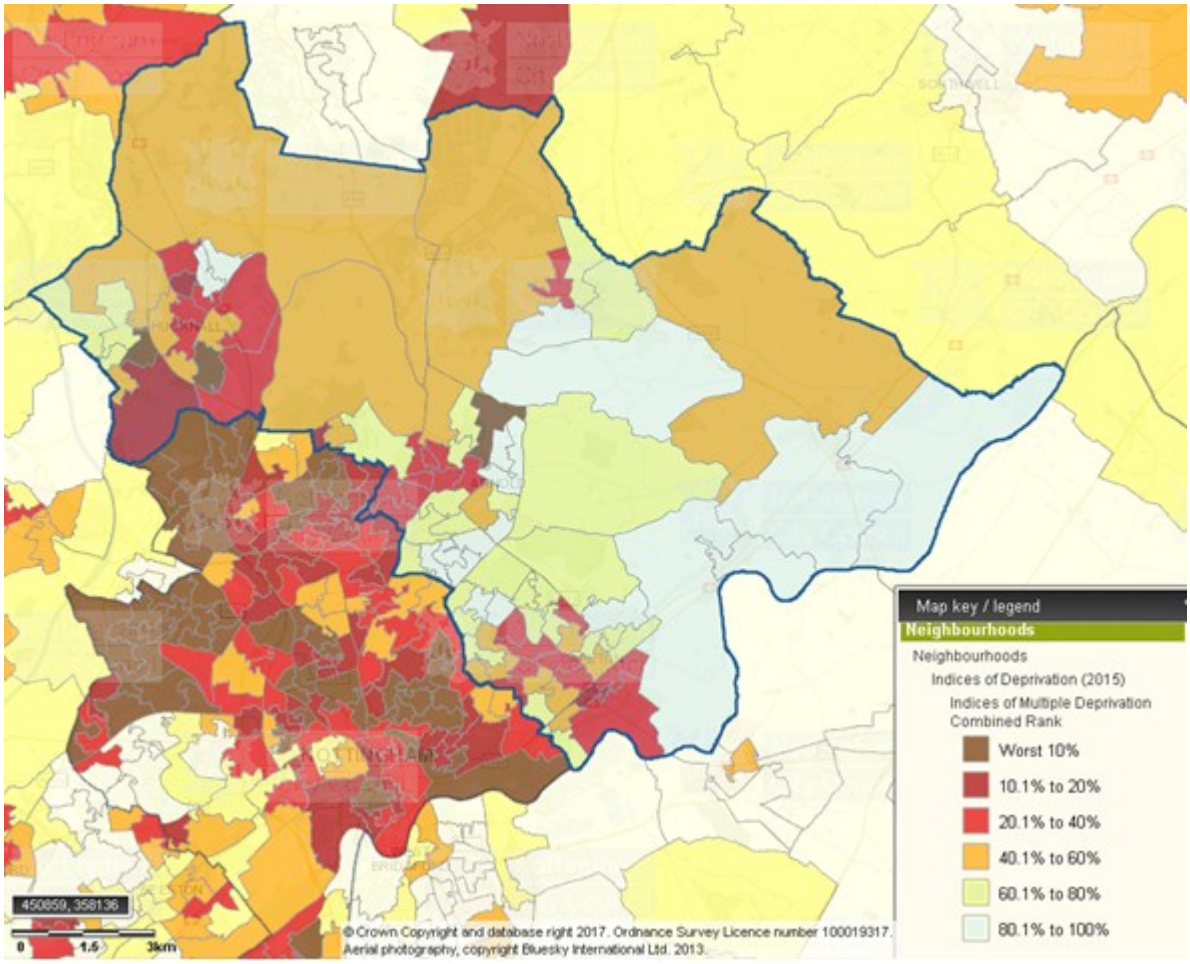


Figure 4: Map showing deprivation

Health conditions and health inequalities

Life expectancy at birth is slightly better for men of NNE relative to England (79.7 and 79.3 years respectively), however life expectancy for women is similar to England's average (82.9 and 83 years respectively) (PHE/ONS 2010-2014).

For deaths all causes, NNE's mortality is 2.9% higher than the England average, and deaths by cancer are also 5.6% higher. Cancer incidence is significantly higher than that of England at 5.9% higher. Rates of colorectal and prostate cancer are all significantly higher compared to England (11.2 and 11.3% higher respectively).

Deaths from circulatory disease and stroke are slightly better however, with a 4.5% and 1% lower rate respectively of death compared to England. NNE's respiratory disease deaths are marginally but not significantly higher than England's average. Electively admissions are very significantly lower for coronary heart disease – 45% lower than England. Emergency admissions are also better than England (4.3% lower). Emergency and elective admissions overall are significantly better than England (6.4% and 3.2% lower respectively).

The proportion of people reporting their health as "bad" or "very bad" is identical to that for England. There are significantly higher levels of self-reported limiting long

term illness or disability in NNE – 19.5% versus 17.6% (11% higher). NNE also has significantly higher proportions of people requiring hip and knee replacements, in part as expected with the older population (PHE/ONS 2010-2014).

NNE has a slightly higher proportion of adults who binge drink, at 21.1% vs. 20% for England's average. Obesity prevalence is higher than that of England at 25% of adults (24.1% for England) (PHE, 2006-08). Children of all ages however are less likely to be overweight or obese – for example, year 6 children are 10% less likely to be obese than equivalent aged children of England. Rates for hospital admissions related to alcohol are however 1.1% lower than England (PHE/ONS 2010-2014). Modelled prevalence of smoking amongst children (11-17) sees almost identical levels to that of the England average (both as occasional and regular smokers).

Regarding performance in end of life care, NNE has a slightly better than the average rate of deaths in usual place of residence at 47% when compared to England (46%). Dementia prevalence is higher at 0.8% versus 0.7% of England; however, this is a reflection of an older population and the success of greatly improved diagnosis rates in Nottinghamshire relative to England (PHE, 2015).

Protected characteristics and health inequalities

What evidence tells us about Nottinghamshire

Available census data shows that there are inequalities in access, health outcomes and service experience which have endured over time despite substantial investment in healthcare. Inequalities are evidenced between groups of people with different characteristics and across geographical areas. For example:

- Gay and lesbian people are 1.7 times more likely than heterosexual people to report being a regular smoker. Bisexual people are 1.6 times more likely than heterosexual people to report being a regular smoker.
- The number of 18-64 year olds with a serious physical disability in Nottinghamshire in 2015 was 11,863 predicted to increase by 204 by 2030. The number of 18-64 year olds with a moderate physical disability in Nottinghamshire in 2015 was 38,729 predicted to decrease by 164 by 2030. Disabled people are: more likely to have no qualifications; less likely to be in employment or training; more likely to be on lower incomes; more likely to live in poor housing; and more likely to experience poorer health and well-being than non-disabled people.
- Data within Nottinghamshire show that for males and females the top four causes are the same: circulatory, cancer, respiratory and digestive, however the proportion that each of these contributes to the gap in life expectancy varies between genders. Understanding which factors contribute to the gap in life expectancy across Nottinghamshire's population can help to target evidence-based interventions which aim to prevent illness and death in the short and longer term.

- If approximately 290 male deaths in the most deprived fifth of Nottinghamshire's population were prevented each year, then around 80% of the life expectancy gap would be eliminated. If approximately 225 female deaths in the most deprived fifth of Nottinghamshire's population were prevented each year, then around 70% of the life expectancy gap would be eliminated.

Our main providers

We commission services from the NHS, local authority, voluntary sector, and private organisations. In order to support integration across the public sector we may also commission from other agencies, particularly in relation to services for prevention. The organisations from which we commission the majority of our services are:

- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust – including mental health and community services
- Circle Nottingham Ltd (based at the Nottingham Treatment Centre)
- East Midlands Ambulance Service NHS Trust

Key issues and risks to the achievement of strategic objectives

The CCG's Governing Body has agreed an integrated risk management policy which determines how risks are identified and managed. Risks which are a threat to the achievement of the CCG's strategic goals are documented on the Risk Assurance Framework which is the primary strategic risk management tool. This document is reviewed regularly by the Executive Team and reported to the Audit and Governance Committee and the Governing Body.

During 2016/17, below target performance for ambulance service response times; A&E four hour waiting target and some cancer targets continued from 2015/16. However, the financial challenge we faced this year has been the main risk to the achievement of strategic objectives. The CCG's financial position alongside our neighbouring CCGs has been impacted by a number of recurrent and non-recurrent pressures including:

- additional national commissioning requirements
- an increase in acute activity and expenditure
- a significant level of NHS continuing healthcare activity.

The four Greater Nottingham CCGs (Nottingham North and East, Nottingham West, Rushcliffe, and Nottingham City) have collectively established a Programme Management Office to identify and deliver plans to achieve financial balance in

2016/17 and reduce the impact in 2017/18. These plans are described further in the **Financial Management** section later in this report.

More details on how we are managing these risks can be found in the **Governance Statement** later in this report.

Performance summary

Below is a summary of the CCG's performance against a selection of targets for 2016/17. Full details and analysis of performance can be found in the **Performance analysis** section.

Measure	Target	Performance
NHS Constitution Standards		
Patients waiting 18 weeks or less from referral to hospital treatment	92%	95.7%
A&E 4 Hour Standard	95%	82.11%
Ambulance Red 1 calls (Life threatening requiring defibrillation) responded to within 8 minutes (East Midlands Ambulance Service)	75%	68.98%
Ambulance Red 1 (Life threatening requiring defibrillation) calls responded to within 19 minutes (East Midlands Ambulance Service)	95%	96.45%
Ambulance Red 2 Life threatening calls responded to within 19 minutes (East Midlands Ambulance Service)	95%	83.75%
Last Minute Cancelled Elective Operations – 28 day rebooking (Nottingham University Hospitals)	0	12
CCG IAF Six Priority Areas		
Cancer 2 Week Wait	93%	93.47%
Cancer diagnosis and treatment commencement within 62 days	85%	79.76%
Mental Health Crisis Resolution Home Treatment	100%	100%
Dementia Diagnostic Rate	67%	70.38%
Proportion of people with a learning disability on the GP register receiving an annual health check	37.1%	33.9%
People with diabetes diagnosed for less than a year who attended a structured education course	5.7%	7%
Diabetes patients that have achieved all the NICE-recommended treatment target	39.8%	37.8%
Women's experience of maternity services		82.2%
Maternal Smoking at Delivery	10.4%	11.6%

Measure	Target	Performance
Quality of Life of Carers	80.0%	82.2%
Quality and Patient Experience		
Clostridium difficile	43	31 Cases
MRSA Blood Stream Infection (BSI)	0	3
Anti-microbial resistance: appropriate prescribing of antibiotics in primary care	9.1%	10.6%
Patient Experience of GP Services	85.2%	84.3%
Financial Performance		
Keep within revenue resource limit		206,705,000
Achieve planned surplus		1,873,000
Achieve National Risk Reserve Surplus		2,011,000
Cash balances within agreed limit		< 237,000
Remain within running cost allowance		3,422,000
Achieve BPPC targets		> 95%

Performance analysis

Clinical Commissioning Group Improvement and Assessment Framework

Clinical commissioning groups (CCGs) are subject to a continuous assurance process – the CCG Improvement and Assessment Framework (IAF) 2016/17 which measures CCG performance against the '**triple aims**' outlined by NHS England:

1. Improving the health and wellbeing of the whole population
2. Better quality for all patients through care redesign
3. Better value for taxpayers in a financially sustainable system

The framework draws together in one place the NHS Constitution and other core performance and finance indicators, outcome goals and transformational challenges. These are split into four domains:

- Better health
- Better care
- Leadership
- Sustainability

Within the Better Health and Better Care domains there are six clinical priority areas:

- Mental health

- Dementia
- Learning disabilities
- Cancer
- Diabetes
- Maternity

The performance indicators for the clinical priority areas are published on MyNHS.

The IAF aims to provide confidence to internal and external stakeholders and the wider public that the CCG is operating effectively to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients.

Better health

Personalisation and choice

Personal health budgets and integrated personal commissioning

All the local CCGs in Nottinghamshire are committed to increasing the proportion of people eligible for NHS continuing care with personal health budgets and to expand access for other groups of individuals who are currently not eligible for NHS continuing care.

In November 2016 confirmation was received that Nottinghamshire had been identified as an early adopter of the Integrated Personal Commissioning model. The aim of this model is to empower people and communities to take an active role in their health and wellbeing with greater choice and control over the care they need. It will drive bold expansion plans and bring forward targets previously set by NHS England.

Health inequalities

The CCG is committed to reducing health inequalities in the local population by targeting those people with the greatest health needs. We are working collectively with other CCGs and the acute hospital trusts to address health inequalities.

Equality and Diversity Forum

In order to ensure that we are working collectively to address health inequalities the CCG is part of an Equality and Diversity Forum. Nottingham University Hospitals NHS Trust (NUH), Rushcliffe CCG and Nottingham West (NW) CCG continue to work together to deliver a strategic framework and project plan for the implementation of the Equality Delivery System 2 (EDS2) through a shared Equality

and Diversity Forum. This approach has delivered a unified working process that has aligned equality activity across the four organisations to better serve the interests of the public. The forum forms part of the CCGs governance structure as a sub-group of the Quality and Risk Committee.

As part of the EDS2 action plan the CCGs and NUH signed up to the British Sign Language Charter in 2014. Work throughout 2016/17 has included further development of an action plan to support the commitment to the five pledges within the charter.

During 2016 the CCG has become a member of the Nottinghamshire Learning and Disability Strategy Group, Suicide Prevention Group, and the Tobacco Declaration Group which have had a direct impacted on patients of protected characteristics in a positive way, some of the successes include:

- medication review of anti-psychotic medication
- development of Health Check template
- quality audit of health checks for patients with a learning disability
- reduction of smoking prevalence in pregnancy from 14.2% to 11.9%.

NUH and the CCGs continued to contract with 'Disabled Go' to complete access surveys and annual visits of health sites including GP practices so patients can find up to date online information on accessibility to and around health buildings. Regular update reports from Disabled Go have been presented and reviewed by the Equality and Diversity Forum.

A patient story from a same sex couple receiving maternity care had been presented to all governing bodies highlighting an incident where the couple had been discriminated against as a result of being in a same sex relationship. This year, learning from this patient experience was shared through the promotion of the story and prompted training for staff.

Equality impact assessments continue to be embedded into governance processes across the organisations and assessments are completed for new services or changes to existing services. The assessments have been reviewed and approved by the Equality and Diversity Forum and escalated to the Quality and Risk Committee for further scrutiny if appropriate. The E&D Forum held a successful Equalities Conference in November 2016 that focused on Tackling Health Inequalities in our communities. The feedback received from the attendees informed the EDS2 objectives.

The E&D Forum has engaged with patients with a learning disability and their carers in relation to the design of posters and information leaflets.

Engaging with people from different protected groups

We passionately believe in putting patients at the centre of the NHS and to do this we have engaged with as diverse a population as possible including across the protected characteristics, more information is in the **Patient and public involvement** section.

Accessible Information Standard

The Equality and Diversity Forum reviewed the Accessible Information Standard and its implications for commissioners and providers. The standard has been promoted to GP practices across the CCGs, this has included attendance at Practice Managers' Forums and production of various materials for practices to utilise in collecting and the recording communication needs of patients. The standard has also been promoted amongst staff at NUH and patient systems updated with necessary codes and alerts to support the standard.

Workforce Race Equality Standard (WRES)

The WRES was introduced in April 2015 to support local and national NHS organisations review their data against nine indicators, to produce action plans to close the gaps in workplace experience between White and Black and Ethnic Minority (BME) staff, and to improve BME representation at Governing Body/board level. The CCG has measured its data against the nine indicators of the WRES. The report provides a summary of the findings and recommendations for improvement and is published on the CCG's website. The CCG is not required to fully apply the WRES as the workforce is too small for the WRES indicators to either work properly or to comply with the Data Protection Act.

The CCG was pleased to report that results of the staff survey suggested that BME staff were not more likely to experience unfair treatment than white staff members; however, the CCG recognises that some staff members chose not to answer all questions and some did not declare their ethnicity. The WRES indicators also highlighted that BME staff were under-represented at senior levels, band 9 and VSM and at Governing Body voting level.

Equality objectives

The Equality Delivery System 2 (EDS2) provides a ready-made way for the NHS to respond to the Public Sector Equality Duty. It is a toolkit developed for NHS organisations to review and improve their equality. The toolkit enables the Equality and Diversity Forum to improve the services provided for local communities, consider health inequalities in the locality and provide better working environments, free of discrimination, for those who work in the NHS. The EDS2 has four goals (with 18 specific outcomes):

- Achieving better outcomes

- Improving patient access and experience
- Developing a representative and supported workforce
- Demonstration of inclusive leadership

The Equality and Diversity Forum completed its first self-assessment of the EDS2 in 2014/15; this grading was supported by a patient grading event in February 2015. Following the grading, equality objectives and an action plan were set collectively for the organisations. Since that time the Forum has completed a further self-assessment of the EDS2 supported by a patient engagement event and agreed the following objectives for 2017/18:

1. Ensure that engagement activities are inclusive of all patient groups
2. Ensure that the services we commission are inclusive of all patient groups
3. Ensure equality and diversity implications are considered throughout the development of the Sustainability and Transformation Plan and within all on-going commissioning
4. Embed a culture of inclusivity and recognising and valuing people's differences within the workforce

Patient and public involvement

How we involve patients and the public

Communicating and engaging with our patients and local people is central to achieving our aims to improve health services in the Nottingham North and East area.

During 2016/17, we have enhanced our processes and strengthened our relationships with the local community in order to ensure that we were listening and acting on patient and carer feedback at all stages of the commissioning cycle.

As a result, the feedback we have received has directly informed the decisions that have been made.

We are always looking at new ways we can communicate and engage with local people, particularly in ways that avoid them having to come to us. One of the areas, we have invested time into is social media and we have an active NNE Facebook page as well as the NHS South Nottingham Facebook account we manage with our colleagues at Nottingham West and Rushcliffe CCGs.

We work in partnership with Healthwatch, our neighbouring CCGs in south Nottinghamshire including NHS Rushcliffe CCG, NHS Nottingham West, and Nottingham University Hospitals NHS Trust. With these partners, a forum has been established to ensure operational ownership in advancing and mainstreaming equality and to make effective use of resources. The forum has mapped a database of 'seldom heard' groups who are targeted during pieces of engagement work.

Governance and assurance information

In 2016, following agreement from the chair and the majority of the patient representatives, we implemented two sub groups of the People's Council which provided for greater input from local residents and GP practice patient groups. This has allowed the Committee of the Governing Body to fully focus on the engagement plans and assurance that the CCG is meeting its duty to involve.

Patient and Public Involvement Committee

The People's Council has been replaced with the Patient and Public Involvement (PPI) Committee, which is accountable to the Governing Body as a Committee with delegated responsibility. This committee provides assurance that commissioning decisions made by NNE CCG have been informed by robust plans for patient, public and service user involvement. It also ensures that patient choice, equality and diversity and tackling health inequalities are central to decision making.

Feeding into this group is:

The PPI QIPP group

The PPI QIPP (quality, innovation, productivity and prevention) Group discusses service changes, changes in prescribing, campaigns, and opportunities to deliver savings along with improved care. Agenda items may also include service changes and proposals that are being delivered through Greater Nottingham Health and Care Partners. This group meets bi-monthly on the last Tuesday of the month.

Patient Participation Group (PPG Group)

The PPG Group covers any items that are relevant to PPGs. The meeting is managed and chaired by a PPG representative in order to ensure that it is relevant to what is happening in practices. The CCG is invited to present an item to the group and uses these meetings to gain input from and feedback into the PPGs. This group meets bi-monthly, alternating with the QIPP Group on the last Tuesday of the month.

Examples of the impact of participation

Access to primary care

Over the last year, we have held consultations and engagement campaigns around a number of issues but particularly about access to primary care. With two recent surgery closures and feedback at Hucknall events, we needed to better understand what barriers people face when they want, or need, to access primary care services.

The consultations, we have initiated around access include:

- access to primary care in Hucknall
- access to primary care in Carlton.

What are patients are telling us about access:

- Improved access in primary care should be a priority to ensure patients can access urgent care and to reduce A&E admissions
- Increases in local population are putting a strain on health services, particularly in Hucknall
- Patients are receiving good service but more appointments slots are needed
- In some areas it's difficult to get an appointment within two weeks
- Parking around practices needs to be improved
- Patients' priorities are to be able to book a same day appointment but also, for those people with a long-term condition, they want the option to plan in appointments two or three weeks in advance

How are we acting on patient feedback?

In Hucknall, we have submitted a bid to NHS England for funding to expand GP services in the town. We were unsuccessful in receiving the amount we bid for. However, we have received some funding, with the possibility of additional funds in the next round. In the interim, we are working with all four practices to look at how they can increase capacity by working together.

Our engagement in Carlton is on-going but we are examining the feedback and working with the local practices to tackle concerns.

The Big Health Debate

In 2016, The Big Health Debate engagement campaign was developed to talk and engage with patients and the public about proposed service changes - particularly with regard to QIPP and the NUH Service Review.

It was launched to coincide with the engagement around the NUH Service Review.

The Big Health Debate engagement 1: The NUH Service Review

During 2016, the Greater Nottingham clinical commissioning groups (Nottingham City, Nottingham North and East, Nottingham West and Rushcliffe) undertook clinically-led reviews on a set of services delivered by Nottingham University Hospitals (NUH) NHS Trust.

The driver for these reviews was to improve quality and to look at where care could be provided closer to home. It was also to ensure that we are getting the very best value for money when commissioning publicly funded health services.

These reviews formed part of 2016/17 contract negotiations between the CCGs and NUH for all non-tariff service commissioned using a 'locally agreed price'.

Patient engagement was integral to this process and an essential part was gathering patient, carer, and public feedback though a variety of engagement methods.

Together, the engagement and communications teams from each of the participating CCGs (Nottingham North and East, Nottingham West and Rushcliffe) developed The Big Health Debate engagement campaign.

Although, The Big Health Debate campaign objectives are broader than just the NUH Service Review – this campaign is used when we are talking to the public about service changes – this was used this as the umbrella 'brand' to reach out to patients across our local communities around the NUH service review.

The Big Health Debate collateral included posters, a leaflet with survey attached and an online survey (www.surveymonkey.com/r/big-health-debate). 192 responses to this survey have been received to date. It was promoted widely across stakeholder, patient, and community groups, and social media.

To support the online survey and under the Big Health Debate heading, a series of focus groups/table top discussions were held across the South Nottinghamshire area – in village halls, at the City Hospital, at patient representative groups (PRGs) at GP surgeries and at the civic centre.

Carers, patients, health professionals and the public attended these groups and were very vocal in giving a range of feedback which was used to inform the new specifications for the services.

Several members of the Nottingham North and East People's Council were very involved in supporting and promoting these focus groups.

In addition, one-to-one surveys and interviews were undertaken at the orthotics department at the Queens Medical Centre to gather patient and carer feedback.

How we acted on patient feedback

Following initial patient engagement, the feedback was analysed and specifications were drawn up which took into account what patients told us about the services they wanted to receive.

Following this, we then embarked on a second stage of engagement and summaries of the new specifications were published on CCG websites and patients, clinicians and local communities were invited to have their say over a six week period (19 December – 5 February 2017).

Again, this second phase of engagement was promoted widely across stakeholder, community, and patient groups, local media, and social media. Some service reviews received a lot of media attention, particularly brain injury, this prompted further focus groups in this six week period.

After going through the patient and clinician feedback process, we scrutinised the feedback for each service individually. Service changes were reviewed and final proposals were agreed in Collaborative Commissioning Congress and considered at

each of the three CCGs' governing bodies. The recommendations were approved on Friday 10 February 2017. The full details can be found on our website.

Some of the key changes which were driven by patient feedback were:

- a decision not to move brain injury and neuro services out to a community provider
- further work to on the Parkinson's provision as part of moving the medicine day care service out into the community. We are currently (March 2017) in the process of running more patient focus groups to look at how we shape these services in the future
- while we still plan to move pain management and back pain into the community, we plan to assess each patient with a view to their injections
- conservative management of renal patients will stay with the hospital with a view to better integrating it with the dialysis home visiting service.

Speaking about the impact of patient engagement on the NUH Service Review, Dr James Hopkinson, Clinical Lead, Nottingham North and East CCG says:

> "Patient, public and clinician feedback was always going to be integral to our commissioning decisions and we're pleased we received such a huge response from patient and professionals via patient groups, our website and patient experience team.
>
> "As a CCG, listening to our communities and our patients is critical. We have been happy to do that, and have made adjustments to our plans based on feedback, along with the feedback from a wide range of clinicians."

The Big Health Debate engagement 2: Should over the counter medicines for minor ailments on prescription?

The three South Nottinghamshire CCGs (Nottingham North and East, Nottingham West, and Rushcliffe) undertook a six-week patient and stakeholder engagement (Dec 16/Feb 17) campaign to ask people whether over the counter medicines should be prescribed for minor ailments, such as a cold, headache, sore throat, hay fever etc.

Rather than visiting their GP, most people can take care of themselves when they have a minor ailment through a combination of self-care and over the counter (OTC) medicines, which can be bought in supermarkets, shops, or pharmacies.

Currently, GPs can prescribe OTC medicines to patients for minor ailments, but it is significantly more expensive for them to do so. The total cost of prescribing OTC

medicines for Nottingham North and East (NNE), Rushcliffe and Nottingham West (NW) CCGs in 2015 was £1,966,265.

The CCGs estimate that by limiting prescriptions for OTC medicines for minor ailments across the three areas, they can deliver a saving of around £196,626.

During the course of the engagement, the CCGs received 403 responses from patients, public and professionals across South Nottinghamshire, and also ran seven public events across the South Nottinghamshire area.

On the whole the patient engagement responses indicate that patients are comfortable with this proposal. Where there are concerns, they are particularly focussed on the following:

- Vulnerable patients who may not be able to access or afford over the counter medicines
- Not extending the plan to include patients with long-term conditions
- That the decision must be widely communicated and have GP support

How we acted on patient feedback

We have taken these concerns into consideration and as a result medicines have not been limited for people with long-term conditions and GPs will be able to prescribe in other circumstances of clinical need.

Feedback from the public engagement, stakeholders and financial and clinical evidence has been collated and the following has been agreed by the South Nottinghamshire County CCGs:

- As part of its self-care strategy, NHS Nottingham North and East, NHS Nottingham West and NHS Rushcliffe recommend that people visit their local pharmacy to purchase medicines and treatments for minor, short term conditions.
- It is advised that all prescribers, including GPs and non-medical prescribers, prescribe by directing individuals to purchase recommended, readily available, over the counter medicines, treatments and products.

Local GP and Nottingham North and East CCG's Clinical Lead Dr James Hopkinson says:

> "We've engaged with patients and we're pleased that they largely support us making these changes. Basically what we are saying is that patients should not expect their GP to prescribe these medicines and products going forwards for short term illnesses, unless the GP deems there is a clinical need to do so."

Further details, including the full engagement report, can be found on Nottingham North and East CCG website.

Surveys

Throughout the year, we have conducted a number of surveys, these include:

- **Men's health (as a vehicle to promote health checks)** – what men told us:
  - 30% get their info about health from social media
  - 60% didn't know they were eligible for a health check
  - Of the patients who had a health check, 85% said it was a good experience and they would go again
- **General health survey - over 65s** – what people aged over 65 told us:
  - Want care to be close to home, or in the home preferably
  - Speedy response to medical crises
  - Support accessing services and social opportunities
  - Values and life experiences should be recognised
  - Respect and be supported to make my own decisions
  - Reaching the right people, at the right time for the right care
  - More support for carers

Events

Over the last year, our philosophy has shifted so that we go out to patients rather than inviting them to come to us.

We have an annual campaign and events programme which during includes attendance at events like the Arnold Carnival, Gedling Show, Hucknall Fair, Nottingham Deaf Society's Health Event, Nottingham Pride, and also attend PPG events, youth councils and school events.

In spring 2016, we carried out an extensive engagement exercise at Hucknall National School, where we asked year 11 what they thought of local health services. The year 11 also worked through the survey with the younger years and we got a great insight into what issues affect 13-16 years in Hucknall. Following this, we arranged a panel of experts to provide a Question Time activity in the school to answer questions about these key issues.

Our annual public meeting in September was attended by over 80 people; in addition to a market place and engaging presentations we also included some patient awards – 'best PPG', 'community health hero' - which were well received.

We are always looking at new ways we can communicate and engage with local people in ways that avoid them having to come to us. One of the areas, we have invested sometime into is social media and we have an active NNE Facebook page as well as the NHS South Notts Facebook account we manage with our colleagues at Nottingham West and Rushcliffe CCGs.

At these events, we have received feedback about a wide range of issues from primary care access to the closure of the Willows, from medicine waste to the future of the NHS.

Some of the issues raised during these events demonstrated the importance of having the right services locally, partnership working with a similar model to mid-Notts, community services issues like the importance of the continued provision of MacMillan nurses, more information about self-care and support to make more informed decisions about healthcare needs.

South Notts patient networking event

On 13 October 2016, we held our first cross South Nottinghamshire patient networking event at Trent Vineyard. The aim of the event was for patients to network across South Nottinghamshire, share best practice and support one another. It was also an opportunity for the CCGs to thank the volunteers and celebrate their contribution.

The event was patient-led, with representatives from all three South CCGs - Nottingham North and East, Nottingham West and Rushcliffe) joining PPI and communications leads to plan the event.

The event was attended by over 85 people and was facilitated by Richard Pentreath. Presentations were made by Dr Nicole Atkinson, GP from Church Street Medical Centre and Designate Chief Clinical Officer for Nottingham West CCG, around a GP's perspective on a successful PPG, and Frances Newell, Patient and Public Partnerships Lead at NHS England, on the importance of patient participation and the future of PPGs.

PPGs also worked with communications leads to showcase some of their PPG's achievements in a poster format. The picture below shows the three posters from the Nottingham North and East area, with their PPG representatives.

NNE PPG representatives with posters showcasing PPG achievements

Outcomes from the meetings

It is clear from the feedback that networking was the highlight of the event. This was followed by the GPs perspective presentation and the table top discussions.

Patient representatives were asked to discuss a number of questions during the table top discussions; these included:

- What is working well within your PPG?
- What do you need help with?
- How do we make sure PPGs are representative of patient population?

Feedback from each question highlighted the following areas:

What is working well in your PPG?

- Good communication with doctors and practice managers which makes PPGs feel more supported, valued, and recognised
- Vital role in CCG inspections
- Organising health events
- Support at flu clinics
- Fundraising

What do you need help with?

- Recruiting different demographic – young people, ethnic minorities, etc.
- Engaging with patients who are not computer literate
- Using social media to interact with other patients and promote PPG
- A jargon buster for NHS-speak!

How do we make sure PPGs are representative of patient population?

- By accommodating the different skills and commitments of members
- Try to recruit a broad spectrum of ages onto the PPG committee which could be helped by attending schools, social clubs and groups
- Also by cascading information to a wider audience through Facebook, virtual groups, and email distribution lists

The feedback overwhelmingly supported a yearly event.

How we reach diverse, potentially excluded and disadvantaged groups

We work in partnership with neighbouring CCGs in south Nottinghamshire including NHS Rushcliffe CCG and NHS Nottingham West CCG, and Nottingham University Hospitals NHS Trust and a forum has been established to ensure operational ownership in advancing and mainstreaming equality and to make effective use of resources. The forum has mapped a database of ‘seldom heard’ groups who are targeted during pieces of engagement work.

The CCG's presence on social media channels has greatly increased. Facebook and Twitter are now key tools for communicating and engaging with the wider public on our plans and priorities. For example, a Facebook photo posted by NNE Comms on the NHS South Notts Facebook page, showing a pharmacy's returned medication over a three week period, led to 63,000 people viewing the post and the waste medicine campaign.

We have also used Facebook and Google ads to reach specific patient groups e.g. young people, or people living in a specific location – so for example when we were running a consultation about the future of primary care in the Colwick area we targeted Facebook adverts at 18-65 year olds in Colwick only.

As mentioned earlier, we also try and talk to people where they are or prefer to be so we go out into our communities to reach people via community and self-help groups.

The CCG regularly promote engagement opportunities and formal consultation being undertaken via our website, Facebook page, through our member database and partner organisations, feedback following the consultation and engagement activity is again promoted through these channels which would include how patient/public views have been considered and decisions made.

A recent example:
www.nottinghamnortheastccg.nhs.uk/nhs/update-on-nuh-services-review-feb-2017/

Information was sent to everybody who had engaged on the proposals (who had provided a contact), all stakeholders, decision makers, etc.

Engagement activities with patient from protected characteristics have included:

- attendance at Nottinghamshire Pride, Caribbean Carnival, Hucknall Access Event, Men's Health Event, and attendance at the Chameleon Nottingham Forum
- supporting the Nottingham Deaf Society information event, including support with translators. The NUH equality lead also delivered an update to delegates on the Accessible Information Standard
- engaging with all groups through promotion of the One You campaign at various events and has worked with GP practices' patient participation groups
- engaging with working age men to provide information on access to services and health promotion with a focus on mental health and preventing suicide.

The CCGs have strengthened their engagement process to ensure that demographic data is collected during each event and reported to the E&D Forum.

Additional communications campaigns

In addition to the communications campaigns which supported the engagement activity, we have also run a lot of campaigns throughout the year.

We continue to use technology for engagement and deliver patient information and services on a range of digital channels, including the CCG website, social media, and regular e-bulletins via MailChimp and surveys via SurveyMonkey.

Media management of GP practice issues - most notably the closure of The Willows (Summer 2016) and following the Colwick closure (March/April 2016).

We are utilising social media much more as a way to engage with patients and deliver our messages. Our social media has grown over the last 12 months to 1,566 followers on Twitter and to over 400 on the NNE Facebook page. We also manage the NHS South Notts Facebook page, which we have grown to over 1,330 followers. We utilise these social media channels to push our messages out but also to encourage people to engage with these messages, comment, and feedback. The key areas for debate over the last year have been medicines waste, big health debate and over the counter medicines.

We involved patients with the development of our communications campaigns - some of which are listed below:

- Over the year, we have delivered regular branded bulletins to the patients on our distribution list to let them know about training and involvement opportunities and our local events
- We created a new e-newsletter: NNE Patient Connect (also available to PPG members as a printed copies on demand)
- We managed the media relations with regard to the NUH Service Review, which achieved coverage across all local TV, radio, and print media
- We send out regular media releases to ensure that the public are up-to-date with developments and campaigns
- We have supported a wide-range of public health and awareness week campaigns via our digital communications channels and media relations
- We have promoted events and consultations, developing messages, designing collateral, and supporting the patient engagement manager with the event setup and plans
- We have taken regular editorial space in each of the Gedling Contacts magazines published over the year with four pages in winter and summer, and two in spring, to promote our services and get key messages out to every resident in Gedling; we plan to do the same in Ashfield over the coming year
- We have provided our GP practices with media packs at key points of the year with some key messages and stories for their websites, relevant posters for their noticeboards and images and suggested tweets and posts to share on their social media

- Media training – working with Baker and Baird two GPs, the operations manager, the quality contracting manager, the finance manager, and QIPP PMO have all been media trained in readiness for more interest in our activity

Key 2016/17 campaigns

Stay Well This Winter

We supported the National Stay Well this Winter campaign with local targeted advertising, poster and leaflet campaign and digital promotion. We particularly targeted parents of under 5s with adverts in the local magazine for parents 'lots for tots'.

The Big Health debate - NUH Service review/ QIPP

We developed a communications plan to promote our engagement activity around QIPP and Local pricing. We developed a creative look and feel and shared our collateral and resources with the other South CCGs. We are currently developing videos to further promote this.

Let's talk about it - IAPT

We continue to develop our communications and tactical activity plan to promote talking therapies to our GP practices and to our patients for self-referrals. We are refreshing our creative for a further push to the over 65s in 2071/18

Helping you to help yourself - Self care

A new campaign launched in March 2016 to support the new guidelines around restrictions to prescriptions for over the counter medicines. This campaign encourages patients to 'take care of yourself and the NHS will take care of you'.

The tactics include leaflets, two sets of posters, media relations and working with partners and stakeholders to get the message out. This is also supported with digital assets and a set of four videos.

Other campaigns

- Leaflets, posters and adverts to promote the new Ripple group for severe COPD
- New COPD leaflets for patients to monitor their condition
- Posters, leaflets, feedback boxes, media relations and social media promo to promote each engagement activity
- Patient case studies to promote healthcare in the community

How to get involved

- Sign up for regular electronic bulletins from the CCG by visiting our website at http://www.nottinghamnortheastccg.nhs.uk and going to the 'Join our Health Forum' page, or call 0115 883 1838. This forum is used to promote vacancies for patient involvement on task and finish groups when services are being looked at for planning, decommissioning or changes being made.
- Contact your GP practice for further details of their patient participation group.

Keep up to date

- Go to http://www.nottinghamnortheastccg.nhs.uk
- Follow us on Twitter (@NHSNNE)

Better care

Clinical priority areas

Cancer

Achieving the national standards for cancer can lead to earlier diagnosis, enhanced patient experience and improved cancer outcomes.

In the year to 31 March 2017:

- 93.78% of patients with suspected cancer were seen by a consultant within 14 days of referral by their GP (national standard 93%)
- 95.43% of patients received their first treatment within 31 days following a diagnosis of cancer (national standard 96%)
- 79.80% of patients diagnosed with cancer were treated within 62 days of a referral from their GP (national standard 85%).

The CCG continues to work with hospitals to reduce the waiting times for patients in receiving their cancer treatment following diagnosis. Action plans are in place with major hospitals to:

- improve processes to minimise late referrals from other hospitals
- reduce waiting times in radiology including a new MRI scanner.

During 2016/17 the Quality Scrutiny Panel received assurance around the clinical harm review process for patients waiting over 104 days. A standard operating procedure has been developed indicating the process for clinicians to follow for harm reviews and oversight of these is provided by the cancer lead nurse (implemented December 2016). Quarter 3 data was reviewed at the QSP which indicates speciality compliance with harm review completion (overall 50%) and no issues requiring escalation relating to harm review outcomes. During 2016/17 the cancer lead nurse has been working with each speciality to increase compliance with harm review completion.

Mental health

Improving Access to Psychological Therapies (IAPT)

As part of NHS England's national programme on parity of esteem, we worked hard to meet the national ambition on IAPT. The aim is that each quarter, at least 3.75% of people with anxiety or depression would have access to a clinically proven talking therapy service, and that those services would achieve 50% recovery rates.

Recovery in IAPT is measured in terms of 'caseness' – a term which means a referral has severe enough symptoms of anxiety or depression to be regarded as a clinical case. A referral has moved to recovery if they were defined as a clinical case

as at the start of their treatment, measured by scores from questionnaires tailored to their specific condition.

In the quarter to 31 December 2016:

- 4.59% of patients estimated to have depression and/or anxiety disorders within the CCG had received psychological therapies (national target is 3.75% for each quarter)
- 55.72 per cent of patients who had completed treatment were moving to recovery (national standard 50 per cent).

Dementia

In April 2016, NHS Nottingham North & East CCG was required to submit dementia diagnosis rate targets, against which we were monitored, as part of our formal planning submission to NHS England. The diagnosis rate target for 2016/17 was 67%.

At 31 March 2017 the achievement figure is:

- 70.43% of patients estimated to have dementia have been identified

Learning disabilities

Nottinghamshire (including Bassetlaw) has been identified as a 'fast track' area following the publication of the Department of Health's report *Transforming Care: A national response to Winterbourne View Hospital* in December 2012, and subsequent reports. The Nottinghamshire Transforming Care Partnership (TCP) plan aims to transform care and support for individuals with a learning disability and/or autism who also have, or are at risk of developing, a mental health condition or behaviours described as challenging so that their care is focused on keeping them healthy, well and supported in the community. Achieving this will minimise the need for inpatient care with the objective of reducing the number of beds we have available over a period of time as the redesign of services and implementation of more community based provision takes effect, for example better provision around addressing crises as they occur including accommodation options.

The CCGs within the TCP are being monitored both in terms of the number of inpatients and the number of inpatient beds. Trajectories have been set for TCP populations rather than individual CCGs or organisations. The table below shows actual performance to date:

TCP category	30/6/16		30/9/16		31/12/16		31/3/17
	Trajec-tory	Actual	Trajec-tory	Actual	Trajec-tory	Actual	Trajectory
Specialised	42	39	40	40	38	44	36
CCGs	31	31	31	31	31	36	29

Total	73	70	71	71	69	80	65

There have been a number of factors impacting on the achievement of these trajectories including late diagnosis and changes to the definition of the cohort; and delays in developing the necessary community services which are key to preventing admissions and expediting discharges.

The TCP has agreed new trajectories for years 2 and 3 and a number of actions to increase performance against these trajectories.

Diabetes

During 2016/17 the CCG has introduced a number of schemes and pathways aimed at improving prevention, diagnosis, treatment, and outcomes for patients with diabetes. These include the following:

- National Diabetes Prevention Programme- a structured education programme aimed at preventing the onset of Type 2 diabetes in those identified as at risk.
- Fit4Life- is a facilitation service aimed at getting inactive type 2 diabetics into exercise
- Hypoglycaemic pathway- to ensure that primary care and/or the Diabetic Nurse Specialist are made aware of patients attended by ambulance or admitted due to a hypo so that recurrence can be prevented
- Greater Nottinghamshire Eye Screening Programme- to ensure diabetic patients receive annual eye checks to prevent deterioration in sight
- Participation in the National Diabetes Audit and establishment of a South Nottinghamshire Diabetes Working Group to address key findings and recommendations from the audit

Maternity

Commissioners and NUH have been working closely over the past 18 months to progress a number of pathway improvements in relation to maternity care and therefore are well placed to begin implementation of the national ‘Better Births’ review published in February 2016.

During 2016/17 the CCG escalated emerging concerns to NHS England North Midlands regarding maternity services at the Trust. The CCGs have worked with the Trust, NHS England, NHS Improvement and the Maternity Clinical Network to develop a joint action plan aimed at addressing these issues and providing on-going assurance.

The action plan will be monitored via the Quality Scrutiny Panel and Quality and Risk Committee.

Other performance indicators

NHS Constitution Standards

We worked hard throughout the year to meet the national targets that were set. Specific detail on our performance during 2016/17 is as follows:

18 Weeks from referral to treatment

The patient's right 'to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer patients a range of alternative providers if this is not possible' remains a key element of the NHS Constitution in England.

During 2016/17 we met or exceeded all the national targets for elective waiting times set by the Department of Health.

In the year to 31 March 2017:

- 95.83% of patients who were still waiting for their treatment had been waiting less than 18 weeks (national standard 92%)
- 85 patients waited more than six weeks for a diagnostics test, which is within the one per cent national tolerance

Accident and Emergency

The national threshold for performance against this standard is that 95% of patients should wait no more than four hours in Accident and Emergency from arrival to admission, transfer, or discharge.

In the year to 31 March 2017:

- 82.24% of patients were treated within four hours of attending Accident and Emergency (national standard 95%).

The local health community has faced significant challenges in delivering the Emergency Department performance standard at Nottingham University Hospitals NHS Trust. A number of initiatives have been implemented throughout the year to improve performance. We are continuing to work with the wider Nottingham health community to improve performance for our population. We recognise this remains a high priority going forward in 2017/18.

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Ambulance – East Midlands Ambulance Service

In the year to 31 March 2017:

- 68.98% of calls assigned as Red 1 (immediately life threatening cases where a defibrillator is required) were responded to within eight minutes (national standard 75%)
- 57.06% of calls assigned as Red 2 (immediately life threatening cases) were responded to within eight minutes (national standard 75%)
- 57.61% of all calls assigned as Red were responded to within eight minutes (national standard 75%).

Ambulance service performance data is at East Midlands' level. Performance was under close scrutiny throughout 2016/17 and we will continue to work with our provider organisation and co-ordinating commissioner, NHS Hardwick CCG, to improve performance in this area through 2017/18. Please see the Governance Statement further on in this report for more detail.

Cancelled elective operations – Nottingham University Hospitals

In the year to 31 March 2017, 12 elective operations were cancelled at the last minute for non-clinical reasons and not rebooked within 28 days (national standard is zero).

We will continue working with our provider organisations to monitor and improve performance in this area during 2017/18.

NHS continuing healthcare (CHC)

The table below shows the CCG comparison with the National average for the CHC indicator in the CCG Improvement and Assessment Framework 2016/17.

Indicator Area	Description	Latest data period	England average	Performance
NHS continuing healthcare	People eligible for standard NHS continuing healthcare (per 50,000 pop.)	Q2 2016/17	46.2	48.4

As a result of a significant level of growth in CHC expenditure a recovery action plan has been developed and a turnaround group comprising CCG and the CHC provider (CityCare) finance, contracting and quality representatives is meeting fortnightly to oversee implementation. Actions to control costs include the following:

- Implementation of a cap on one to one hourly rates of £12 per hour
- Review of one to one provision
- Review of high cost packages
- Review of fast track referrals to ensure appropriateness
- Raising awareness of fast track eligibility amongst referrers

- Management of accruals
- Implementation of revised risk based review intervals for stable patients
- Implementation of the West Norfolk screening model to support discharge to assess

Process mapping of the end to end process of CHC to identify opportunities to improve efficiency and scrutiny was undertaken during December 2016 and recommendations arising from this are overseen by the turnaround group.

There is a drive to reduce the number of assessments undertaken in acute hospital settings as it is recognised that this is not the most appropriate environment or time to assess an individual's on-going health needs. The CCG Quality Premium includes a standard of less than 15% of all full CHC assessments should be undertaken in the acute setting. Latest data (March 2017) show that currently 50% of assessments are undertaken in the acute settings in for Nottingham North and East. The CCGs are liaising with West Norfolk regarding a revised model for assessing eligibility that has been successfully implemented there with significant savings achieved and improvements in the percentage of assessments undertaken in the acute setting. It is anticipated that the implementation of this model will support achievement of this standard.

The CCG Quality Premium also includes a standard that CCGs must ensure that in more than 80% of cases with a positive NHS CHC Checklist, the NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification of potential eligibility). Latest data (February 2017) shows that the County CCGs are currently meeting this target, with performance of 81.7%. Work is on-going with the provider to streamline processes to ensure more timely assessment. Weekly panels are held to ensure timely CCG decision making.

In December 2016 NHS England announced the launch of the NHS Continuing Healthcare Strategic Improvement Programme. A collaborative engagement method will be at the centre of the programme's approach. The NHS England team will work with CCGs to identify best practice and explore new approaches to improve NHS CHC. The County CCGs have joined the programme as learning partners. Regular sessions are held to share learning and develop future policy.

Primary medical care

Primary care access

The CCG has used the results of the GP patient survey (July 2016) to identify inequalities across practices in terms of access. Targeted support has been provided to GP practices where access has been identified as an issue. This support will continue during 2017-19. In addition, the CCG has commissioned a Care and Quality in General Practice local enhanced service. Delivery of this enhanced service will reduce inequalities and improve access to primary care across a range of indicators,

including: telephone access during core hours, physical access to premises during core hours, same day appointments for urgent needs, progress towards routine appointments within 3 working days, use of technology to book and provide appointments. In the second half of 2017/18 the access elements of the Care and Quality in General Practice service specification will be reviewed in conjunction with the results of the GP patient survey that will be undertaken in July 2017.

During the early part of 2017/18 the CCG will work with GP practices and engage with the local population to determine the requirement for extended hours within each of the three CCG localities. This will include an assessment of the level of demand at a locality level for appointments in the evenings and at weekends. In the latter part of 2017/18 the CCG will co-design its model of extended access to general practice with practices and patients.

Quality in primary medical care

Practice name	Outcome
Calverton Practice	Outstanding
Park House Medical Centre	Good
Om Surgery	Good
Newthorpe Medical Centre	Good
Giltbrook Surgery	Outstanding
Plains View Surgery	Good
Daybrook Medical Practice	Good
Trentside Medical Group	Good
Torkard Hill Medical Centre	Good
Apple Tree Medical Practice	Good
Unity Surgery	Good
Westdale Lane Surgery	Good
Whyburn Medical Practice	Good
Oakenhall Medical Practice	Good
Stenhouse Medical Centre	Good
Ivy Medical Group	Requires Improvement
Jubilee Practice	Good
West Oak Surgery	Good
Highcroft Surgery	Good
Peacock Healthcare	Good

At the end of September 2016, The Willows Medical Centre closed following concerns raised in relation to quality and patient safety. In December 2016 a ‘lessons learnt’ meeting took place between the CCG, NHSE and the CQC. The purpose of

the meeting was to ascertain what future indicators and information could be collected or requested from practices or elsewhere to potentially act as warning signals and provide earlier identification of practices that may be struggling or require support. A document has been produced which provides a summary of the lessons identified and actions to be taken. This has been widely shared with all CCGs in Nottinghamshire and Derbyshire and nationally via NHSE.

The Ivy Medical Group was rated 'Requires Improvement' overall with 'Good' for the 'Effective', 'Caring' and 'Responsive' domains, 'Requires Improvement' for the 'Well-led' domain and 'Inadequate' for the 'Safe' domain. As a result of this a Warning Notice was issued to the practice by the CQC on 25 July 2016. An unannounced focused inspection was subsequently undertaken on 30 August 2016 to follow up the Warning Notice. The CQC found that significant improvements to ensure patients received a safe service had been made and that the practice had complied with the Warning Notice. The ratings do not change however following the focused inspection, and there will be a full re-inspection before the end of April 2017.

Investment in primary care premises

The CCG was successful in securing funding to enable a significant refurbishment of a practice with the intention that in following years the practice will be able to extend and meet the growing demand from patients as a result of major housing development. Smaller amounts of funding were also awarded to 3 further practices to improve the accessibility of their premises and add clinical capacity. This will improve the quality of care offered to patients and enable practices to grow to meet the growing demand for primary care services.

'Care and Quality in Primary Care' enhanced service

The CCG has invested over £700k in an enhanced service from our GP practices that is focussed on improving the care that our patients receive whilst also generating savings on our contracts with other providers. The service asks practices to meet standards around access to primary care, improving the health of the local population, improving the diagnosis and management of long term health conditions like diabetes and hypertension and effectively managing the amount of money they spend on hospital services and medicines.

As a result of the enhanced service, more patients should:

- undertake activities to improve their health
- be diagnosed with long term health conditions
- receive the appropriate treatment to manage their health condition which should reduce future costs for the health service.

Quality performance

Quality strategy and framework

Commissioning is a tool for ensuring high quality, cost–effective care. Quality is a key thread that underpins the work undertaken by clinical commissioning groups. The mission is to improve the health and wellbeing of people in Nottinghamshire with a specific aim to improve quality by delivering improvements across the three domains of quality:

- Patient safety
- Patient experience
- Clinical effectiveness

Quality is only achieved when all three domains are met; delivering on one or two is not enough. To achieve a good quality service the values and behaviours of those working in the NHS need to remain focussed on patients first.

Our ambition is to commission excellent, safe, and cost effective healthcare for Nottinghamshire.

The Quality Strategy (2014-2019) sets out how we will achieve this ambition by ensuring that quality is at the heart of commissioning. The Quality Framework sets out our Governance processes for achieving this.

Healthcare-associated infections

Targets for CCGs are set nationally and are population based. Cases are designated as pre or post 72 hours, using the Public Health England definition, which is:

- Pre 72 hour/community acquired = diagnosis confirmed by a stool (*C.diff)* or blood (MRSA) sample taken within 72 hours of admission to hospital or diagnosis from a GP sample.
- Post 72 hour/hospital acquired = diagnosis confirmed by a stool (*C.diff*) or blood (MRSA) sample taken 72 hours after admission to hospital.

The table below shows the position at 31 March 2017 against limits (subject to validation):

Organisation	*Clostridium difficile*			MRSA Blood Stream Infection (BSI)	
	Full Year Limit to end 2016/17	Actual to end 2016/17	Pre/Post 72 Hours	Full Year Limit	Actual to end 2016/17
NNE CCG	47	32	16 pre/16 post	0	0
NUH	91	93*	All post	0	5**

*includes 24 lapses in care (post infection reviews not yet completed for March cases) so this number may increase
**includes 1 contaminant (not true bacteraemia), 1 clinically unavoidable and 3 clinically avoidable

All cases of *Clostridium difficile (C. diff)* and meticillin-resistant Staphylococcus aureus (MRSA) blood stream infections (BSI) are subject to a root cause analysis (RCA) or post infection review (PIR). Where lapses in care are identified appropriate action plans are developed to mitigate risk and learning is shared across the health community.

CCG performance

The CCG achieved the target for *C. diff* and continues to compare favourably with other similar organisations. Categorisation of CCGs by RightCare has been linked to the Office of National Statistics (ONS) clusters. Nottingham North and East CCG is located within the Manufacturing Towns group.

The CCG originally reported one case of MRSA Blood Stream Infections however following post infection review has been re-assigned to a third party.

Nottingham University Hospitals (NUH) Performance

NUH exceeded the *C. diff* target by two cases in 2016/17. This is an improvement on the previous year when the target was exceeded by four cases. *C. diff* toxin positive assessments identified lapses in the quality of care in 24 cases year to date. 17 cases were identified as avoidable (two cases reported in March 2017 were still under investigation at the time of writing this report). Lapses in care include:

- Cross-infection
- Inappropriate antimicrobials
- Delayed diagnosis and treatment

Of the five MRSA bacteraemia cases reported by NUH in 2016/17, three to date have been identified as clinically avoidable following post infection review which is subject to CCG scrutiny. The Trust continues to deliver training and audit compliance with infection prevention and control policy and practices.

The CCG Quality Team continued to undertake joint infection prevention and control focussed quality visits to NUH with the Trust Development Authority (TDA) during 2016/17 in response to concerns in relation to cleanliness and to seek assurance

that previous issues in relation to staff adherence to policy and practices had been resolved. The visiting group was assured that:

- strategic leadership of infection control was strong and the Board was fully engaged
- infection prevention and control was owned at all levels
- concerns in relation to the cleanliness of some clinical areas persisted during 2016/17, and as a result the Trust have terminated their contract with an external provider and taken the service in house from April 2017.

The challenge going forward is to sustain this improvement and the CCGs will continue to work closely with the Trust to achieve this.

Serious incidents

The table below identifies the number of serious incidents (SIs) reported by providers where the South Nottingham CCGs are co-ordinating commissioners. These providers are: Nottingham University Hospitals Trust (NUH), Health Partnerships (HP), Circle Nottingham (CN), Nottingham Woodthorpe Hospital (NWH) and BMI The Park. The main categories of serious incidents reported are grade 3 or 4 pressure ulcers, falls, maternity incidents and healthcare associated infections.

It should be noted that the data provided is to the end of 2016/17 but is not validated at the time of writing this report. Numbers may therefore change dependent on the outcome of root cause analysis reviews.

Organisation	Concise[1]	Comprehensive[2]	Independent[3]	2016/17 Year to Date Total
NUH	71	28	0	90
HP	75	2	0	75
Circle	0	0	0	0
NWH	0	0	0	0
BMI The Park	0	0	0	0
NNE primary care	0	0	0	1
Total	**136**	**30**	**0**	**166**

Never events

Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are in place to

[1] Concise - less complex incidents managed by individuals or a small group at a local level
[2] Comprehensive - complex issues managed by a multidisciplinary team involving experts and/or specialist investigators where applicable
[3] Independent - required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved

ensure they should never happen. The table below shows the number of never events reported by organisation during 2016/17:

Organisation	2015/16 Full Year	2016/17 Year to Date
NUH	5	8
HP	1	0
Circle	0	0
NWH	0	0
BMI The Park	0	0
NNE primary care	0	0

Eight never events have been reported by NUH in 2016/17 which consisted of the following:

- Wrong surgical implant (hip implant)
- Misplaced nasogastric feeding tube
- Overdose of insulin
- Retained vaginal swab
- Wrong site surgery – wrong sided anaesthetic block for wrist surgery patient
- Wrong route administration of medication – patient incorrectly received fentanyl/levobupivicaine mix intravenously and Syntocinon® epidurally
- Wrong route administration of medication – vaccine
- Retained foreign object post procedure – guidewire

Given the increase in never events additional assurance was requested and received from NUH which formed part of the Quality Scrutiny Panel (QSP) agendas.

The Trust presented findings of analysis undertaken of the never events which have occurred since September 2015 at the September 2016 QSP. The contributory factors in order of frequency cited are:

1. Human error
2. Clarity of policy/guidance
3. Physical connection, design (designing out error)
4. Second checking process
5. Process – deviation from the “norm”
6. Handover/handoffs
7. Knowledge base
8. Clarity of prescribing

The Trust has focused their patient safety improvement work on system based solutions as well as considering interventions such as second checking and rules, policies, guidelines and education.

Further assurance was received at the Quality Scrutiny Panel in December 2016 which indicated significant actions to improve safety, including simulation and human

factors work. Additional assurance was also received in January 2017 which reviewed eleven never event investigation action plans overall, identifying a number of key recommendations for NUH in their work to prevent never events. These consist of focusing on fewer higher impact actions and linking them to measurable outcomes, incident training focusing on systems rather than individuals and using the findings to undertake a project with the East Midlands Patient Safety Collaborative, University Hospitals Leicester (UHL) and Dr Murray Anderson Wallace applying the Human Factors methodology which aims to strengthen further learning and actions locally and nationally around safe care.

Safeguarding

During 2016/17 the CCGs engaged with both Adults' and Children's Safeguarding Boards to ensure that emerging safeguarding priorities and risks were appropriately identified and managed including child sexual exploitation, modern slavery and female genital mutilation. Lessons from serious case reviews, domestic homicide reviews and safeguarding adult reviews were widely shared to ensure learning and adoption of best practice.

We also engaged with providers to ensure that their safeguarding systems and processes were robust using safeguarding adult's assurance frameworks, markers of good practice and Section 11 audits to identify areas of good practice and areas for further development. We received quarterly PREVENT returns from providers to ensure that appropriate staff training had taken place and to monitor referral activity.

As part of the internal audit programme a follow-up review of adult safeguarding processes was undertaken during the latter part of 2016/17 to ensure compliance with the Care Act. The original report provided a Significant Assurance opinion with only five recommended actions for the South Nottinghamshire CCGs (2 medium, risk, 3 low risks). Action has been taken to comply with the recommendations and a follow-up report was issued in April 2017 confirming that all required actions have been implemented.

An internal audit of children's safeguarding processes is currently being undertaken and is expected to report in quarter 1 of 2017/18. The CCG has recently purchased licences for the Safeguarding Assurance Tool (SAT) which will enable the collation of safeguarding assurance evidence.

Patient experience and complaints management

The voice of the patient is actively sought through ensuring robust feedback mechanisms, the continuing development and influence of patient participation groups, and triangulation of patient experience data including complaints, survey results, patient stories, and the Friends and Family Test.

Patient Advice and Liaison Service (PALS)

The following table shows contacts with the PALS during 2016/17. PALS include general enquiries and low level concerns where the referrer does not wish to make a formal complaint.

CCG PALS	2016/17 Total
Anonymous/Out of Area	117
NHS Nottingham North and East	586
NHS Nottingham West	81
NHS Rushcliffe	81
Cross South Nottingham CCGs	398
Totals	**1265**

There was a rise in PALS contacts during the summer following the closure of The Willows surgery as a result of quality concerns and subsequent suspension then cancellation of the registration by the CQC. The PALS number was used as a patient helpline offering advice and guidance on how to access alternative GP provision. Towards the latter part of the year the PALS team were involved in engagement in relation to a number of proposed service changes including changes to prescribing of medicines available over the counter and proposed relocation of a number of services from NUH to the community following clinical service review.

Complaints

The following table shows the CCG complaints received during 2016/17. All of the complaints were responded to in the timescale agreed with the complainant at the time of receipt. None have to date been referred to the ombudsman. CCGs are provided with details of primary care complaints that are received, investigated, and responded to by the Central Customer Contact Centre hosted by NHS England. At the time of writing only primary care complaints data to the end of quarter 3 was available from NHSE.

CCG COMPLAINTS	2016/17 Total
NHS Rushcliffe	25
NHS Rushcliffe primary care	15
NHS Nottingham West	15
NHS Nottingham West primary care	16
NHS Nottingham North and East	22
NHS Nottingham North and East primary care	23
Other	7
TOTAL	**123**

There is no particular recurring theme or trend in the complaints received, all of which were responded to individually.

We have also monitored provider complaint numbers, themes, and response times through Quality Scrutiny Panel meetings and monthly dashboards and triangulated this with other data sources including Friends and Family Test (FFT) data. Where themes were identified, assurance was sought that appropriate action had been taken by the provider to reduce recurrence.

During 2016/17 we worked with the primary care leads with practices to increase utilisation of the FFT in primary care. This resulted in a significant increase in the number of practices regularly submitting data. We are now working with practices to ensure that the response rates improve and that the information is used to bring about improvements. We have also encouraged GPs and practice staff to register any provider concerns on eHealthScope so that this intelligence can be triangulated with other sources of data to support quality monitoring and assurance.

Quality Priorities 2017/19

The specific areas of focus for the CCG during 2017-2019, based on national and local priorities are as follows:

- Improving 4 hour A&E access performance and ambulance response times by implementing system transformation to reduce attendances and improve timely discharge
- Reducing cancer and diagnostic waits by ensuring that capacity and demand is matched and efficient systems are in operation
- Reducing the number of patients with Learning Disabilities admitted to hospital by undertaking regular care and treatment reviews, provision of crisis intervention services and alternative community based provision
- Improving staff health and well-being by ensuring that initiatives are implemented that support musculoskeletal, mental health, and healthy eating
- Supporting safe and proactive discharge by developing transfer to assess services and improving provider to provider communication and collaboration
- Reducing impact of serious infections (in particular sepsis) by ensuring appropriate use of early warning tools, staff training and antibiotic therapy
- Improving services for patients with mental health needs who attend A&E by supporting mental health and acute hospital providers, working together and with partners (primary care, police, ambulance, substance misuse, social care, voluntary sector) to ensure that people presenting at A&E with primary or secondary mental health needs have these needs met more effectively through an improved, integrated service offer
- Reducing avoidable emergency admissions by ensuring effective advice and guidance is available to referring clinicians and improved GP access
- Maximising choice by ensuring that all first outpatient referrals are able to be received through the e-Referral Service

- Preventing ill health by risky behaviours (alcohol and tobacco in particular) by ensuring that staff have appropriate training and confidence to assess and where appropriate offer brief intervention training and onward referral or treatment
- Improving the assessment of wounds that have not healed within 4 weeks by implementing full wound assessments
- Improving access to and transitions between mental health services for children and young people by supporting sending and receiving services to work collaboratively and ensuring that individual transitions meetings are held
- Increasing personalised care and support planning by staff training to support increased patient activation
- Increasing the uptake of personal health budgets and integrated personal commissioning by working in collaboration with our local authority colleagues to maximise the sustainability of the care market, in particular appropriately trained personal assistants
- Reducing the number of 999 calls that result in conveyance to A&E and increasing the number of 111 calls that result in referral to services other than A&E by appropriate training and support for frontline staff and provision of effective alternative pathways
- Reducing clinical variation by using intelligence to identify opportunities for improvement
- Improving early cancer and dementia diagnosis by appropriate staff training and access to diagnostics and specialist services
- Reducing mortality and improve quality of life for people with long term conditions by early diagnosis, a proactive approach to prevention and targeted support for individuals and communities at highest risk
- Improving the care, experience and choice for pregnant women by implementing the recommendations in 'Better Births'

Our achievements during 2016/17

NHS Diabetes Prevention Programme (NHS DPP)

In 2016/17 NNE were successful in becoming a wave 2 site for the NHS DPP, which is an evidence-based behavioural programme focused on achieving healthy weight, increasing physical activity and improving the diet of those individuals identified as being at high risk of developing Type 2 diabetes.

The aim of the programme is to prevent type 2 diabetes from developing in patients who are identified at being at risk and supporting people to take control of their own health. The long-term aims of the NHS DPP is to reduce the incidence of type 2 diabetes, reduce the incidence of complications associated with diabetes - heart, stroke, kidney, eye and foot problems related to diabetes and longer term to reduce health inequalities associated with incidence of diabetes.

NNE began referring patients in August 2016 and to date over 300 patients have been referred.

The NHS DPP is an evidence based programme and when compared to usual diabetes care found that on average 26% lower incidence of diabetes were observed.

Shared Decision Making – Let's talk about it

The "Let's talk about it" campaign embraces Shared Decision Making (SDM) and is about informing and empowering our patients to have a better conversation with their doctor or healthcare professional.

Shared Decision Making is a process where patients are encouraged to have a proper talk with their Doctor or healthcare professional. This talk should help them to make informed decisions about treatments when there is more than one option available.

The doctor will provide patients with the expertise on their illness and the treatment options available. They will also be able to point patients in the direction of more information and decision aids. This doesn't necessarily mean a longer conversation just a better, more informed one.

Patients are asked to consider their lifestyle, what they enjoy doing and decide on their preference having discussed the benefits and risks of the options with their doctor.

"Let's talk about it" is about helping patients to take control of their own health and know the options available to them. Posters and leaflets have been distributed to local Practices, pharmacies etc. and can be downloaded from the CCG internet. Information has also been

Community Musculoskeletal Assessment and Treatment Service (CMATS)

The CMATS service was commissioned in April 2016, to bring together community physiotherapy and musculoskeletal care into one service, to reduce duplication and fragmentation of services.

The CMATS service offers a single point of access (SPA) for all referrals and is a "one stop shop" musculoskeletal service for patients aged 16 years and over. The SPA triages all referrals to establish the most appropriate pathway without the need for additional referrals, unless hospital based treatment is required.

The service is delivered through a multidisciplinary approach, with a range of professionals involved at all points of the pathway in order to manage the full range of patients' needs. This includes physiotherapists, orthopaedic and spinal consultants, sport and exercise medicine consultants (SEMs), and extended scope physiotherapists (ESPs).

The benefits of the service include the following:

- Patients are seen and treated closer to home in an environment most appropriate to their needs
- Reduction in patient's need for on-going care provision by increasing their levels of independence
- Reduced waiting times for patients with musculoskeletal conditions
- Reduced demand and waiting times for secondary care orthopaedic services

Cost effective, high quality prescribing

The CCG's Medicines Management Team have been working closely with GP practices to reduce prescribing spend by promoting cost effective prescribing. Prescribing decision support software (Optimise-Rx) is in place for all practices to provide individualised patient-centred advice on the best clinical and cost effective drug choices. The Medicines Management Team continues to support and deliver the MMF (medicines management facilitator) scheme. For this, all practices are encouraged to nominate a representative; this role involves attending workshops throughout the year and implementing approved workstreams to improve prescribing.

The CCG's Medicines Management Team has continued to focus on safety by the on-going implementation of PINCER. PINCER is a pharmacist information technology intervention for reducing clinically important errors in medication management. A member of the team also acts as designated medicines safety officer (MSO) representing the CCG as part of the Nottinghamshire and Derbyshire Medicines Safety Officers Network. This enables CCG MSO leads to work together to ensure medicines are prescribed safely across the local area.

Care homes

The CCG has ensured that systems and processes for medicines management are safe as well as focusing on particular areas of prescribing and carrying out individual multidisciplinary medication reviews for residents of care homes.

The Care Home pharmacist is actively involved in the PEACH project (ProactivE heAlth care for older people in care homes) which is centred on improving the support and quality of health care delivery to care home residents. Specifically the care home pharmacist has developed a medication review checklist in order to both support GPs and other clinical practitioners to carry out medication reviews for older people living in care homes. The medication review checklist has a patient-centred approach, focusing on the clinical considerations of commonly prescribed medicines as well as ensuring cost effective prescribing, and highlighting practical considerations around prescribing in care homes.

Alongside undertaking multidisciplinary medication reviews with GPs, there has been a particular focus on the audit and review of oral nutritional supplements (ONS)

prescribed to care home residents. The care home pharmacist is involved in developing a local tool to support GPs and other clinical practitioners in ensuring best practice and the on-going regular review of ONS prescriptions.

The care home pharmacist has also worked with the Nottinghamshire Care Home Pharmacist Network Group to develop a Good Practice Guide for Ordering Repeat Monthly Prescriptions in Care Homes to ensure a robust medication ordering system is in place for care home residents, ensuring correct medicines are supplied in a timely manner to meet their needs and minimise pharmaceutical waste. A waste reduction scheme has been initiated within the care homes within NNE CCG to support this.

Self-care and medications

During 2016/17 the CCG's Medicines Management Team has continued to support patients to get the best out of their medication in a number of ways. Initiatives include medication reviews in GP practices. As an example, the prescribing team work with GP practices to identify and support with reviews where individuals are on 20 or more medications. The CCG's team of pharmacists also reach out to those who would benefit from more information on their prescriptions. This work includes presenting on medications at a pulmonary rehabilitation course for people with chronic obstructive pulmonary disease; this involves talking about the effects / side effects of medications as well as working with patients on the correct way to use inhalers. Through a local housing association the CCG pharmacists run "Let's Talk Medicines" sessions which covers, benefits/risks of taking medicines, ensuring individuals are taking their medicines correctly, safe storage of medicines and ways to improve medicines safety. Finally, the CCG has identified that a substantial number of prescriptions are being issued where individuals have seen a GP and received a medication on prescription when there could be the opportunity to see a local community pharmacist or an individual could consider self-care for a minor ailment. As a result, GPs are encouraging patients to purchase medications over the counter and to see their community pharmacist prior to visiting their GP.

Leadership

Quality of leadership

In 2016/17 our leadership has been enhanced through the appointment of a new clinical lead and chair. Dr James Hopkinson has been a strong member of the Governing Body since the CCG was first formed and as a result, has a passion and drive to take forward the CCG. 2016/17 also saw changes to the Governing Body including the appointment of three new GPs, a new secondary care consultant and two new lay members. The Governing Body has a strong skillset and has proven to be a robust team.

Clinical leadership has been strengthened with more GPs on the Governing Body allowing for increased clinical input into the strategic direction of the CCG as well as on-going input to service improvement. In recognising the need for change in primary care, the CCG has also sponsored a GP lead to work with member practices on opportunities for new models of care that allow for the sustainability of primary care that meets the needs of the local population.

Patient and public leadership continues to be vital for the CCG and 2016/17 has seen an increase in the number of lay members on the Governing Body to support this. In 2016/17 the CCG has also enhanced the patient and public committee structure to ensure that delegated responsibilities from the Governing Body are met and the patient voice is central to all that we do.

Collaborative working is essential for the CCG and the executive team continue to take lead roles working across Greater Nottingham as well as ensuring that the CCG has the leadership it needs within a continually evolving and dynamic environment.

In the last quarter of 2016/17 the CCG leadership indicator in the Improvement and Assessment Framework was changed from green to amber and this was as a result of the on-going financial challenges.

The CCG's local relationships

360 Stakeholder Survey

The CCG participated in the CCG 360 Stakeholder Survey for 2017 as this forms a central part of the CCG annual assessment process. All local GP practices were invited to participate along with local authority representatives, other local CCGs, providers and patient groups. The CCG had an overall response rate to the survey of 84%. The CCG received very positive feedback with stakeholders praising the overall levels of engagement, commissioning of services, the leadership at the CCG, monitoring and reviewing of services and CCG plans and priorities.

Probity and corporate governance

Health and safety

The CCG has a shared Health and Safety sub-group of the Quality and Risk Committee with NHS Nottingham West and NHS Rushcliffe. The sub-group co-ordinates activities required for each CCG to comply with the Health and Safety Act 1974 and other statutory provisions and to provide a healthy and safe environment for all people who work in, use or visit their premises.

The CCG has a Governing Body-approved Health and Safety Policy and a procedure for reporting incidents and near misses, which includes RIDDOR requirements.

During 2016/17 for Nottingham North and East CCG there was one reported health and safety incident:

- Lost ID badge – appropriate action taken

Throughout the year, the sub-group continued to review and re-write health and safety policies relevant for CCGs completing the full suite of policies in January 2017 with the completion of the following policies:

- First aid
- Electrical safety
- Fire safety

The group also monitors the mandatory training uptake figures for health and safety and fire safety. For NNE CCG at the end of March 2017 these were:

Health & safety	Fire safety
100%	82%

The CCGs work closely with NHS Property Services on all health and safety requirements and any high risk areas identified.

At the start of the year, NHS Protect issued Security Management Standards for Commissioners with the requirement to appoint a security management specialist. 360 Assurance were appointed and the local security management specialist (LSMS) joined the Health and Safety Group in October 2016 to take this work forward. The director of nursing and quality was registered with NHS Protect as the security management director. The Security Policy and related policies were reviewed for compliance with the standards and security risk assessments and staff awareness sessions were organised. A self-review tool was completed and submitted for each CCG in November 2016. All three CCGs were rated ‘green’.

Freedom of information

The Freedom of Information Act 2000 promotes greater openness of public authorities. The Act provides general access to public authority information, helping the public to understand how public authorities carry out their duties, make decisions, and spend public money.

The CCG has complied with its statutory duty to respond to requests for information. During 2016/17 we received 247 requests under the Freedom of Information Act 2000, which were all responded to within the statutory timescales.

Emergency preparedness, resilience and response (EPRR)

The NHS needs to plan for and respond to a wide range of emergencies and business continuity incidents that could affect the health/patient safety of individuals or populations. Typically these are related to severe weather, outbreaks of diseases – for example flu – and major transport incidents. A significant amount of planning

and testing takes place across the public sector under the Civil Contingencies Act (2004). In the health service this work is referred to as EPRR.

The CCG is a category 2 responder for major incidents and is therefore not required statutorily to have major incident plans in place. However, in the event of a major incident, the CCG would support NHS England as a category 1 responder and work with it to implement the shared incident response plan for which it holds responsibility for the local health community.

Core standards for EPRR have been developed nationally and NHS England has required all relevant organisations to complete a self-assessment matrix with a RAG (red, amber, green) rating against these core standards.

A self-assessment rated as Green was approved by the Governing Body in July 2016 confirming the CCG's responsibility in emergency planning and that the necessary processes and infrastructure were in place in relation to the core standards of a category 2 responder. Following the 'confirm and challenge' session with NHS England later in the year, the CCG received 'Full' compliance.

The CCG is fully integrated in the system wide strategic planning of EPRR through the Local Health Resilience Partnership (LHRP) and also on the Health Protection Strategy Group.

Business continuity

The CCG has its own business continuity plans which would be enacted in the event of any incident that impacted on the day-to-day running of the organisation.

Counter fraud

The CCG has a Local Counter Fraud Specialist Advice Service and robust arrangements in place to protect NHS resources from fraud, corruption, and bribery in line with NHS Protect compliance guidance. Please refer to the Governance Statement further for more detail on the CCG's work in this area.

Innovation, research, education, and training

The CCG is a member of the East Midlands Clinical Research Network and is aware of its statutory responsibilities in this area. For example, together with partner CCGs in Nottinghamshire, it has a process for considering and approving excess treatment costs. Throughout 2017/18 the CCG will continue to support research, in particular looking at opportunities to develop research capacity and capability in primary care. At the end of quarter 3 2016/17, 37 patients had been recruited to participate across 14 new research projects. Research topics include:

- **Understanding the nature and frequency of avoidable harm In primary care**
- **Dementia undetected or undiagnosed in primary care**
- **Cloudy with a chance of pain**

- **Novel START novel Symbicort Turbuhaler asthma reliever therapy**

The CCG strives to adopt innovative approaches and to enable that we:

- have access to the research and development activities of the range of National Institute of Health Research (NIHR) infrastructure organisations within the East Midlands Biomedical Research Units in Nottingham and Leicester, clinical trials units, the Clinical Research Network, and the Collaboration for Leadership in Applied Health Research and Care (CLAHRC)
- are members of the East Midlands Academic Health Science Network (AHSN), which offers opportunities to adopt and spread research outcomes and evidence-based practice
- are partners of CLAHRC East Midlands, to support the reduction of clinical variation in public health and chronic disease across the patient population
- have defined/are developing key metrics in order to understand organisational performance in relation to invention, adoption and spread
- have further developed information systems to facilitate sharing of innovative ideas and service improvements
- are working with industry partners to accelerate the adoption of proven technologies in clinical practice
- have worked with the East Midlands Leadership Academy (EMLA)/Health Education East Midlands (HEEM) to develop our workforce in relation to leadership, research and innovation
- encourage providers to 'innovate' through the Quality Contract/Commissioning for Quality and Innovation (CQUIN) schedule.

We are dedicated to delivering clinical education for our member practices and support regular education events for all member practices that cover clinical topics for GPs and practice managers. Topics in 2016/17 included:

For clinical staff	For practice managers
Heart Failure	Supporting Carers, Change Point, Introducing the new Stop Smoking Service
Mental Health	Community Services, Winter Pressures, Information Governance
ED Audit, Urgent Care Centre, Fast Track CHC Audit Findings, OptimiseRx	Refugee Forum
CMATS, Prescribing – Pain, Pain Management, LMC – GP-S overview, GP Appraisals and revalidation	
Nottingham Paediatric Pathways, Paed Emergencies – bronchiolitis, gastroenteritis, head injuries, table top discussions	
Safeguarding	

Organisational development

During 2016/17 we held a staff 'time out' session and used the results from the 2015 staff survey as a basis for discussion.

A review was also undertaken with Arden & GEM CSU across the three South CCGs in relation to the Shared Development Programme and the workshops offered in order to fit better with the training needs identified by staff. As a result, workshops on building personal and team resilience, responding effectively to change, maximising appraisal effectiveness and maximising personal effectiveness.

The CCG is a member of the East Midlands Leadership Academy, which provides education, leadership and organisational support. During 2016/17 our staff attended 59 sessions for topics such as Leadership Essentials, Organisational Development and advanced coaching skills.

Sustainable development

As an NHS organisation and as a spender of public funds the CCG recognises that in delivering and commissioning healthcare services, its activities may have adverse impacts on the environment and it is essential that these are minimised and maintained. In the health and care system, sustainable development means working within all the available resources to protect and improve health now and for future generations.

The Social Value (Public Services) Act 2012 – in force from 31 January 2013, requires all commissioners of public services to consider taking into account economic, social and environmental value, not just price, when buying goods and services. The CCG complies with all relevant environmental legislation and is committed to minimising the environmental impact of our activities and our ambition is to reduce our overall carbon footprint by 18% from a baseline set in 2013 of 87.47 tonnes CO2e to 71.73 tonnes CO2e, by 2020.

Good quality healthcare, delivered by sustainable providers, at the right time and in the right place to the right person, reduces the use of resources, carbon and improves sustainability. The CCG leads by example and works in a way that has a positive effect on the communities for which we commission and procure healthcare services. We have already established strategic commissioning partnerships with Nottingham West and Nottingham North & East CCGs and have jointly developed a Sustainable Management Development and action Plan (SMDP). http://www.nottinghamnortheastccg.nhs.uk/delivering-as-a-ccg/delivering-sustainability/

We expect a commitment to the same principles from our providers and suppliers as the majority of the CCG's environmental and social impacts are through the goods and services we commission. Effective contract mechanisms enable us to operate effectively with our providers to support sustainable healthcare delivery. For our commissioned services there is a 'sustainability comparator' established by the

Sustainable Development Unit (SDU) which measures the performance of our service providers. This can be found on the SDU website: www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx

Summary of sustainability performance

Greenhouse gas emissions are categorised into three groups or 'scopes' by the most widely-used international accounting tool, the Greenhouse Gas (GHG) Protocol. While scope 1 and 2 cover direct emissions sources (for example fuel used in company vehicles and purchased electricity), scope 3 emissions cover all indirect emissions due to the activities of an organisation. All the CCG's emissions are classed as Scope 3 using DEFRA foot printing methodology. This is due to the fact that the CCG occupies rented space in a shared building and neither owns nor leases vehicles. Our assessment indicated the largest areas of our corporate emissions are through our building energy use and travel. We have also assessed the CCG's emissions as a result of the procurement of non-healthcare products and services and commissioning of healthcare services.

The CCG has been part of the Nottinghamshire Community Sustainable Network where we engage with, and learn from, partners to ensure we embed sustainability and carbon reduction into everything we do, from our internal activities to delivering and commissioning frontline services in the communities we serve.

The CCG is also a member of the Investors in the Environment Network. The network forms the core of the Local Enterprise Partnership's Low Carbon Hub which supports organisations to reduce their direct reliance on increasingly expensive energy and natural resources, cutting costs and emissions, while gaining a visible externally verified quality mark to evidence their progress. The CCG was formally presented with the Network's highest level Green Award for our continued commitment to improving our environmental management - an integral part of healthcare provision.

The following performance table sets out the CCG's progress in reducing its overall carbon emissions since the baseline was set in 2013. Although there has been a slight increase in most areas and the overall carbon footprint in year, emissions based on Whole Time Equivalent (WTE) staff numbers has decreased from last year. Staff received training last year on awareness of their environmental impact through day to day activities and they are positively encouraged to promote new ideas for integrating the principles of sustainability into the workplace to help reduce our carbon footprint. Installation of a new photocopier and implementation of on-going efficiency savings has also reduced the quantities of paper used across the organisation enabling a tonnes CO_2e reduction of 0.21 of in this area. Reported water consumption has increased significantly compared with usage data of previous years; this will be reviewed during 2017/18 to ensure this is a true reflection of our usage.

Area (totals)		2013/14	2014/15	2015/16	2016/17
GHG emissions (tCO_2e gross)		48.89	50.28	48.29	46.32
tCO2e/WTE		1.19	1.12	1.05	1.02
Energy in buildings	**Use (kWh)**	77,230	80,379	82,370	75,783
	tCO_2e	28	31	30	30
	KWh/ WTE	1.88	1.79	1.78	7.80
Water	**Consumption (m^3)**	636	704	702	706
	tCO_2e	0.58	0.64	0.74	0.70
	m^3/WTE	15.45	15.67	15.21	15.21
Transport	**Distance (miles)**	48,754	43,805	45,232	44,906
	tCO_2e	18	16.1	16.4	16.2
	Expenditure (£)	20,297	18,237	25,330	25,147
Waste	**Recycling (tonnes)**	0.809	0.89	1.11	0.67*
	Recycling (tCO_2e)	0.017	0.019	0.023	0.024
	Landfill (tonnes)	7.29	7.29	7.29	7.29
	landfill (tCO_2e)	1.451	1.451	0.678	0.720
Paper	**A4 Sheets**	165,000	216,000	135,500	94,000
	A3 Sheets	5,000	4,800	4,500	2,000
	tCO2e	0.83	1.07	0.49	0.46

*From 1st April 2016 to 31st Jan 2017

Provider[4]	Contract Value	SDMP (or equivalent)	Adaptation Plan	Healthy transport plan	15/16 Annual Sustainability Report? (SDU assessment)	Energy use (MWh/FTE/yr.) R= increasing G= decreasing	Water use (m3/FTE/yr.) R= increasing G= decreasing	% Total contract value
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	74,690,916	Y	N	N	Y (Excellent)	8.2	67	53%
NOTTINGHAMSHIRE HEALTHCARE NHS TRUST	24,186,841	Y	N	Y	Y (Good)	2.2	29	17%
Services commissioned from NHS RUSHCLIFFE CCG	14,462,762	Y	N	N	Y (Excellent)	7.2[5]	5[2]	10%
CIRCLE NOTTINGHAM LTD	7,094,985	TBC	TBC	TBC	TBC	TBC	TBC	5%
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	5,508,229	TBC	TBC	TBC	TBC	TBC	TBC	4%
EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	3,767,375	Y	Y	N	Y (Poor)	1.3	10	3%
NOTTINGHAM WOODTHORPE HOSPITAL	2,786,335	TBC	TBC	TBC	TBC	TBC	TBC	2%
NHS NEWARK & SHERWOOD CCG	993,888	N	N	N	Y (Minimum)	TBC	TBC	1%
ARRIVA TRANSPORT SOLUTIONS	902,903	TBC	TBC	TBC	TBC	TBC	TBC	1%
Services commissioned from NHS NOTTINGHAM CITY CCG	826,031	Y	N	N	Y (Excellent)	3.4[2]	12.4[2]	1%

[4] Unless otherwise stated, data obtained from SDU published 'Organisational Summaries' derived from ERIC returns and providers own Sustainability Reports
[5] Data taken from CCGs own Sustainability Reports

Sustainability and Transformation Plan

Creating a Sustainable Health and Care System in Greater Nottingham

The Nottingham and Nottinghamshire Sustainability and Transformation Plan (STP), developed and published in 2016/17, sets out the local plan to address the three main challenges, or 'gaps' that our current health and care system has identified. These 'gaps' relate to improving health and wellbeing, improving the care provided and the quality of services and tackling the growing pressure on health and social care budgets. Locally, we have also identified a fourth gap, relating to our culture. We believe we need to change the culture of organisations and how local organisations work together if we are to achieve our aims.

The STP comprises five priority areas, where we believe we can make the biggest impact on improving services and the health and wellbeing of the population. These are:

1. **Promote wellbeing, prevention, independence and self-care:** increase healthy life expectancy by three years by 2020/21 with a focus on decreasing the prevalence of smoking and reducing levels of obesity in the first two years. Enhance health and wellbeing to promote independence and expand levels of self-care.
2. **Strengthen primary, community, social care and carer services:** ensure people stay healthier for longer by increasing access and resilience in general practice and improve the quality of life for people with long-term conditions and their carers.
3. **Simplify urgent and emergency care:** deliver the right advice or service at the right time including improving the urgent and emergency care pathway, and redesigning the system to enable reduction of 200 beds in acute hospitals in the first two years of this plan.
4. **Deliver technology-enabled care:** help citizens stay healthy and manage their own care; help clinicians and other staff deliver more care more efficiently and use new technology to support independent living and care at home.
5. **Ensure consistent and evidence-based pathways in planned care:** standardise care pathways reducing unwarranted variation, improve the prevention, early diagnosis and recovery in cancer care.

The STP is also shaped around what our local people have told us they want. People have told us that they want support to stay well and independent, to be able to care for themselves and they want their care to be more joined-up and delivered close to home where possible.

The Greater Nottingham area, covering Nottingham City, Nottingham North and East, Nottingham West and Rushcliffe CCG areas, will form one delivery unit of the Nottinghamshire STP, with Mid Nottinghamshire (Newark and Sherwood and

Mansfield and Ashfield CCG areas) being the other. The delivery units will work together to deliver the ambitions set out in the STP but the approach may vary to reflect the current position of the areas and the specific challenges faced.

In delivering the STP, Greater Nottingham has confirmed the ambition to bring together its Vanguard and Integrated Pioneer communities, including the Multispecialty Community Provider (MCP) in Rushcliffe. This will allow scaling and replicating of innovations in best practice as appropriate (such as in support to care homes as confirmed in the high impact initiatives). Going further, the delivery unit has stated an intention to create a new integrated accountable care system (ACS) for the 700,000 population it serves. The first step in developing this ACS focused on the completion of a detailed work undertaken by actuaries (people who compile and analyse statistics and use them to calculate insurance risks and premiums) to understand where user activity and costs are in the system with the identification of the opportunities to move to person and population-centred care (reshaping the care system, with a specific focus on tailoring services to the user groups with the biggest opportunity to improve the added value of the care) to fundamentally improve quality and reduce system costs.

The primary insight from this analysis has confirmed a very significant opportunity in terms of the potential to reduce activity and spend within the acute sector (40% plus of patients potentially could receive care in a lower cost setting equating to a potential gross saving of £690m over five years). The opportunity is far greater than that identified by other benchmarking tools such as RightCare.

For community care, social care, and mental health provision, the analysis confirmed it was difficult to draw meaningful conclusions regarding their effectiveness based on the data quality and completeness. This in itself is a key conclusion, which Greater Nottingham understands to be relatively consistent with the starting point of most fragmented systems that have successfully transformed into high-performing systems.

The second stage of the process, in developing the ACS, has focused on a period of detailed design work from July to mid-November 2016 inclusive. This design phase was supported by international experts who have successfully brought about well managed integrated health and care systems in other parts of the world.

The design work that we have undertaken aims to confirm how an integrated health and care system will look in a way which will realise the opportunities that have been highlighted through the analysis undertaken by actuaries. This will set out the services required and the obligations of each partner in the system, together with the solutions that an ACS would need to put in place to address the current gaps in capacity and resource.

The proposed solution includes the characteristics of an integrated accountable care system and the optimal contractual framework for this system. This solution has incorporated the innovative service changes and new models of collaboration being

progressed through our Vanguards and Integration Pioneers and is being aligned to our STP.

The design phase has specifically focused on an assessment against an integrated accountable care framework – which confirms the indirect enablers and integration functions needed – and is being progressed through six design work-streams, namely patient pathways, population health, social care, IM&T, provider payment models, and ACS governance and contract design.

Greater Nottingham has confirmed that its plans for 2017/18 and beyond will be iterated in accordance with the outputs of this design work and resulting locally agreed next steps. These will be shared in the form of refreshed Vanguard Value Propositions which confirm plans to replicate and scale-up successes to date. In addition a Greater Nottingham ACS Value Proposition has been produced, with support from and submission to the New Care Models Programme and other national and regional stakeholder organisations. This Greater Nottingham Value Proposition sets out three overarching models of care which have close alignment with work already being undertaken within the Greater Nottingham system. The intention of the Value Proposition is to build on and enhance the current work to enable it to be significantly more effective in terms of the results achieved within the system.

The three overarching models of care to be focused on are:

6. **Population health management** including admission avoidance, corresponding to the STP sections on prevention and out of hospital care. The proposed example of this within the Value Proposition is a system-wide process of A&E diversion. The proposed model of A&E diversion would raise awareness of alternative care settings, better incentivise primary care providers, provide regular meaningful data for urgent and emergency care across the health and care system and allow us to better match system capacity to demand.
7. **Elective care referral management**, corresponding to the STP section on ensuring consistent and evidence-based pathways in planned care. The example of this set out in the Value Proposition is a Referral Management Hub, or Health and Care Co-ordination Centre. This will provide a single point of access for community, mental health and social care services and will manage and co-ordinate secondary care elective referrals. The proposed model would put in place standardised criteria and process for referrals, a single point of accountability and oversight for referrals, a coherent means of coordinating referrals across providers and a single set of referral documentation, and will have an overview of referrals as a care transition pathway.
8. **Integrated urgent and emergency care discharge management**, corresponding to the STP section on simplifying urgent and emergency care. The example of this in the Value Proposition is the proposed Integrated

Discharge Unit. This will provide a single point of accountability for discharges, standardised criteria for discharge planning, more proactive discharge planning, clarity regarding assessment procedures, better communication between in and out of hospital providers, effective resourcing and meaningful data to ensure an effective discharge process.

Sustainability

Financial management: capability and performance

2016/17 was a challenging financial year for Nottingham North and East due to a planned savings target of £8.1 million required to maintain financial balance. As with previous years, growth and demand on both acute services and continuing healthcare services compounded the QIPP savings requirement making the financial environment extremely tough.

During the year, financial pressures led to the CCG entering internal financial recovery and in collaboration with NHS Nottingham West and NHS Rushcliffe, the CCG established a formal Financial Recovery Plan (FRP) with a Programme Management Office (PMO) structure to oversee the formation and delivery of financial recovery.

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

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Nottingham North and East CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £2,011,000. This additional surplus will be carried forward for drawdown in future years. The duties are summarised below:

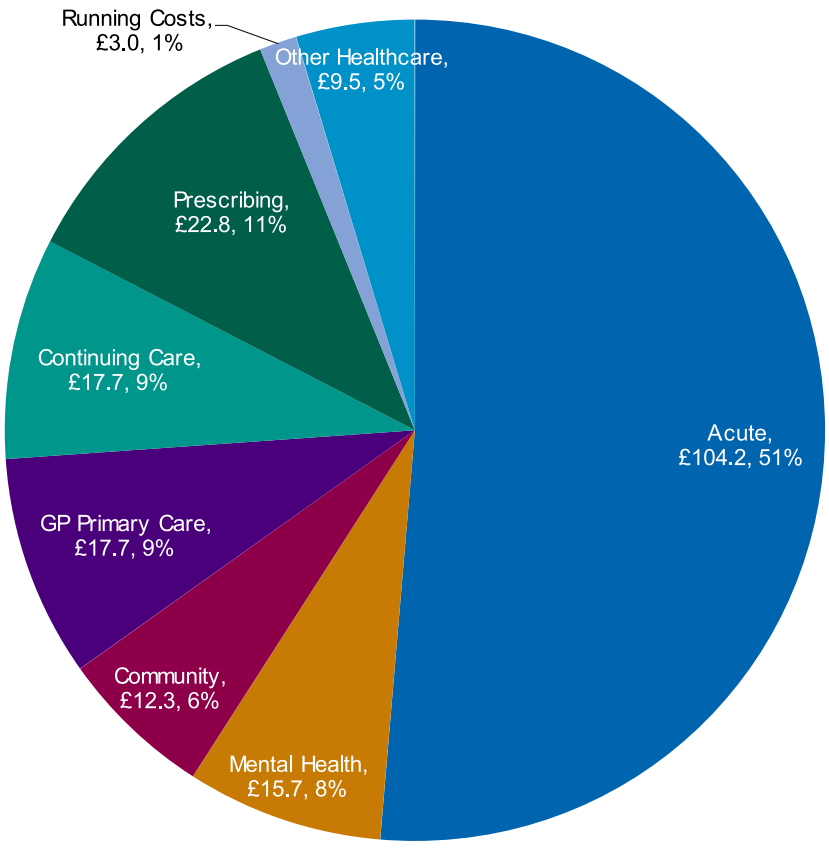
Delivery of 2016/17 financial duties

Financial duty	Target £	Delivery
Keep within revenue resource limit	206,705,000	✓
Achieve planned surplus	1,873,000	✓
Achieve National Risk Reserve Surplus	2,011,000	✓
Cash balances within agreed limit	< 237,000	✓
Remain within running cost allowance	3,422,000	✓
Achieve BPPC targets	> 95%	✓

The Better Payment Practice Code (BPPC) requires clinical commissioning groups to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. The CCG was compliant with the code achieving all BPPC targets.

The CCG spends its allocation across a range of programme areas, and has a set limit against which to run the organisation ('running cost allowance'). After accounting for the planned surplus and the national risk pool surplus the chart below shows where we spent our resource:

Expenditure



NNE CCG Expenditure 2016/17, £million

Delivery of the QIPP target was a key area for the PMO to oversee. The overall £8.1 million target was met by the CCG, with £4.0 million recurrently delivered through programme QIPP and the balance met through non-recurrent resources. The amount of savings achieved by programme area is as follows:

QIPP delivery by programme

Programme	£
Community services	40,000
Continuing care	820,000
Contracting	970,000
Planned care	366,000
Prescribing	1,580,000
Unplanned care	195,000
Other	7,000
Non recurrent	4,108,000

Financial governance

In line with the national picture, the CCG has been subject to an increasing level of financial governance processes. Our own internal financial governance framework includes the Finance and Information Group, which meets monthly and oversees the financial and QIPP position of the CCG, and the financial recovery PMO noted earlier.

The internal audit work plan for the CCG covered budgetary control and key financial systems. **Full assurance** was attained from the audits, contributing to the subsequent Head of Internal Audit opinion as overall significant assurance for the CCG.

We have detailed accounting policies approved by the Audit and Governance Committee which comply with the NHS Group Accounting Manual and International Financial Reporting Standards. Our accounting policies are detailed in the full set of financial accounts. The CCG's external auditors completed their year-end audit preparation with the pre-audit and value for money assessment neither raising any significant concerns.

2017/18 financial plans

The new financial year continues to see a challenging financial environment, for the CCG and the local health economy overall. The CCG received a 2.3% increase in its recurrent revenue allocation. However there are a number of national pre-commitments against this uplift together with inflationary pressures related to the impact of the national tariff payment mechanism, cost pressures related to the acute local services price review and also increased demand on acute and continuing care

services as a consequence of the ageing population. As a result the CCG has a 2017/18 QIPP target of £12.4 million (5.9% of allocation) in order to deliver the NHS England business rules.

This QIPP target is significantly higher than savings delivered in previous years and presents serious financial risk. Achievement will be reliant upon the transformation and system changes that the health economy has signed up to being delivered via the Sustainability and Transformation Plans (STP). The financial recovery PMO has been extended across the Greater Notts CCGs to include Nottingham City CCG for 2017/18 and will closely manage, scrutinise and monitor delivery of the QIPP requirement.

The key metrics for the 2017/18 financial year are as follows:

2017/18 financial plan metrics

Metric	£k
Business rules – (plan meets all business rule requirements)	
Surplus – deliver cumulative surplus (in year breakeven)	1,873
Running cost allowance	3,242 Plan 3,193
Contingency – 0.5% requirement	1,038
Non recurrent reserve – 1.0% requirement, 50% of which is uncommitted for national risk pool	2,056
Resultant plan	
Recurrent underlying position	1,163 (0.6%)
QIPP	12,359 (5.9%)

GP primary care commissioning and the Better Care Fund (BCF) enter the third full year in 2017/18. The CCG continues to invest significant resource into integrating services in conjunction with social care and other CCG partners. Financial plans to support the development of integrated primary care, community care beds and services and home care services continue.

Paper-free at the point of care

Nottinghamshire CCGs, through Connected Nottinghamshire, have supported the development of the digital agenda by bringing together the ambitions of both the Sustainability and Transformation Plan (STP) and Local Digital Roadmap (LDR) to inform the CCGs strategic direction. In order to support the delivery of the digital agenda five key work stream areas have been identified which are information sharing, infrastructure, patient access to their records, digital maturity and assistive technology, these work streams will have oversight of each of the projects identified within the strategic plan.

A number of innovative information technology (IT) solutions have been implemented in 2016/2017 in order to support the development of new models of care, including shared care records and IT interoperability across the GP practices.

Further work has been undertaken during 2016/17 to support information sharing under the enhanced data sharing model (eDSM) and as of January 2017 93% of patient records in SystmOne practices are available to be viewed via systems such as MIG by clinicians in urgent and emergency settings thereby greatly improving the speed of informed decisions and better patient experiences and outcomes.

All practices are now able to provide patients with access to information held in their GP record using patient online services. Patient online services allow patients to book appointments, access information relating to medication and coded record data and provide a simpler method for precise ordering of repeat medication from the practice. Future considerations will include accessing the full online record.

There are a number of projects underway which utilise TeleCare devices in patient's homes. In Greater Nottingham this includes self-care applications and a tele-dermatology service, these projects enable improved access to services by utilising technology to support care delivered outside of traditional care settings and that support self-care by patient/citizens. Future work is expected to involve “wearable” technology.

Estates strategy

Having the right infrastructure in place in primary and community settings is crucial for the successful delivery of the Sustainability and Transformation Plan (STP) ambitions and the GP Forward View (GPFV). The ability to transform care and keep services sustainable will only be possible if efficient, fit-for-purpose, high quality facilities underpin the delivery of services.

Within Greater Nottingham, two Local Estates Forums (LEFs) – one covering Nottingham City CCG and one for the south Nottinghamshire CCGs (Nottingham North and East/Nottingham West and Rushcliffe) - were established 18 months ago to develop local estates strategies focussing initially on primary and community estates. Both LEFs have made good progress in identifying strengths and opportunities of the existing infrastructure.

The Estates and Technology Transformation Fund (ETTF) announced in June 2016 provided opportunities for Nottingham North and East to progress priorities identified in the local estates strategies:

- **Calverton:** to meet the immediate needs of a growing population, a proposal has been supported by the national ETTF £180k in 2016/17 and £351k in 2017/18 for expansion of the Calverton practice, which represents 66% funding for the cost of the project.

- **Hucknall:** the CCG commissioned an options appraisal in 2016 and submitted a proposal to the ETTF for a clinical hub development in Hucknall to include two GP practices, a pharmacy and community services. This proposal has approval in principle for Cohort 2 as published nationally by NHS England in October 2016. The funding currently available to support this new build is £400k.

Better Care Fund

The £5.3 billion Better Care Fund (BCF) was announced by the Government in the June 2013 and increased the funding further in 2015. It is intended to drive closer integration between services and so improve outcomes for patients, service users and carers. The fund is set up as a single pooled budget for a local area so that NHS and local government work closely together in a type of partnership arrangement to contribute an agreed level of resource into the single pot (the 'pooled budget'), which is then used to commission or deliver health and social care services.

In Nottinghamshire a BCF plan has been developed between the six Nottinghamshire CCGs (Bassetlaw, Mansfield and Ashfield, Newark and Sherwood, Nottingham North and East, Nottingham West and Rushcliffe CCGs) and Nottinghamshire County Council. Nottinghamshire County Council is the host of the pooled budget and money is jointly managed by all the parties under the terms of a 'section 75' agreement. All BCF schemes are focused on the BCF national conditions and metrics and include:

- Seven-day working
- GP access
- Community care coordination
- Support for carers
- Reablement/rehabilitation services
- Transformation programme
- Protecting social care services
- Disabled facilities grant
- Care Act implementation

The BCF will continue to March 2018/19 building on previous plans. Partners have committed to continuing to work together to implement BCF plans and maintain progress on the BCF national conditions.

Better Care Fund metrics

During 2016/17 partners worked together to monitor implementation of schemes and progress against national conditions and key metrics. The key metrics demonstrate the progress made in 2016/7 in Nottinghamshire up to the 31st March 2017:

Standard (to Q3 2016/17)	Target	NNE	System-wide
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	13,393 System-wide: 79,353	13.612	86.644
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	563 System-wide: 579	649	583
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	91.2%	N/A	80.04%
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	Q1 1,116 Q2 1,086 Q3 1,137 Q4 1,101	N/A	756.28
Percentage of users satisfied that the adaptations met their identified needs	75%	N/A	100%
From the GP Patient Survey: In the last six months, have you had enough support from local services or organisations to help manage long-term health condition(s)?	65.4%	N/A	64.4% (July)
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes directly from a hospital setting per 100 admissions of older people (aged 65 and over) to residential and nursing care homes	34%	N/A	22.9%

Health and Wellbeing Strategy

The Health and Wellbeing Strategy is a plan to improve health and wellbeing in Nottinghamshire. It is written by the Nottinghamshire Health and Wellbeing Board. This plan is based on the Joint Strategic Needs Assessment (JSNA), which identifies current and future needs for adults and children. Our clinical lead is an active member of the Health and Wellbeing Board providing visible leadership in the CCG's contribution to the delivery of the joint Health and Wellbeing Strategy and the JSNA. Our deputy chief officer sits on the operational group for the JSNA.

The Health and Wellbeing Board identified four key ambitions for the people of Nottinghamshire in its strategy for 2014-17:

- To give everyone a good start
- To encourage living well
- To enable coping well
- To encourage and allow working together

In order to achieve these ambitions, 20 priority areas were identified.

In 2015 the Health and Wellbeing Board took part in a Local Government Association peer review programme which scrutinised all aspects of the Board, including the Health and Wellbeing Strategy. The peer challenge panel suggested that the Health and Wellbeing Board concentrate its efforts on health and wellbeing priorities to which the partnership could add value.

In considering this the Board agreed that the Strategy should remain in place, monitored by the Health and Wellbeing Implementation Group and the Board would focus on a number of annual strategic actions:

1. Improve uptake of breastfeeding
2. Improve children and young people's mental health and wellbeing across. Nottinghamshire:
    a. Partnership agreement to tackle child sexual exploitation
    b. Implement the Nottinghamshire Children's Mental Health & Wellbeing Transformation Plan
3. Reduce the number of people that smoke in Nottinghamshire
4. Develop healthier environments to live and work in Nottinghamshire
5. Ensure crisis support (including housing) is available for people with mental health problems living in the community
6. Ensure vulnerable people living in the community can access the housing support they need

Regular updates have been provided throughout the year by the Health and Wellbeing Implementation Group on progress against these strategic actions.

A refresh of the Strategy will take place later in 2017 and will offer an opportunity to focus the efforts of the Board on priorities requiring a partnership approach to which

the Board can add value. These priorities will overlap with those priorities within the Sustainability and Transformation Plans to ensure consistency, coherence, and commitment across the partners.

The CCG consulted the Health and Wellbeing Board in the preparation of this report which was considered at its 26 April 2017 meeting. This will be evidenced in the minutes of that meeting following publication of this annual report.

Working in partnership

Co-located with Gedling Borough Council benefits the local population through collaboration on population health improvement. As part of this the CCG sit on the Gedling Borough Council Health and Wellbeing Group and have a joint strategy and approach. The continued joint approach is recognition that population health can be significantly improved through joint focused effort to tackle the wider determinants of health.

The CCG also represents south Nottinghamshire CCGs on the strategic and operational Community Safety Partnership, working closely with police, local authorities, fire service and other agencies. As part of this, the CCG has supported the fire service with the implementation of health and wellbeing checks in Gedling.

Signature of the accountable officer

I certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the NHS Act 2006 (as amended).

Signed:

Sam Walters
Accountable Officer

26th May 2017

Accountability report

Corporate governance report

Members report

Member practices

The Membership of our CCG is composed of the following member practices that are working together to plan and pay for local health services for 150,000 patients.

1. Apple Tree Medical Practice Burton Joyce
2. Calverton Practice, Calverton
3. Daybrook Medical Practice, Daybrook
4. Giltbrook Surgery, Giltbrook
5. Highcroft Surgery, Arnold
6. Ivy Medical Group, Burton Joyce
7. Jubilee Practice, Lowdham
8. Newthorpe Medical Centre, Eastwood
9. Oakenhall Medical Practice, Hucknall
10. Om Surgery, Hucknall
11. Park House Medical Centre, Carlton
12. Peacock Heathcare, Carlton
13. Plains View Surgery, Mapperley
14. Stenhouse Medical Centre, Arnold
15. Torkard Hill Medical Centre, Hucknall
16. Trentside Medical Group, Colwick
17. Unity Surgery, Mapperley
18. Westdale Lane Surgery, Gedling
19. West Oak Surgery, Mapperley
20. Whyburn Medical Practice, Hucknall

The Governing Body membership 2016/17

Member	Role
Dr James Hopkinson	Chair and Clinical Lead (from Sept 2016)
Sam Walters	Chief Officer
Jonathan Bemrose	Chief Finance Officer
Dr Paramjit Panesar	Assistant Clinical Lead

Member	Role
Dr Ian Campbell	GP Member (from June 2016)
Dr Caitriona Kennedy	GP Member (from June 2016)
Dr Elaine Maddock	GP Member (from June 2016)
Dr Ben Teasdale	Secondary Care Consultant (from June 2016)
Nichola Bramhall	Registered Nurse/Director of Nursing and Quality
Terry Allen	Lay Member Financial Management and Audit
Janet Champion	Lay Member Patient and Public Involvement
Mike Wilkins	Lay Member Primary Care (from December 2016)
Dr Mohammed Al –Uzri	Secondary Care Consultant (until May 2016)
Paul Mckay	Observer

The Governing Body membership is supported by one observer who is an Officer from the Local Authority. The Observer is fully active participants in the CCG and the Governing Body, whilst maintaining their independence and complement the skill set of the members and provide added insight into decision-making. As at 31st March 2017, the Governing Body comprised of 12 members – seven male and five female.

The Governing Body has self-assessed themselves against the Standards for Members of NHS Boards and Governing Bodies in England, Framework for Excellence in Clinical Commissioning for CCGs and The Healthy NHS Board 2013.

The Governing Body has been effective in discharging the functions of the CCG. The Governing Body's work has covered items under finance, performance, quality, engagement and inclusion, planning and governance. Performance reports in relation to finance, provider contractual performance and quality have been presented to the Governing Body.

The Audit and Governance Committee membership 2016/17

Member	Role
Terry Allen	Lay Member Financial Management and Audit
Janet Champion	Lay Member Patient and Public Involvement
Mike Wilkins	Lay Member Primary Care (from December 2016)
GP Member Governing Body	

Membership may also be drawn from other Governing Body members.

The Committee critically reviews the Clinical Commissioning Group's financial reporting, risk and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.

Financial reporting

The Committee monitors the integrity of the financial statements of the CCG and any formal announcements relating to the CCGs' financial performance. It ensures that the systems for financial reporting to the CCG Governing Body, including those of budgetary control are subject to review as to completeness and accuracy of the information provided to the CCG governing body. The committee has reviewed the annual report and financial statements before submission to the CCG Governing Body.

Internal control and risk

The committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group's activities that support the achievement of the Clinical Commissioning Group's objectives.

Conflicts of interest

NNE is responsible for the stewardship of significant public resources when making decisions about the commissioning health and social care services. In order to ensure and evidence that these decisions secure the best possible services for the population it serves, the CCG must demonstrate accountability to relevant stakeholders, probity and transparency in the decision making process.

NNE actively maintains a declaration of interest register which is publically available on the NNE website and can be provided upon request.

The Conflicts of Interest Register can be found here:
http://www.nottinghamnortheastccg.nhs.uk/contact-us/freedom-of-information/conflicts-of-interest

Information on personal data related incidents where these have been formally reported to the information commissioners

During 2015/16 there has been one personal data related incidents reported; however, it was not rated as being serious in nature and appropriate action was promptly taken, lessons learnt were implemented and there have been no further re-occurrences. These incidents are shown in the following table:

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	0
V	Other	0

Statement of disclosure to auditors

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

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

Modern Slavery Act

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

Statement of accountable officer's responsibilities

The National Health Service Act 2006 (as amended) states that each clinical commissioning group shall have an accountable officer and that officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the chief officer to be the accountable officer of NHS Nottingham North and East CCG.

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

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

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

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

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

To the best of my knowledge and belief, 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.

Governance statement

Introduction and context

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

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

Scope of responsibility

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

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

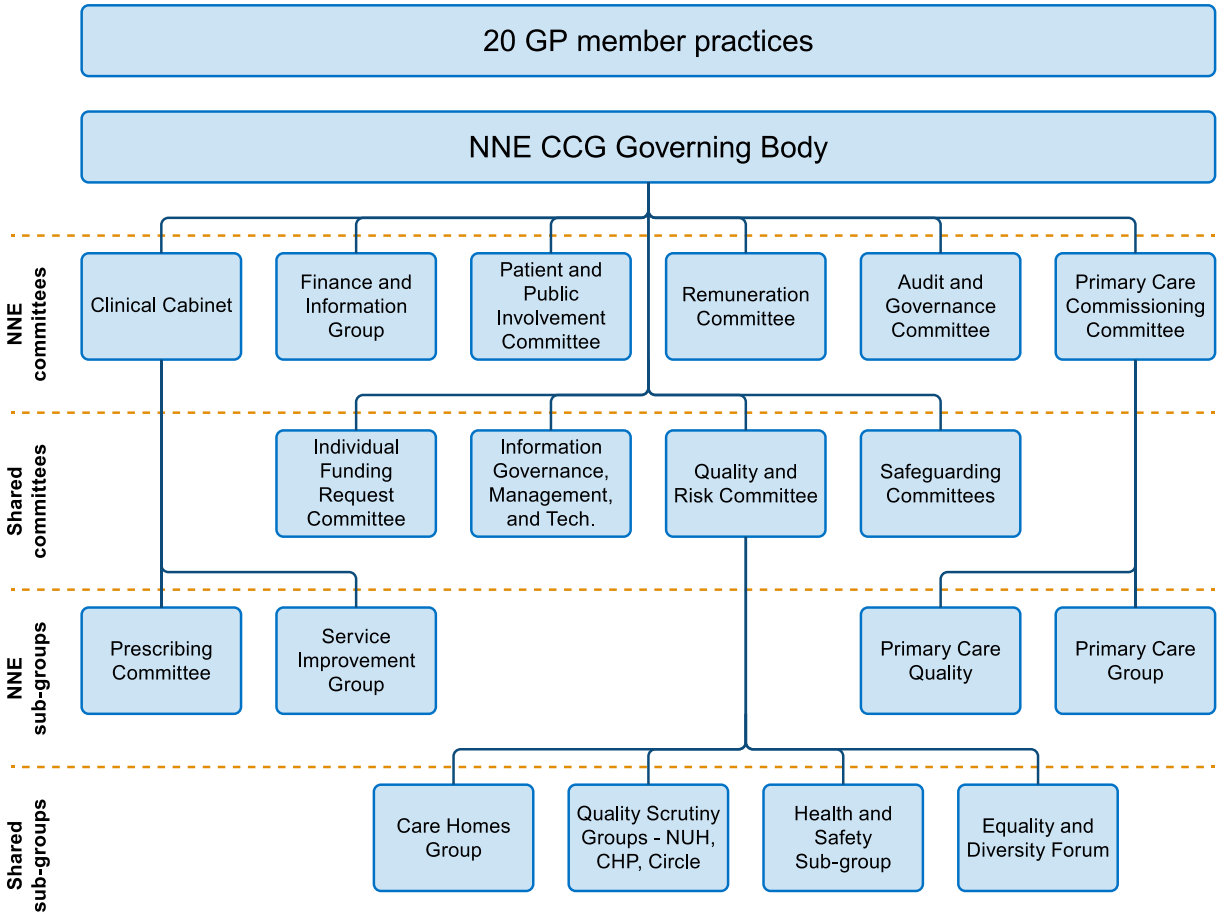
Governance arrangements and effectiveness

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

The functions, general duties and scheme of delegation are outlined in the constitution. The constitution sets out:

- the arrangements that the CCG has made to discharge its functions and general duties and those of its Governing Body and committees
- roles and responsibilities of practice representatives and Governing Body members
- the key processes for decision making
- arrangements for securing transparency in the decision making of the Governing Body and its committees
- the arrangements made for standards of business conduct and managing conflicts of interest.

To discharge its duties effectively, the Governing Body has a number of formally constituted committees with delegated responsibilities as set out in the CCG Constitution and Scheme of Reservation and Delegation. A number of these committees are established jointly with NHS Nottingham West CCG and Rushcliffe CCG to support the delivery of assurance whilst utilising the economies of scale from a shared workforce as well as partnering across the wider commissioning community. The diagram below illustrates the overarching governance framework for the CCG:



NNE governing committees structure incliding sub-groups (Nov 2016)

The Membership Body

The Membership Body is composed of the following member practices:

1. Apple Tree Medical Practice Burton Joyce
2. Calverton Practice, Calverton
3. Daybrook Medical Practice, Daybrook
4. Giltbrook Surgery, Giltbrook
5. Highcroft Surgery, Arnold
6. Ivy Medical Group, Burton Joyce
7. Jubilee Practice, Lowdham
8. Newthorpe Medical Centre, Eastwood
9. Oakenhall Medical Practice, Hucknall
10. Om Surgery, Hucknall
11. Park House Medical Centre, Carlton
12. Peacock Heathcare, Carlton
13. Plains View Surgery, Mapperley
14. Stenhouse Medical Centre, Arnold
15. Torkard Hill Medical Centre, Hucknall
16. Trentside Medical Group, Netherfield and Colwick
17. Unity Surgery, Mapperley
18. Westdale Lane Surgery, Gedling
19. West Oak Surgery, Mapperley
20. Whyburn Medical Practice, Hucknall

Each has a commissioning lead and the role description is outlined in the Constitution. The Membership Body have a Practice Forum which is convened as required to discuss reserved responsibilities.

The membership body met during 2016/17 to discuss reserved matters including changes to the CCG Constitution, Governing Body membership, voting arrangements and when to vote. The membership body also met to discuss non reserved matters including the primary care strategy, general practice sustainability and collaborative working and enhanced support to care homes.

The Governing Body

The Governing Body is recognised and constituted as described in the Constitution of NHS Nottingham North and East CCG and is accountable to its member practices.

The Governing Body has the following functions conferred on it by sections14L(2) and (3)of the 2006 Act, inserted by section 25the 2012 Act, together with any other functions connected with its main function as may be specified in regulations or in this constitution.

The Governing Body has responsibility for:

- ensuring that the Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Groups principles of good governance56 (its main function)
- determining the remuneration, fees and other allowances payable to employees or other persons providing services to the Group and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act
- approving any functions of the Group that are specified in regulations57
- acting, when exercising its functions, consistently with the duty of the Secretary of State and NHS England to promote a comprehensive health service
- meeting the public sector equality duty
- working in partnership with the local authority to develop joint strategic needs assessments and joint health and wellbeing strategies
- making arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements
- promoting awareness of, and act with a view to securing that health services are provided in a way that promotes awareness of, and have regard to the NHS constitution
- acting with a view to securing continuous improvement to the quality of services
- assisting and support NHS England in relation to the Board's duty to improve quality of primary medical services
- having regard to the need to reduce inequalities
- promoting the involvement of patients, their carers and representatives in decisions about their healthcare
- acting with a view to enabling patients to make choices
- obtaining appropriate advice from persons who, taken together, have a broad range of professional expertise in healthcare and public health
- promoting innovation
- promoting research and the use of research
- having regard to the need to promote education and training for persons who are employed, or who are considering becoming employed, in an activity which involves or is connected with the provision of services as part of the health services in England so as to assist the Secretary of State for Health in the discharge of his related duty
- acting with a view to promoting integration.

Governing Body membership

The composition of the Governing Body of NHS Nottingham North and East CCG is outlined in section 6 of the CCG Constitution and is outlined below. Each member of the Governing Body shares responsibility as part of a team to ensure that NHS Nottingham North and East CCG exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

2016/17 saw a considerable change in Governing Body membership. The members of the CCG also took the opportunity in 2016/17 to strengthen the GP representation on the Governing Body. The Chair of the Governing Body was previously a GP member and Assistant Clinical Lead since the inception of the CCG and was promoted in June 2016.

Governing Body member	Governing Body position	Total/ possible
Dr James Hopkinson	Chair and Clinical Lead (from June 2016)	6/6 3 as Chair
Sam Walters	Chief Officer	6/6
Jonathan Bemrose	Chief Finance Officer	6/6
Dr Paramjit Panesar	Assistant Clinical Lead	6/6
Dr Ian Campbell	GP Member (from June 2016)	5/5
Dr Caitriona Kennedy	GP Member (from June 2016)	4/5
Dr Elaine Maddock	GP Member (from June 2016)	3/5
Dr Ben Teasdale	Secondary Care Consultant (from June 2016)	2/5
Nichola Bramhall	Registered Nurse/Director of Nursing and Quality	6/6 1 Deputy
Terry Allen	Lay Member Financial Management and Audit	5/6
Janet Champion	Lay Member Patient and Public Involvement	5/6 2 as Chair
Mike Wilkins	Lay Member Primary Care (from December 2016)	1/2
Dr Mohammed Al –Uzri	Secondary Care Consultant (until May 2016)	1/1

To discharge its duties effectively, the Governing Body has a number of formally constituted committees with delegated responsibilities as set out in the CCG Constitution and Scheme of Reservation and Delegation:

- Audit and Governance Committee
- Finance and Information Group
- Remuneration Committee
- Primary Care Commissioning Committee

- Clinical Cabinet
- Patient and Public Involvement Committee

The following committees have also been established under a Memorandum of Understanding and provide assurance to the Governing Body whilst utilising the economies of scale from a shared workforce as well as partnering across the wider commissioning community:

- Quality and Risk Committee
  hosted by NHS Nottingham North and East CCG on behalf of NHS Rushcliffe CCG and NHS Nottingham West CCG
- Information Governance, Management and Technology Committee
  hosted by NHS Rushcliffe CCG on behalf of NHS Nottingham North & East CCG, NHS Nottingham West CCG, NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG
- Safeguarding Adults and Children's Committees
  hosted by NHS Newark and Sherwood CCG on behalf of NHS Rushcliffe CCG, NHS Nottingham North and East CCG, NHS Nottingham West CCG, NHS Mansfield and Ashfield CCG and NHS Bassetlaw CCG
- Individual Funding Review Panel
  hosted by NHS Nottingham West CCG on behalf of NHS Rushcliffe CCG, NHS Nottingham North and East CCG, NHS Newark and Sherwood and NHS Mansfield and Ashfield CCG
- East Midlands Affiliated Commissioning Committee
  hosted by NHS Nottingham West CCG on behalf of 19 East Midlands clinical commissioning groups:
  - NHS Southern Derbyshire CCG
  - NHS North Derbyshire CCG
  - NHS Erewash CCG
  - NHS Hardwick CCG
  - NHS Nottingham City CCG
  - NHS Nottingham West CCG
  - NHS Nottingham North & East CCG
  - NHS Rushcliffe CCG
  - NHS Newark & Sherwood CCG
  - NHS Mansfield & Ashfield CCG
  - NHS Corby CCG
  - NHS Nene CCG
  - NHS West Leicestershire CCG
  - NHS Leicester City CCG
  - NHS East Leicestershire & Rutland CCG
  - NHS Lincolnshire West CCG
  - NHS South West Lincolnshire CCG
  - NHS South Lincolnshire CCG

- NHS Lincolnshire East CCG

Committees

Audit and Governance Committee

Key responsibilities

The Audit and Governance Committee has been established to provide the Governing Body with an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance.

The Committee also seeks reports and assurances from senior managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This is evidenced through the Audit and Governance Committee's use of the CCG's Assurance Framework established to guide its work and that of the audit and assurance functions that report to it.

The Committee shall critically review the Clinical Commissioning Group's financial reporting, risk and internal control principles and ensure an appropriate relationship with both internal and external auditors is maintained.

Financial reporting

The Committee will monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCGs' financial performance. It will ensure that the systems for financial reporting to the CCG Governing Body, including those of budgetary control are subject to review as to completeness and accuracy of the information provided to the CCG governing body. The committee will review the annual report and financial statements before submission to the CCG Governing Body.

Internal control and risk

The committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group's activities that support the achievement of the Clinical Commissioning Group's objectives.

In particular, the Committee reviews the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the Clinical Commissioning Group
- the underlying assurance processes that indicate the degree of achievement of Clinical Commissioning Group objectives, the effectiveness of the

management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service
- compliance with Standing Orders, the Scheme of Delegation and Standing Financial Instructions
- corporate and governance structures

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions including any reviews by Department of Health arm's length bodies or regulators/inspectors (for example Care Quality Commission and NHS Litigation Authority), but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management, and internal control, together with indicators of their effectiveness.

Membership

NNE CCG lay members:

- Financial management and audit
- Patient and public involvement
- Primary care

Membership may be drawn from other Governing Body members.

Highlights of work

In early 2016/17, the Committee approved on behalf of the Governing Body, the CCG's Annual Report and Accounts 2015/16. The Committee ensured a level of scrutiny to both the content and process which gave full assurance to the Governing Body that this key statutory requirement was completed successfully.

Over the year, the Committee reviewed the CCG's Assurance Framework and integrated risk management arrangements, receiving deep dive reviews and regular updates on the financial position and QIPP and latterly on the financial plan 2017/18. The Committee also received an assurance report on cyber security.

In addition, the Committee approved the internal audit and counter fraud work plans including the counter fraud self-review tool submissions for 2016/17 and 2017/18 (submission date brought forward to 1 April 2017). This latter submission showed the CCG's score as 'green' overall, and approved the security management work plan to meet the new requirements for CCGs of NHS Protect's security management standards for commissioners – this work plan is linked and managed through the health and safety group and reports to the Quality and Risk Committee. The Audit

and Governance Committee approves resources and maintains an overview of progress.

The Committee reviewed and recommended for approval by the Governing Body the Integrated Risk Management Policy, and reviewed the quarterly and annual conflicts of interest self-certification submissions - a new requirement for 2016/17.

Attendance

Committee member	Committee position	Total/possible
Terry Allen	Lay Member Financial Management and Audit - Chair	5/5
Janet Champion	Lay Member Patient and Public Involvement	5/5
Mike Wilkins	Lay Member Primary Care	1/2

Finance and Information Group

Key Responsibilities

The Finance & Information Group (FIG) has been established in accordance with NHS Nottingham North East Clinical Commissioning Group's constitution. The FIG has delegated authority from the Governing Body to monitor budgets, activity (and other performance information) and ensure their delivery against plan, reporting all deviations and respective corrective action to the Governing Body. The Finance and Information Group is responsible for monitoring delivery against the QIPP and financial recovery plans. The Finance and Information Group also oversees the financial planning process, agreeing the financial plan assumptions and principles.

Specifically the Finance and Information Group has the following responsibilities:

- Receive and discuss the monthly financial performance report
- Receive and discuss monthly activity reports.
- Consider relevant financial, activity and information issues affecting the CCG
- Assess financial risk and recommend mitigating actions to the Governing Body
- Receive updates on QIPP initiatives and monitor returns against priorities and schedule of delivery
- Identify risks of non-delivery in the QIPP plan and recommend mitigating actions in relation to realignment of the plan against initiatives that are delivering and schedule of delivery
- Agree financial plan principles and assumptions
- Receive regular updates on the financial plan and key milestones, together with funding gaps/QIPP requirements
- Review Service Improvement Group plans and Medicines Management Group plans for future QIPP initiatives to address the financial plan gap.
- Consider topic specific issues as required

Membership

- Lay member lead for finance (chair)
- Clinical lead (or designate) of the CCG
- Chief officer
- Deputy chief finance officer
- NNE information and contract analyst
- Deputy chief officer
- Director of operations
- Director of contracting

Highlights of work

- Review and agree turnaround arrangements including project management office
- Review progress against turnaround plan
- Receive and discuss the monthly financial performance report
- Receive and discuss monthly activity reports
- Consider relevant financial, activity and information issues affecting the CCG
- Assess financial risk and recommend mitigating actions to the Governing Body
- Receive updates on QIPP initiatives and monitor returns against priorities and schedule of delivery
- Identify risks of non-delivery in the QIPP plan and recommend mitigating actions in relation to realignment of the plan against initiatives that are delivering and schedule of delivery
- Agree financial plan principles and assumptions
- Receive regular updates on the financial plan and key milestones, together with funding gaps/QIPP requirements
- Review Service Improvement Group plans and Medicines Management Group plans for future QIPP initiatives to address the financial plan gap
- Consider topic specific issues as required

Attendance

Committee member	Committee position	Total/ possible
Terry Allen	Lay Member Financial Management and Audit - Chair	10/10
Hazel Buchanan	Director of Operations	8/10
Maxine Bunn	Director of Contracting	7/7 (1 deputy)
James Hopkinson	GP Clinical Lead	7/10
Ian Livsey	Deputy Chief Finance Officer	10/10
Sergio Pappalettera	Contract & Information Manager	8/10

Committee member	Committee position	Total/ possible
Sharon Pickett	Deputy Chief Officer	9/10
Sam Walters	Chief Officer	6/10

Remuneration Committee

Key responsibilities

NHS Nottingham North East Clinical Commissioning Group has established a Remuneration Committee in accordance with its Constitution. The Remuneration Committee makes recommendations to the Governing Body on determinations about remuneration, fees and allowances for employees of the CCG and people who provide services to the CCG; and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme. The Committee meets not less than once per fiscal year. The principal duties of the Committee are to:

- advise the Governing Body on the remuneration and terms of service of the chief officer, chief finance officer, and other senior staff on pay and conditions of service, ensuring that they are fairly rewarded for their individual contribution, having due regard to the CCG's circumstances and to any provisions prescribed by the NHS Commissioning Board
- monitor and evaluate the performance of the chief officer, chief finance officer, and other senior staff in respect of any bonus or supplementary pay
- advise on and oversee appropriate contractual arrangements for senior staff including the proper calculation and scrutiny of termination payments, taking account of national guidance as appropriate
- advise the Governing Body on any proposed remuneration for the chair, GP Governing Body members and clinical lead/accountable officer in connection with their leadership roles within the CCG, to take in to account national guidance and with due regard for the CCG's circumstances
- advise the Governing Body on arrangements for establishing and administering one or more pension schemes as appropriate
- advise the Governing Body on arrangements for providing pensions, allowances or gratuities for its employees
- consider and advise on any other remuneration or compensation issue referred to it by either the chair or chief officer.

Membership

- Lay Member financial management and audit
- Lay member patient and public involvement
- Other members may be drawn from the Governing Body, relevant to agenda items and direct conflicts of interest.

Highlights of work

- VSM pay and 1% pay award
- Clinical lead remuneration
- Incremental pay progression
- Confirmation of off-payroll engagements
- Director of nursing and quality remuneration

Attendance

Remuneration Committee member	Committee position	Total/ possible
Terry Allen	Lay Member Financial Management and Audit - Chair	3/3
Janet Champion	Lay Member Patient and Public Involvement	3/3

Primary Care Co-Commissioning Committee

Key responsibilities

The Primary Care Co-Commissioning Committee has been established in accordance with the respective statutory provisions to enable the members to make decisions on the review, planning, and procurement of primary care services of Nottingham North East, under delegated authority from NHS England.

In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG, which will sit alongside the delegation and terms of reference.

The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The responsibilities of the Committee include:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract)
- newly designed enhanced services (“Local Enhanced Services” and “Directed Enhanced Services”)
- design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF)
- decision making on whether to establish new GP practices in an area;
- approving practice mergers
- making decisions on ‘discretionary’ payment (e.g. returner/retainer schemes)
- making decisions based on primary care needs assessment
- overseeing delivery against milestones and targets, escalating issues and concerns as appropriate.

The Committee also ensures that the CCG carries out the following activities:

- To plan, including needs assessment, primary care services in Nottingham North and East
- To undertake reviews of primary care services in Nottingham North East
- To co-ordinate a common approach to the commissioning of primary care services generally
- To manage the budget for commissioning of primary care services in Nottingham North and East

Highlights of work

- Financial update
- Primary Care Strategy and action plan
- Primary care quality
- Primary care risk register
- Primary care Transformation Fund proposals
- GP practice boundaries
- Closure of The Willows Medical Centre
- GP practice temporary list closures
- GP practice estates funding

Attendance

Committee member	Committee position	Total/possible
Mike Wilkins	Lay Member – Primary Care	6/8
Terry Allen	Lay Member – Financial Management & Audit	8/8
Janet Champion	Lay Member – Patient and Public Involvement	2/2
Caitriona Kennedy Parm Panesar	GP Representatives	6/8
Ian Livsey	Deputy Chief Finance Officer	8/8 1 deputy
Esther Gaskill	Head Of Quality, Patient Safety & Experience	7/8 1 deputy
Sharon Pickett	Deputy Chief Officer	7/8 1 deputy

The Clinical Cabinet

The Clinical Cabinet has been delegated responsibility for clinical decision making (within limits and subject to appropriate scrutiny and oversight by the Governing Body). To ensure robust clinically led decision making it is attended by a GP representative from each of the member practices.

Key responsibilities

The Governing Body has conferred or delegated the following functions to the Clinical Cabinet:

- Approve new pathways and changes to pathways for all services relative to delegated limits, except those that the NHS England or local authorities are responsible for commissioning
- Advise the Governing Body on the commissioning of healthcare services to meet the reasonable needs of the persons for whom the CCG is responsible, within limits and subject to appropriate scrutiny
- Deliver value for money
- Support the delivery of the QIPP agenda
- To obtain appropriate advice to enable the CCG to discharge its functions effectively from people who have a broad range of professional expertise in the prevention, diagnosis, or treatment of illness and in the protection or improvement of public health
- To acknowledge arrangements to secure public involvement in the planning of commissioning arrangements and in developing, considering and making decisions (within limits) on any proposals for changes in commissioning arrangements that would have an impact on service delivery or the range of health services available
- Promote innovation in the provision of health services
- Act with a view to enabling patients to make choices about aspects of health services provided to them
- Have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them
- Act with a view to securing that health services are provided in an integrated way, and that provision of health services is integrated with provision of health-related or social care services, where the CCG considers that this would improve quality of services or reduce inequalities
- Assist and support the Group in securing continuous improvements in primary care
- Promote the NHS Constitution
- Help plan services for carers

Highlights of work

A summary of specific items covered during the year includes the following:

- Financial performance including a monthly financial update and activity report
- Adult social care strategy
- Community beds model
- QIPP plans
- Sustainability and transformation plans
- Greater Nottingham Health and Care Partners – Transformation

- Diabetes Prevention Programme
- Cardiovascular disease strategy
- A&E attendance
- Better Care Fund
- Willows Medical Practice
- Primary care access
- Community Respiratory Service
- The Future of General Practice - GP Federation and Primary Care Home
- Care Delivery Groups
- Falls prevention
- Mental health services
- Care homes
- Prescribing changes and performance

Attendance

Practice	Total/ possible	Practice	Total/ possible
Apple Tree Medical Practice	10/11	Stenhouse Medical Centre	11/11
Daybrook Medical Practice	8/11	Torkard Hill Medical Practice	11/11
Giltbrook Surgery	8/11	Trentside Medical Practice	10/11
Highcroft Surgery	9/11	Unity Surgery	9/11
Jubilee Practice	1/11	West Oak Surgery	4/11
Newthorpe Medical Centre	9/11	Westdale Lane Surgery	11/11
Oakenhall Medical Centre	3/11	Whyburn Medical Practice	8/11
OM Surgery	11/11	Practice Manager	6/11
Park House Medical Centre	9/11	Practice Nurse	4/11
Plains View Surgery	10/11	Peacock Medical Practice	0/11
Non-practice representation			
Name and role	**Total/ possible**	**Name and role**	**Total/ possible**
Dr Ben Teasdale Secondary Care Consultant	4/8	Dr Paramjit Panesar Assistant Clinical Chair	7/11
Jonathan Bemrose Chief Finance Officer	10/11 3 Deputy	Sharon Pickett Deputy Chief Officer	11/11 4 Deputy
Patient and Public Representatives	11/11	Dr John Tomlinson Public Health	9/11 1 Deputy
Dr James Hopkinson Clinical Lead and Chair	10/11	Sam Walters Chief Officer	11/11 1 Deputy
Paul McKay Local Authority	2/11 1 Deputy		

Patient and Public Involvement Committee

During 2015/16, the governance structure around patient and public involvement was changed in order to facilitate increased discussion and debate on changes whilst also ensuring that governance is carried out accordingly. As a result the People's Council was changed to The Patient Public Involvement (PPI) Committee with a working group called the PPI QIPP Group.

Key responsibilities

The Patient and Public Involvement Committee, which is accountable to the Governing Body as a Committee with delegated responsibility, is established to provide assurance to the NNE CCG Governing Body that commissioning decisions made by NNE CCG have been informed by robust plans for patient, public and service user involvement.

The duties that the NNE CCG Governing Body has partly been delegated to the Patient and Public Involvement Committee include:

- To ensure arrangements are made to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements
- To ensure the promotion of the involvement of individual patients and their carers about their healthcare
- To ensure the promotion of the involvement of the public and local communities in decisions relating to the prevention or diagnosis of illness, service delivery and care pathways
- To support arrangements of the CCG to promote patient and public involvement having regard for the need to reduce inequalities, promote innovation, improve access and promote and protect patient choice.
- To review patient and public involvement carried out in relation to plans

The CCG is under a duty by virtue of section 14Z2 of the NHS Act. The Committee will assure the Governing Body that the CCG have secured/made every effort to secure that individuals to whom health services are being or may be provided are involved:

1. In the planning of the commissioning arrangements by the group
2. In the development and consideration of proposals by the group for changes in commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them and
3. In decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact

Highlights of work

- Gluten free prescribing
- Over the counter prescribing
- Respiratory review
- Patient and public involvement work plan and monthly update
- The closure of The Willows Medical Centre
- GP practice survey
- Cardiovascular disease strategy
- GP incentive scheme
- Macmillan nurses
- Health promotion and prevention
- National Diabetes Prevention Programme
- GP practice estates
- Cancer
- Care delivery groups
- QIPP plan
- Turnaround plans

Attendance

People's Council

Committee member	Committee position	Total/ possible
Hazel Buchanan	Director of Operations	4/5
Janet Champion	Lay Member Patient and Public Involvement - Chair	4/5
Bruce Cameron	Independent Patient Representative	5/5
James Hopkinson	GP Clinical Lead	3/5
Stephen Storr	Patient & Public Rep NNE Governing Body	3/5
Nikki Biddlestone	Manager, Patient and Public Involvement NNE CCG	4/5
Mariea Kennedy	PALS Officer	3/5
Apple Tree Medical Practice	Practice Representative	5/5
The Calverton Practice	Practice Representative	5/5
Daybrook Medical Practice	Practice Representative	1/5
Giltbrook Surgery	Practice Representative	0/5
Highcroft Medical Centre	Practice Representative	4/5
The Ivy Medical Group	Practice Representative	5/5
The Jubilee Practice	Practice Representative	0/5
Newthorpe Medical Centre	Practice Representative	4/5
Oakenhall Medical Practice	Practice Representative	3/5

Committee member	Committee position	Total/ possible
The Om Surgery	Practice Representative	0/5
Park House Medical Centre	Practice Representative	5/5
Peacock Practice	Practice Representative	5/5
Plains View Surgery	Practice Representative	4/5
Stenhouse Medical Centre	Practice Representative	5/5
Torkard Hill Medical Centre	Practice Representative	3/5
Trentside Medical Group	Practice Representative	4/5
Unity Surgery	Practice Representative	2/5
West Oak Surgery	Practice Representative	0/5
Westdale Lane	Practice Representative	4/5
Whyburn Medical Practice	Practice Representative	4/5

Patient and Public Involvement Committee

Committee member	Committee position	Total/ possible
Janet Champion	Lay Member Patient and Public Involvement - Chair	1/1
	6 Patient/Public Representatives	1/1
Hazel Buchanan	Director of Operations	1/1
Helen Horsfield	Patient Experience Manager	1/1
Sharon Pickett	Deputy Chief Officer	1/1
	GP Governing Body	1/1

Information Governance, Management and Technology (IGMT) Committee

The IGMT Committee supports and drives the broader information governance (IG) and information management and technology (IM&T) agendas, including ensuring risks relating to information governance and health informatics are identified and managed, leading the development of community-wide IG and IM&T strategies and developing IM&T to improve communication between services for the benefit of patients.

Highlights of work

- Continuing progression of the implementation of the necessary changes to ensure compliance with changes in statutory legislation
- Further progression of the use of Data Services for Commissioners
- Reviewing cyber security to ensure CCGs and GP practices are well placed to mitigate any risk associated with malicious attempts to breach security arrangements

- Monitoring the CCGs' progress of completion of the Information Governance Toolkit
- Maintaining an information governance risk register for the CCGs
- Receiving quarterly data quality reports on SUS data submitted by trusts relating to their patients
- Following the progress of all local IT projects and agreeing a range of policies and procedures
- Agreed relevant information governance, information management and information technology policies with amendments as necessary reflecting changes in legislation or local ambition
- Maintaining the contract management arrangements with Nottinghamshire Health Informatics Service (NHIS) in order to demonstrate improvements to the delivery of services to the agreed standards
- Receiving assurances from NHIS regarding migration and implementation of infrastructure projects

The IGMT Committee approved the following documents in 2016/17:

- Information Governance Management Framework
- Information Asset Register Procedure
- Electronic Remote Working Policy
- Records Management Policy
- Information Security Policy
- Safe Haven Procedure
- Confidentiality and Data Protection Policy
- Freedom of Information and Environmental Information Regulations Policy
- Subject Access Request Procedure
- Internet and Electronic Mail Use Policy
- Information Governance, Management and Technology Committee Terms of Reference
- Information Governance Leads Meeting Terms of Reference
- IGMT Strategy

Attendance

Committee member	Committee position	Total/ possible
Andy Hall	Director of Outcomes and Information and Senior Information Risk Owner (SIRO) Rushcliffe CCG (Chair)	4/4
Alexis Farrow (to 27/05/2016)	Head of Information Governance, Arden and GEM CSU	1/1
Angela Oakley (from 30/05/2016)	Head of Information Governance, Arden and GEM CSU	1/1

Committee member	Committee position	Total/ possible
Bronwyn Jackson	Information Governance representative, Arden and GEM CSU	2/2
Paul Gardner	Head of Information Governance, Nottingham City CCG	4/4
Nichola Bramhall	Caldicott Guardian South CCGs	3/4
Dr Mike O'Neil	General Practitioner Nottingham West CCG and Senior Information Risk Owner (SIRO) Nottingham West	3/4
Hazel Buchanan	Senior Information Risk Owner (SIRO) Nottingham North and East	3/4 +1 deputy
Elaine Moss	Caldicott Guardian Mansfield and Ashfield CCG and Newark and Sherwood CCG	2/4 +1 deputy
Sarah Bray	Senior Information Risk Owner (SIRO) for Mansfield and Ashfield CCG and Newark and Sherwood CCG	4/4 deputy
Paul Morris (until 30 September 2016)	Governing Body Lay Members of Newark & Sherwood CCG	0/2
Dr Sean Ottey	General Practitioner Rushcliffe CCG	0/4
Eddie Olla	Director of Health Informatics, NHIS	3/4
Jaki Taylor (until May 2016)	Head of Transformation	1/1

Quality and Risk Committee

The role of the Quality and Risk Committee is to monitor, review, and provide assurance that services commissioned by the CCGs are being delivered in a high quality and safe manner, and to promote a culture of continuous improvement and innovation by focussing on the three quality domains:

- Patient safety – the safety of treatment and care provided to patients
- Patient experience – the experience patients and their carers have of the treatment and care they receive
- Clinical effectiveness – measured by both clinical outcomes and patient-related outcomes

The committee acts on behalf of the CCGs to fulfil their obligations in respect of the following functions:

- Clinical governance
- Risk management
- Infection prevention and control
- Equality and diversity and EDS2
- Patient feedback including complaints and PALS
- Health and safety

Highlights of work

- **Provider quality dashboards, quarterly CCG quality reports,** and minutes from the provider Quality Scrutiny Panel meetings were reviewed to provide assurance regarding the quality of commissioned services and highlight any key areas of work. During 2016/17 this included harm impact reviews undertaken at Nottingham University Hospitals and East Midlands Ambulance Service as a result of continued failure to achieve A&E and cancer access targets and ambulance response times. A&E quality indicators and nursing metrics were also introduced this year. Annual or bi-annual provider focus reports have also been introduced to enable improved triangulation of quality information and onward assurance to and from associate commissioners.
- **Minutes and progress reports from the three sub-groups** including Health and Safety (H&S), Care Homes and Equality and Diversity (E&D) Forum were received. The purpose of the E&D forum has been revised during 2016/17 to refocus it on the operational delivery of the EDS2 and statutory E&D requirements by ensuring the work plans are aligned to the engagement plans of the respective CCGs (this was an action arising from the self-assessment undertaken in February 2016). Assurance regarding the implementation of home care provider monitoring was also received.
- **The Clinical Risk Register** has been reviewed and updated at each meeting. During 2016/17 four risks have been archived (smaller contract quality monitoring, provider cost improvement programme quality impact assessments, mental health inpatient bed capacity and impact of local authority budget cuts). Three new risks have been added (continuing healthcare assessment backlog, deprivation of liberty safeguards and impact of financial challenges). One risk has significantly increased (potential harm as a result of ambulance performance and CQC quality concerns). A number of risks have reduced in year (potential harm as a result of A&E/cancer performance, quality concerns at Sherwood Forest Hospitals Trust and quality monitoring in primary care). Other risks have stayed the same (home care quality monitoring and homecare and care home capacity).
- **A log of quality impact assessments** (QIA) has been received by the Committee. During 2016/17 details of 54 QIAs have been shared with the Committee. Two have met the threshold for requiring stage 2 assessments and full review by the Committee. An extra-ordinary meeting was held to consider the QIAs associated with the clinical reviews of locally priced services and the meeting was joined by City CCG quality team representatives due to a number of the services covering all four CCGs.
- **The Primary Care Quality Assurance Framework** was received along with terms of reference for Primary Care Quality Sub-groups which it was agreed would formally report to the Primary Care Commissioning Committees but highlight reports have been received by QRC for information.

- **Special Educational Needs and Disability Reforms Assurance Reports** were received to provide assurance that the CCGs are meeting statutory requirements in relation to this agenda.
- **Safeguarding Committee Highlight Reports** were shared to enable the Committee to be kept updated with developments in this area and take assurance that the Safeguarding Committee is effective.
- **Care Quality Commission Reports** from commissioned providers and service reviews were received. During 2016/17 these included a joint CQC/Ofsted review of the implementation of special education needs and disability reforms and a CQC inspection of looked-after children and safeguarding in Nottinghamshire.
- **Quality Surveillance Group** feedback from the meetings chaired by NHSE and attended by all Nottinghamshire and Derbyshire CCGs, NHS Improvement, Care Quality Commission, Public Health commissioners, local authority, HealthWatch, and specialised commissioners was provided at each meeting.
- **Freedom to Speak Up Action Plan** was monitored and completed during 2016/17.
- **Quality and Risk Committee Self- Assessment Action Plan** was monitored and completed during 2016/17 including development and implementation of the new QRC induction pack for new members.

Attendance

Quality and Risk Committee member	Committee position	Total/ possible
Susan Bishop	Lay Member, NW CCG (Chair of QRC)	4/4
Nichola Bramhall	Director of Nursing and Quality, South Notts CCGs	4/4
Rebecca Stone	Deputy Director of Nursing and Quality, South Notts CCGs (Chair of Care Homes sub- group Sep 16- Jan 17)	3/4
Hazel Buchanan	Director of Operations, NNE	3/4 +1 deputy
Craig Sharples	Head of Quality, Governance and Engagement, NW CCG (Chair of E&D sub-group)	3/4 +1 deputy
Lynne Sharp	Head of Governance and Integration, RCCG (Chair of H&S sub-group)	4/4
John Tomlinson	Consultant in Public Health	2/4
Max Booth	Patient Representative, RCCG	3/4
Michael Rich	Patient Representative, NW CCG	4/4
Dr Ben Teasdale	Secondary Care Consultant (from Aug 16)	2/3
Dr Ram Patel	General Practitioner, RCCG	3/4

Quality and Risk Committee member	Committee position	Total/ possible
Dr Paramjit Panesar	General Practitioner, NNE CCG	3/4
Esther Gaskill	Head of Quality, Patient Safety and Experience, South Notts CCGs	3/4
Gail Colley-Contort	Head of Quality and Adult Safeguarding, South Notts CCGs (Chair of Care Homes sub group until Sep 16)	2/2
Jean Gregory	Head of Quality and Adult Safeguarding, South Notts CCGs (Chair of Care Homes sub group from Jan 17)	1/1

Safeguarding Committee

The Committee aims to ensure that systems and processes are in place to safeguard vulnerable adults and children as a core component of the services provided and commissioned by the Nottinghamshire CCGs. The committee responds to matters referred to it by the Nottinghamshire CCG governing bodies and Nottinghamshire safeguarding children and adult boards. Wider clinical consultation takes place across the Nottingham health community, the Care Quality Commission, local authority, police, and other statutory agencies.

Highlights of work

- Implementation of recommendations from national guidance relating to child sexual exploitation
- Monitoring of risks relating to victims/survivors of historical child abuse
- Contributing to and implementing recommendations from the Southern Health Review action plan
- The Committee convened a Confirm and Challenge event with providers following the CQC's report into the review of safeguarding and looked after children in Nottinghamshire. The Committee also continues to monitor the action plan for this
- Monitoring of risks relating to the placement of unaccompanied asylum seeking children in Nottinghamshire
- Monitoring and implementing recommendations from the Children in Care, Adoption and Fostering action plan
- Monitoring and implementing recommendations from the Sepsis Audit action plan
- Monitoring of the recommendations of the Adult Safeguarding Internal Audit Report
- Monitoring of care home concerns where there are concerns around abuse or neglect
- The Safeguarding Operational Working Group, sub-committee of the Safeguarding Committee, has been found to make a positive benefit to the progression of key issues for the Safeguarding Committee

The following were approved by the Committee in 2016/17:

- Managing of allegations and concerns that an employee or those who act in the capacity of employees who may be harming a child, young person or an adult in need of safeguarding policy
- The Missing Family Alert Protocol
- Nottinghamshire Transitions Protocol and Pathway
- Unaccompanied Asylum Seeking Children and Reunification of Children Pathway
- Terms of Reference for the Operation Equinox Health Care Advisory Group (OEHCAG)

Priorities for 2017/18:

- Oversee implementation of the newly introduced NHS England Safeguarding Assurance Tool (SAT) to identify areas for improvement, and monitor progress
- Oversee the progression of multi-agency safeguarding priorities identified in the local Nottinghamshire Safeguarding Children Board and Nottinghamshire Safeguarding Adults Board work-plans

Attendance

Committee member	Committee position	Total/ possible
Elaine Moss	Chief Nurse and Director of Quality for Newark and Sherwood and Mansfield and Ashfield CCGs (Chair)	2/4 +2 deputy
Nichola Bramhall	Director of Nursing and Quality, South Notts CCGs (Vice Chair)	3/4 +1 deputy
Gail Colley-Bontoft (until September 2016) Jean Gregory (from Oct 2016)	Head of Quality and Adult Safeguarding, South Notts CCGs	4/4
Rosa Waddingham	Deputy Chief Nurse, for Newark and Sherwood and Mansfield and Ashfield CCGs (post vacant since September 2015)	1/4 +3 deputy
Sue Barnitt (from October 2016)	Head of Quality and Patient Safety for Newark and Sherwood and Mansfield and Ashfield CCGs	1/1
Cathy Burke	Nurse Consultant Safeguarding (Designated Professional Adults and Children) for Bassetlaw CCG	2/4 +2 deputy
Val Simnett	Designated Nurse Safeguarding Children for 5 Nottinghamshire CCGs	3/4 +1 deputy
Nicola Ryan	Deputy Chief Nurse for Bassetlaw CCG	3/4 +1 deputy

Committee member	Committee position	Total/ possible
Amanda Jones	Adult Safeguarding Lead for South Nottinghamshire CCGs	0/4 +4 deputy
Dr Fiona Straw	Designated Doctor Safeguarding Children, South Nottinghamshire CCGs	3/4
Dr Becky Sands	Designated Doctor Safeguarding Children, North Nottinghamshire CCGs	3/4
Kathryn Higgins	Designated Nurse Children in Care for 5 Nottinghamshire CCGs	3/4 +1 deputy
Dr Victoria Walker	Designated Doctor Children in Care , North Nottinghamshire CCGs	2/4 +2 deputy
Dr Melanie Bracewell	Designated Doctor Children in Care, South Nottinghamshire CCGs	0/4 +4 deputy
Dr Jane Selwyn	General Practitioner	3/4
Kerrie Adams	Public Health Manager (children lead) nominated by the Director of Public Health, Nottinghamshire County Council	2/4
Patricia Higham (from January 2017)	Lay member	1/1

Individual Funding Request Panel

Clinical commissioning groups are required to have a process for considering funding for individuals who seek NHS commissioned services outside established commissioning policies. This may either be a request for funding treatment where there is no commissioning policy, where the medical condition is not included in a current policy or the request does not meet the criteria set out in the policy.

The individual funding request (IFR) panel has been running successfully since 2007 ensuring that all funding requests are considered in a fair and transparent way across the five CCGs within Nottinghamshire County. It provides a robust mechanism for making decisions based on the best available evidence and in accordance with the CCGs commissioning principles.

The individual funding request panel is hosted under a memorandum of understanding by NHS Nottingham West CCG in conjunction with NHS Nottingham North and East, NHS Mansfield and Ashfield, NHS Newark and Sherwood, and NHS Rushcliffe CCG.

The IFR panel is constituted in accordance with the scheme of reservation and delegation of Nottingham West CCG. The applicable policies and procedures are owned and maintained by Nottingham West CCG.

Highlights of work

- The panel met to review previous cases for clinical benefit, where funding had already been previously approved.
- There were 22 individual funding request applications processed in accordance with the IFR Policy eligibility criteria:
  - The IFR panel considered two requests; one request was declined by the panel on the grounds of affordability and cost effectiveness and one is currently pending a decision.
  - Nine cases were screened in line with the policy; two approved for consideration by the panel and seven declined for consideration by the IFR panel as they did not demonstrate clinical exceptionality.
  - Nine cases were redirected/returned
  - Two cases were declined at pre-screening as policies are already in place with criteria for the requested procedures i.e. breast reduction and removal of sterilisation.

Attendance

Committee member	Committee position	Total/ possible
Peter Robinson	Chair (Lay Representative)	4/5
Usha Gandhi	Nominated Deputy Chair (Lay Representative)	2/5
Jonathan Gribbin	Consultant in Public Health, Public Health Nottinghamshire County	5/5
Vicky Bailey	Chief Officer, NHS Rushcliffe and NHS Nottingham West CCG	2/5
Sharon Pickett	(Deputy Chief Officer) NHS Nottingham North and East CCG	3/5
Dr Simon Brenchley	GP – Lombard Medical Practice – NHS Newark and Sherwood CCG	4/5
Dr Sean Ottey	GP – West Bridgford Medical Practice – NHS Rushcliffe CCG	5/5
Dr James Read	GP – The Manor Surgery – NHS Nottingham West CCG	4/5
Marilyn James	Health Economist – The University of Nottingham	0/5
Jane Urquhart	IFR Manager – NHS Mansfield and Ashfield CCG	5/5
Nicky Bird	Senior Prescribing Advisor (South) –– NHS Mansfield and Ashfield CCG	4/5
Laura Catt	Prescribing Interface Advisor	1/1

East Midlands Affiliated Commissioning Committee (EMACC)

Nineteen East Midlands Clinical Commissioning Groups (CCGs) have established a joint committee which enables the CCGs to work collaboratively on the development and maintenance of:

- policies for services which CCGs have responsibility for commissioning
- new policies identified as being appropriate for identical implementation on a regional scale.

The Committee held its inaugural meeting in November 2016. It has delegated authority from each of the participating CCGs working on the following principles:

- **Optimise health outcomes:** agree policies that aim to achieve the greatest possible improvement in health outcomes for the East Midlands population within the resources that are available
- **Clinical effectiveness:** ensure that the decisions are based on sound evidence of clinical effectiveness
- **Cost effectiveness:** take into account cost-effectiveness analyses of healthcare interventions (where available) to assess which interventions yield the greatest benefits relative to the cost of providing them as part of agreeing policies
- **Equity:** operate within the context of each individual within the East Midlands population being of equal value
- **Access:** ensure that policy decisions reflect the need for care to be delivered as close to where patients live as possible
- **Patient choice:** respect the right of individuals to determine the course of their own lives, including the right to be fully involved in decisions concerning their health care. However, this has to be balanced against the responsibility to ensure equitable and consistent access to appropriate quality healthcare for all the population
- **Affordability:** ensure policies that are approved are evidence based to deliver clinical and cost effective delivery of care within the resources available to the CCGs. Where policies exceed the available resources of the CCGs, EMACC will consider prioritisation of the policies based on national and local policies and strategies, including local assessments of the health needs of the population
- **Disinvestment:** as well as agreeing new policies on the basis of the criteria above, EMACC will keep policies under constant review to ensure that they continue to deliver clinical and cost-effective services at affordable cost
- **Quality:** EMACC will aim to agree policies that offer high quality services as evidenced against national and international best practice.

Highlights of work

- Developed an Annual Work Programme which sets out the policies to be developed by EMACC for approval by the governing bodies of the participating CCGs
- Approved the terms of reference for the Clinical Priorities Steering Group (CPSG)
- Developed the process for reviewing/developing collaborative commissioning policies
- Approved the Collaborative Policy Approval Framework
- Agreed the Lead Area Model

Attendance

Committee member	Committee position	Total/ possible
Dr Doug Black	Independent Chair	1/1
Jonathan Gribbin	Public Health Lead and Chair of Clinical Priorities Steering Group	1/1
Sally Seeley	Nottinghamshire Clinical Representative	1/1
Matt Schofield	Nottinghamshire Representative	1/1
Dr Ben Milton	Derbyshire Clinical Representative	1/1
Steve Hulme	Derbyshire Representative	0/1
Andy Rix	Lincolnshire Representative	1/1
Dr Vindi Bhandal Dr Sunhil Hindocha	Lincolnshire Clinical Representative	1/1
Tracy Jesa	Leicestershire Representative	1/1
Helen Mather	Leicestershire Representative	0/1
Chris Murphy	Northamptonshire Representative	1/1
Kathryn Moody	Northamptonshire Representative	0/1
Andy Roylance	Commissioning Manager	1/1

Nottinghamshire Health and Wellbeing Board

The primary purpose of the Nottinghamshire Health and Wellbeing Board is to provide overall strategic leadership to improve the health and wellbeing of residents in the city. Local authorities are required to establish Health and Wellbeing Boards under the Health and Social Care Act 2012. This Board has responsibility for driving health improvements for residents and a much stronger role in shaping local services, including the administration and allocation of expenditure of the Better Care Fund. The CCG is represented on the Nottinghamshire Health and Wellbeing Board by the Clinical Lead, Dr James Hopkinson.

Governing Body performance and effectiveness

The Clinical Commissioning Group is led by a Governing Body which includes GP clinical lead and chair, assistant clinical lead, accountable officer, chief finance officer, GP members, lay members, registered nurse/director of nursing and quality, and a secondary care representative, all with significant experience of operating at board level. The combined leadership brings professional and both a clinical and a lay perspective, providing a positive impact on governance and accountability.

A self-assessment of Governing Body performance and effectiveness was undertaken during 2016/17. 2016/17 saw considerable changes in the membership of the Governing Body and the self-assessment provided an opportunity to review the confidence of members which came out high. The self-assessment included personal behaviour, technical competence, and business practices. The findings were discussed by the Governing Body and an action plan produced.

Training for Governing Body members has been carried out through the Governing Body development sessions which are held throughout the year. Development has been reflective of the change in leadership and the addition of new members and as such has focused on working as a team, briefings on the work of the CCG, challenges for 2016/17, transformation, and the accountable care system.

Compliance with the UK Corporate Governance Code

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

The findings of this report have been presented to the CCG Audit and Governance Committee. Whilst the report made a number of recommendations, it can be confirmed that for the financial year ended 31 March 2016, and up to the date of signing this statement there were no departures from the provisions of the UK Corporate Governance Code which we deem relevant

Discharge of statutory functions

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

Responsibility for each duty and power has been clearly allocated to a lead Director/ Senior Manager who has confirmed that their structures provide the necessary capability and capacity to undertake all of the Clinical Commissioning Group's statutory duties.

Risk management arrangements and effectiveness

Prevention of risk

The CCG is committed to achieving an integrated approach to risk management, ensuring where possible the union of both clinical and non-clinical risk. The Integrated Risk Management Framework describes the CCG's arrangements for ensuring all risks, potential or otherwise, are correctly identified and that necessary controls are in place to mitigate those risks to the organisation or that of any stakeholder impact. The CCG appreciates that the management of risk is based on an element of prediction. Consequently, however robust the process, there can never be an absolute guarantee that untoward events will not occur. However, practicing risk management ensures it is much less likely that an untoward incident will occur, and this strategy intends to build on existing good practice to bring together the intelligence gained from incident, complaints, and claim reporting to provide a holistic approach.

Deterrent of risks

The Clinical Commissioning Group has a Local Counter Fraud Specialist Advice Service and robust arrangements in place to protect NHS resources from fraud, corruption, and bribery in line with NHS Protect compliance guidance. The CCG has a Governing Body approved fraud, bribery, and corruption policy and has produced a risk assessment and work plan across the four key areas of work:

- Strategic governance
- Inform and involve
- Prevent and deter
- Hold to account

The work plan for 2015/16 included the new NHS Protect Standards for Commissioners and the completion of the Self-Review Tool (SRT) by which the CCG has assessed its own compliance against each standard with the results reported to NHS Protect. An improvement action plan was developed and progressed throughout the year with a focus on creating an anti-fraud bribery and corruption culture. This significant progress will be reflected in the SRT for 2016/17, the completion of which will assist in identifying areas requiring further action.

Staff are the best source of information in countering fraud, bribery, and corruption, and have completed the eLearning module on Counter Fraud. Budget holder and HR eLearning modules have also been developed for relevant staff.

In order to measure the effectiveness of awareness work, staff understanding of their responsibilities and the overall strength of the anti-crime culture, a Counter Fraud survey was issued. The results showed that very significant progress had been made in developing staff knowledge and were used to inform the development of the Counter Fraud work plan for 2016/17.

Risks to data security are specifically managed and controlled through internal processes. The NNE CCG Caldicott guardian and all staff assigned responsibility for co-ordinating and implementing the confidentiality and data protection work programme have been appropriately trained to carry out their roles.

All information governance incidents are taken extremely seriously. The Clinical Commissioning Group is committed to reporting, managing, and investigating all information governance incidents and near misses. Staff are encouraged to report all incidents and near misses to ensure learning can be collated and disseminated within the organisation.

The Clinical Commissioning Group did not report any serious untoward incidents involving information, confidentiality, or security between April 2016 and March 2017.

Management of current risks

The Governing Body uses the Risk Assurance Framework as its primary strategic risk management tool for the identification of risk. Risk registers are maintained for corporate, clinical, financial, safeguarding and information governance risks. These are reviewed in the relevant committees and are owned by Directors of the CCG.

In addition to the Governing Body assurance framework facilitating risk identification from a top down approach, the Governing Body agenda items are linked directly to the strategic objectives and risks. Any operational risks that are linked to delivery of the strategic objectives are highlighted through the discussions on the Governing Body agenda items and strategic risks.

Risk appetite

Risk appetite is one element of the CCG's assessment of its ability (or capacity) to take and manage risks and is an integral and iterative part of the risk management process in order to inform decisions about the willingness to accept risks in pursuit of strategic objectives. This is recorded in the Risk Assurance Framework as a target risk rating. The assessment of appetite is informed by factors such as impact on patients or staff, value of assets lost or wasted in the event of adverse impact, stakeholder perception of impact, the balance of cost of control and the extent of exposure and the balance or potential benefits to the gained or loses to be with stood. Hence the risk appetite for different risks, even within the same category, may vary.

Implementation of the Integrated Risk Management Framework is coordinated and monitored by the CCG executive team. The framework clearly states the processes

that the Clinical Commissioning Group follows when identifying, assessing, and addressing a risk. The process ensures that strategic risks progress through to the Risk Assurance Framework with a systematic approach presented for the management of corporate and operational risks. The Audit and Governance Committee has a role to ensure that the framework is embedded in the day to day business of the CCG.

Risk management is embedded into the wider working of the CCG, examples of which are the use of equality impact assessments, privacy impact assessment and quality impact assessment of policies and service procurements and developments. These impact assessments are reviewed by the respective senior officer in the CCG prior to presentation at the relevant committee of the Governing Body to provide assurance. The CCG also operates an incident reporting system across the three South Nottinghamshire CCGs to ensure that NHS Nottingham North East CCG is informed of any incidents reported and ensure that any risk to the organisation is considered, escalated to the risk register or Risk Assurance Framework as appropriate.

It is not the intention of the CCG's Integrated Risk Management Framework to eliminate all risk. The organisation promotes a balanced and mature approach to risk where, in certain situations, the likely impact of the risk is weighted up with the potential benefits of a particular course of action. The organisation does not tolerate unnecessary risk in relation to quality and patient safety but the risks associated with a business venture would be weighted up against the potential benefits of the course of action.

Risk pooling

The financial risk pool that was agreed by the six Greater Nottingham and Mid-Nottinghamshire CCGs in 2014/15 continued to be operated in 2015/16 and 2016/17.

The operation of the 2016/17 Risk Pool Agreement is summarised as:

- high cost patients (a patient whose costs in the calendar year for acute secondary and critical care services within the scope of the CCG exceed £80,000)
- one-off 'major incidents' (events that (i) are expected to occur less frequently than once in every two years; and (ii) have been recognised by Public Health England and/or an appropriate local health authority as an outbreak or emergency); both would be risk shared at a City/County basis.

In addition, the five Nottinghamshire County CCGs have a financial risk agreement for continuing healthcare and non-NHS low secure/locked rehabilitation; and a high cost patient (non-acute) prescribing agreement that continue to be in place on the same basis as when they were established in 2013/14.

Cases where risk sharing of resources under this agreement took place were reported to the Governing Body in the finance report at each meeting.

Public stakeholders

Public stakeholders are involved in managing risks which impact on them through direct engagement and communication with the CCG. Also, a key element for the CCG is listening to patient experiences. The following mechanisms are available:

- Lay Members and Patient Representative on the Governing Body
- Patient and Public Engagement events which are held regularly and allow for questions and answers
- Through a dedicated patient experience team, including PALS, with direct reporting of experiences to CCG committees and the Governing Body
- The Patient and Public Involvement Committee, PPI QIPP Group and Practice Patient Group Working Group
- Practice Patient Group meetings are attended by CCG representatives
- Direct links with the district/borough councils

During 2016/17, the CCG have presented to the Nottinghamshire Joint Health Scrutiny Committee In addition, the CCG has a statutory duty to involve service users and the public on issues such as commissioning developments and proposals for change, and decisions affecting the operation of commissioning arrangements that may impact on service users, the catalyst for which may be driven by local, national and environmental risk factors. To this end, the CCG has engaged with public stakeholders on number of issues throughout 2016/17, including the proposal to promote self-care and a service review of 30 individual acute care services.

Capacity to handle risk

The chief officer as accountable officer has taken ultimate responsibility for establishing and implementing a risk management system in the Clinical Commissioning Group. This is demonstrated by:

- continually promoting risk management and demonstrating leadership, involvement and support
- ensuring an appropriate committee structure is in place, with regular reports to the Governing Body
- ensuring that directors and senior managers are appointed with managerial responsibility for risk management
- ensuring appropriate policies, procedures and guidelines are in place and operating throughout the Clinical Commissioning Group.

Detailed procedures are set out in the Clinical Commissioning Group's Integrated Risk Management Policy, which was reviewed and approved by the Audit and Governance Committee In January 2017.

- The Assurance Framework is reviewed by the Audit and Governance Committee in detail at each meeting. In addition the Governing Body also reviews the Assurance Framework regularly throughout the year and informed in so doing by the Audit and Governance Committee.
- Self-certification requirements for statutory functions required by NHS England are reviewed by the Audit and Governance Committee prior to each quarterly submission.
- The Governing Body receives regular reports on performance against targets, compliance with statutory financial duties, quality including equality and complaints duties and PPI at every meeting throughout the year.
- Development sessions are focussed on supplementing this level of scrutiny with detailed presentations and discussion.

In conjunction with these structures, systems and processes, staff training is delivered through face to face team training sessions and dissemination of the policy. The policy provides all staff with the appropriate information and the tools to identify score and treat risk appropriately according to level and severity.

The Clinical Commissioning Group constantly reviews its policy and procedures for managing risk in the light of the work of fellow clinical commissioning groups and in respect of Internal Audit best practice papers and benchmarking reports.

Risk assessment

The Governing Body uses the Board Assurance Framework as its primary strategic risk management tool for the identification of risk. This document is reviewed on a regular basis by the Executive Team and reported to the Audit and Committee and the Governing Body.

In addition to the framework facilitating risk identification from a top down approach, the significant risks identified through the risk management process – bottom up - that have an impact on the ability of the CCG to deliver its strategic goals are documented on the Board Assurance Framework.

The table below represents the position at the end of March 2017 and is followed by a description of how these risks were managed throughout the year.

Risk ID	Lead and committee	Risk narrative	Initial risk rating			Risk Rating Performance							Trend from previous report	Target risk rating
			Impact	Likeli-hood	Score	Mar 16	May 16	Jul 16	Sep 16	Nov 16	Jan 17	Mar 17		
R01	Jonathan Bemrose, Finance and Information Group	The CCG is unable to deliver against plan due to continually increasing activity, unexpected costs and an inability to maintain QIPP savings.	5	4	20	20	20	20	20	20	20	20	⟷	10
R02	Jonathan Bemrose, Finance and Information Group	The fragility of the system impacts on the capability of the CCG to deliver against its financial duties.	5	4	15	15	15	15	15	20	20	10	↓	10
R03	Sam Walters / Sharon Pickett, Various	Demands for transformation, including the STP, GNHCP, and new models of care impact on the capability to focus on short term performance. Due to competing demands and the complexity of the system the CCG is unable to provide leadership in co-ordinating the delivery of core standards and recovery actions.	5	4	20	20	20	20	20	20	20	20	⟷	10
R04	Nichola Bramhall, Quality and Risk Committee	The CCG is unable to provide confidence to its local population that it is commissioning clinically safe, high quality, compassionate services. Lack of adequate focus and challenge may lead to compromised quality, outcomes or inappropriate prioritisation.	5	2	10	10	10	10	10	10	10	10	⟷	6
R05	Hazel Buchanan, Clinical Cabinet and Service Imrovement Group	Due to a lack of understanding and/or effort to recognise the different population segments, the CCG is unable to plan effectively and reduce health inequalities and/or demonstrate continuous improvements for the protected characteristics.	5	2	10	10	10	10	10	10	10	10	⟷	6
R06	Sam Walters, Governing Body	There is a risk that pressures and fragility within the system impact on the CCG's capability to deliver against targets.	5	4	20	20	20	20	20	20	20	20	⟷	8
R07	Chair, Clinical Cabinet and Governing Body	Limited engagement between member practices and with the CCG impacts on the capability to work together on delivery of transformational change, including gaining benefits through commissioning, federation and to improve the quality of primary medical	4	3	12	12	12	12	12	12	12	12	⟷	6
R08	Sam Walters, Governing Body	Leaders are not visible and are not able to focus on the short and longer term priorities of the CCG, due to the resource and focus required as lead commissioner for NUH.	4	3	8	8	8	8	8	12	12	12	↑	6
R09	Sam Walters, Governing Body	High turnover and lack of succession planning in the leadership team and the Governing Body impacts on the capability to evidence robust leadership.	2	2	8	8	8	8	8	8	4	4	↓	2

Risk Assurance Framework – executive summary

Amendments to existing risks identified during the year

Emergency Department

Performance of the national target of 95% of patients waiting less than 4 hours to receive an assessment and treatment has not been achieved consistently throughout the year at Nottingham University Hospitals Trust (NUH), with performance at times below 70%.

Over the summer national support has been provided through the Emergency Care Improvement Programme (ECIP) which undertook a diagnostic analysis of performance and worked with the A&E Delivery Board to support the plan for improvement.

A number of additional services were commissioned to reduce pressure on A&E by improving flow through the hospital to allow patients to be transferred from A&E in a timely way; and providing support in the community to reduce unnecessary

attendances. These included making changes to community service pathways, commissioning additional community beds, commissioning additional homecare, having GPs working in A&E at weekends and evenings, extending the period of out of hours services, enhanced care home support from GPs, and an in-reach programme from community services, social care and primary care to Healthcare of Older People wards to expedite the discharge of patients who are medically fit.

CCGs have agreed a remedial action plan (RAP) with NUH which includes further actions to improve performance for example the development of a Frailty Pathway to support patients to return home following an attendance in the Emergency Department or back into the community following an unplanned admission. An Exemplar Ward programme has also been introduced across NUH to support hospital discharge, and patient flow across the system; areas of focus include: patient transport, medication to take home and equipment supply.

Regular weekly meetings continue to take place between all system partners to develop and improve pathways and model of care which will support patients to be discharged in a timely manner following a hospital episode.

The CCG has worked closely with the NUH to assess and monitor the impact on quality including the use of quality indicators, nursing metrics and root cause analysis of 12 hour breaches. This has shown that NUH has robust mechanisms in place to identify and mitigate risks to quality and in particular safety. This was also reiterated in the CQC report arising from their unannounced inspection of the Emergency Department in December 2016. An overall rating of 'requires improvement' was achieved with 'requires improvement' in 'safe' and 'responsive' and 'good' in 'caring', 'effective' and 'well-led'. No warning or enforcement notices were issued and at a Quality Summit held on 4 April 2017 completion of all recommendations by the end of April 2017 was confirmed.

At the time of writing this report, the local health system remains in full escalation to NHS England for performance against this target.

Ambulance service

The response times for emergency ambulances in Nottingham North and East remained below the national standards for 2016/17 and this continued the performance seen during the previous year. In addition, the CQC inspection report published in May 2016 rated the Trust as 'requires improvement' overall with an 'inadequate' rating for safety and 'requires improvement' ratings for effective and well-led measures.

During the year the Governing Body received reports on Harm Reviews which were undertaken to establish the clinical impact on patients where the target had been missed. The reviews indicated that no significant harm had been experienced by patients as a result of missed response targets.

An ‘announced’ CQC follow up inspection took place in February 2017, the results of which are yet to be published.

Cancer

Performance against some of the cancer standards has been just below the national target this year. However, the 62 day referral to treatment target has been more challenging to achieve due to below target performance throughout the year at NUH. The previous recovery trajectory of July 2016 was not achieved and as a result the risk score was increased mid-year from 6 (low/possible) to 12 (medium/likely).

Analysis shows that there are two tumour sites where performance has been consistently below standard over the last 12 months – lower gastrointestinal and lung. A remedial action plan is in place specifically focussing on these two areas together with plans to reduce the backlog, actions around late referrals from other hospitals and actions to reduce waiting times in radiology including a new MRI scanner

Cancer has been included in the Sustainable Transformation Plan as a key clinical priority with targets of achieving 75% one-year (all cancers) survival rates and diagnosis of 95% of cancers within four weeks. The CCGs are working to the national cancer strategy and will review the recently published implementation plan to ensure that best practice is being followed to transform the approach to supporting people living with and beyond cancer

Continuing healthcare (CHC)

The increase in financial spend was highlighted at the end of quarter 1 with Nottinghamshire significantly above the England average. A CHC turnaround group was established to plan and challenge changes to areas of the service which would yield savings without compromising on quality of care.

Recognising that collectively the CCGs are still significantly overspent on CHC (30%), there is evidence that the actions taken to date are having an impact (down to 10%). Savings of over £2m per annum have been delivered in cash terms when compared to levels of expenditure incurred in September 2016.

Reduction in expenditure has occurred in children’s, fast track, and older people’s mental health packages, whilst 'after-care' packages (following sectioning under the Mental Health Act 1983) continue to rise.

As a result of this progress, the risk score has been reduced from 16 to 12 but will remain on the Assurance Framework for monitoring and scrutiny by the Audit and Governance Committee and Governing Body.

However, the reducing trend ensures a lower anticipated starting point for 2017/18 and whilst challenging, 2017/18 savings targets are achievable if current scrutiny and plans continue to be implemented at pace.

Sustainability and Transformation Plan (STP)

The STP was submitted in October 2016 setting out how local services will evolve and become sustainable over the next five years – ultimately delivering the NHS Five Year Forward View vision of better health, better patient care, and improved NHS efficiency.

The scale of transformation and the capacity to deliver the ambitions of the STP was raised as a risk mid-year with the backdrop of managerial and clinical leadership capacity focussing on short term financial recovery in both CCGs and providers.

The governance structure for the Greater Nottingham Health and Care Partners Delivery Unit has been reviewed to incorporate CCG financial recovery and QIPP delivery alongside transformation to ensure that short and medium to long term objectives are reconciled.

The Five Year Forward View Delivery Plan is due to be published by NHS England before the end of March 2017. This will provide national context and direction for the next steps.

Home care quality monitoring

Concerns around the quality monitoring of home care packages resulted in this risk escalating to the Assurance Framework in December 2016 from the clinical risk register.

Actions implemented recently have resulted in a downgrading of this risk to 9 (medium/possible) and include an audit tool to monitor provider quality; a schedule of annual home care provider quality reviews reported in the quarterly quality report to the Governing Body; an annual review of continuing healthcare patients in receipt of home care; and allocation of responsibility to partner CCGs to take responsibility for specific home care providers.

This risk has been stepped down from the Assurance Framework but will continue to be monitored through the clinical risk register reporting to the Quality and Risk Committee and Governing Body through the quarterly quality report.

Financial plan 2016/17

The CCG has met all of its financial duties for the year, including delivery of the planned surplus target. This has been a challenging year with growth and demand on both acute services and continuing healthcare services and financial performance has been carefully monitored by the Audit and Governance Committee and Governing Body where deep dive reviews have been presented giving opportunity for challenge and scrutiny.

In collaboration with NHS Nottingham West and Rushcliffe CCG, financial pressures during the year lead to the CCG entering internal financial recovery and establishing a formal Financial Recovery Plan (FRP) with a Programme Management Office (PMO) structure to oversee the formation and delivery of the recovery. The focus of

the plan was implementing priority actions for 2016/17 and developing implementation plans for 2017/18 priority schemes. More detail on the FRP can be found later in this Governance Statement.

The level of financial challenge for 2017/18 and beyond is unprecedented and an overarching strategic risk regarding financial instability in the health and social care economy has been escalated to the Assurance Framework in the second half of the year.

These risks will continue to be managed through the risk management and assurance processes throughout 2017/18. Where appropriate, the CCG will discuss risks which threaten the achievement of objectives with providers, partners in healthcare and social care services, the local authority, voluntary bodies and through the involvement of patients and their representatives.

Other sources of assurance

Internal control framework

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

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

The Governing Body has the ultimate responsibility for internal control and the oversight and risk management throughout the CCG. The Governing Body receives reports from the Audit and Governance Committee on its assessment of the effectiveness of internal control following the review of the Board Assurance Framework and reports form the CCG internal and external auditors at its meetings.

The CCGs strategic objectives form for the basis of the Risk Assurance Framework. The strategic objectives ensure a robust organisation and are linked to internal controls and assurance sources. Mitigating actions, controls and assurances are recorded and monitored to deliver reasonable assurance for prevention of risks, deterrent to risks arising and the management of current risks. The control mechanisms in place are designed to minimise or eliminate the risk of failure to deliver business objectives, including robust corporate and performance management frameworks, service level agreements and contract monitoring, policies and procedures.

The CCG executive team undertake a regular review of the Risk Assurance Framework to ensure that it remains a dynamic document accurately reflecting the risk exposure of the CCG and the mitigating controls and actions that that are in

place, ensuring that the Audit and Governance Committee and the Governing Body can form judgements on risk based on contemporary information.

The Governing Body has delegated the detailed oversight of the Risk Assurance Framework to the Audit and Governance Committee. To enable it to provide sufficient assurance to the Governing Body on the effectiveness of the risk management framework, the committee considers the findings from internal and external audit reviews in addition to calling officers of the CCG to account for their risk portfolios and monitoring the Risk Assurance Framework.

The quality, safety, and experiences of patients of the services commissioned are overseen by the Quality and Risk Committee. The Governing Body receives quarterly reports on the quality and safety of commissioned services from the director of nursing and quality.

Specialised risk management activities, for example information governance, emergency planning and business continuity, health and safety, fire and security are operationally managed by the governance manager who provides assurance reports on risk and compliance to the Governing Body and its committees.

Control measures ensure that all of the CCG's obligations under equality, diversity, and human rights legislation are in place. These include: policies, Governing Body level leadership by the Lay Member Patient and Public Involvement and the governance manager, annual reporting to the Governing Body, the Equality and Diversity Forum, and the CCG self-assessment against the Equality Delivery System 2, demonstrating compliance and progress against equality and diversity best practice.

Annual audit of conflicts of interest management

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

Internal Audit carried out a review in 2017 and the following was the outcome of the audit, including scope areas:

Scope area	Compliance level
Governance arrangements	Partially compliant
Declarations of interest and gifts and hospitality	Partially compliant
Registers of interest, gifts and hospitality and procurement decisions	Fully compliant
Decision making processes and contract monitoring	Partially compliant
Identifying and managing non-compliance	Partially compliant

Data quality

The Clinical Commissioning Group has robust controls in place to ensure the required standards for data quality from all providers where it commissions services. Locally defined schedules of the NHS standard contract include elements requiring standards for data quality. In addition, the Clinical Commissioning Group has signed off the provider Trusts' data quality strategies.

The Information Governance Management and Technology Committee includes a standing agenda item to receive quarterly data quality reports which summarises the data quality issues associated with key provider organisations, the relative benchmarking of data quality for these providers and any national expected standards. The report also outlines the actions being taken within and out-with the CCG to improve the quality of data to an acceptable level. Updates are provided to the Governing Body via the meeting minutes and highlight report.

A joint Data Management Team across Nottinghamshire CCGs is hosted by NHS Rushcliffe CCG. The Data Management Team is responsible for processing and validating data as well as developing business intelligence solutions, managing all data flows into and out of the Clinical Commissioning Group including testing the accuracy of data being submitted nationally and locally by providers. Ultimately allows the CCG to reinstate some of the data quality checks which were suspended following the national information governance restrictions mandated under the Health & Social Care Act 2012.

Information governance

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

The CCG is compliant with all criteria within the Information Governance Toolkit at level two or above for 2016/17.

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

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

Cyber-attack and impact on NNE CCG

On 12th May, many NHS organisations across the country reported that they were unable to use IT and clinical systems following a cyber-attack. This was triggered by a form of malware named by NHS Digital as 'Wanna Decryptor'. The cyber-attack was not specifically targeted at the NHS and affected many organisations around the world from a range of sectors.

The CCG's IT service provider (Nottinghamshire Health Informatics Service) took the decision to close down the CCG's IT systems as a precautionary measure to mitigate risk of data loss, which may have included patient sensitive data held by GP practices. At the time of reporting, there is no evidence to suggest that patient data has been compromised by the attack.

The CCG worked with its IT provider to return systems back to normal. Early information from the IT provider indicated that none of the data in the CCG's systems were infected. The CCG enacted its business continuity plan and was able to continue to operate and mitigate risk to critical functions.

Working with partners, which includes providers, the CCG will undertake a post recovery phase de-brief in co-operation with NHSE North Midlands to understand the effectiveness of the CCG's plans and to further improve IG resilience as a result of cyber-attack.

Business critical models

In accordance with the Information Governance Toolkit requirements, the CCG has documented its business critical models across its operation. Quality assurance is in place and the methods used are dependent upon the nature and purpose of the business critical model.

For financial modelling the following quality assurance processes are in place:

- Adherence to published NHS England planning guidance and NHS England locality requirements
- Use of version control and in-built validation checks in the financial model
- Financial Plans submitted to NHS England and details from the financial modelling as and when required
- Critical evaluation via external peer review from NHS England
- Internal peer review of financial model and financial plan templates within the Finance Department

- On-going process to inform contract team of initial envelopes and updates to Financial Plan and envelopes in line with contract negotiations until contacts formally signed off
- Subject to internal audit assurance as part of the Financial Management Audit

In addition to the above, for the development of acute contract activity plans the following processes are in place:

- External confirm and challenge process with acute provider directorates
- Final formalised sign off following acceptance checking by providers

Third party assurances

The CCG has contracts in place with The Phoenix Partnership (TPP), Nottinghamshire Health Informatics Service (NHIS) and North of England Commissioning Support (NECS) to supply and process data. TPP and NECS are NHS Digital-accredited organisations. NHIS is hosted by Sherwood Forest Hospitals Foundation Trust, which has achieved Level 2 of the IG Toolkit. Service delivery expectations, as set out in the respective contracts or service level agreements with each of these organisations, are monitored by the CCG via the Data Management Group and the IGM&T Committee.

NHS England has issued instructions to CCGs with delegated authority for commissioning primary medical services to discuss alternative assurance arrangements with external Auditors following the service auditor report for Capita that had given an **Adverse Opinion** in respect of the operation of control. Capita are the provider of GP payment processes and support.

The CCG's external auditors are aware of this issue and will look for how the CCG assures itself on controls around the delegated budgets for primary care and how the CCG gains assurance that the financial position is accurate. The CCG has produced a statement for external audit about how it gains assurance from the local Primary Care Contracting and Finance team at NHS England, and also places reliance upon the ISA3402 service audit report on NHS Digital and the ISA 3402 service audit report on SBS ISFE, which have been issued nationally.

In terms of detail, the CCG works closely with the NHSE Primary care Finance Team, and the following outlines the additional controls that the NHSE team have in place, in turn providing assurance to the CCG..

The NHSE Finance Team sets the initial budget at practice level, incorporating all negotiated uplifts and contract changes as well as making adjustments to budgets on a periodic basis for changes in list size, impact of rent reviews. GMS Contract payments are generated directly through systems such as Exeter and CQRS and interfaced directly into ISFE, assurance for these systems are provided by the NHS Digital Service Audit. Primary Medical Service Contracts, Premises, some enhanced services, out of hours deduction and LMC Levies are calculated by the NHS England Finance Team and entered on a payment schedule which is sent through to Capita

(PCSE) for processing payment. The CCG approve final payment of GP Contract Runs before the BACS is submitted.

As part of the Management Accounts service provided by the local Primary Care Finance Team detailed working papers are maintained that reconcile payments made by Capita shown in the ledger to the budget set at the start of the year and updated on an on-going basis as required by changes in areas such as GP Practice List Sizes. Any variances in payments against budget that cannot be explained locally are investigated with Capita. The local Primary Care Finance Team also takes part in a National Primary Care Finance Leads meeting on a monthly basis to discuss updates on issues with PCSE. This information is then cascaded to CCG finance leads. Further to this a monthly financial report is produced outlining the CCG's current and forecast financial position with explanation of any material variances from budget.

In overall terms, the CCG notes that this is a national issue and that any further assurance required by the external auditors is likely to be part of a national solution

Control issues

A number of areas where performance was below expected target were identified in the month 9 interim governance statement. These risks have been closely monitored throughout the year through the Joint Assurance Framework. More detail on each individual risk can be found earlier in this report in the **Risk assessment** section.

The Governing Body and Audit and Governance Committee have received briefings throughout the year on the financial pressures facing the CCG in-year. Whilst the CCG has achieved all of its financial duties in 2016/17, this has been achieved through the use of non-recurrent funding. The underlying financial position is deteriorating presenting a significant challenge in 2017/18 and beyond.

A number of areas where performance was below expected target were identified in the month 9 interim governance statement. These risks have been closely monitored throughout the year through relevant committees and reporting mechanisms including the Governing Body Assurance Framework. More detail on each individual risk can be found earlier in this report in the **Risk assessment** section.

In the month 9 statement the CCG highlighted the financial pressures. At year end the CCG has achieved all of its financial duties through the use of non-recurrent funding, however the underlying financial position continues to deteriorate, presenting a significant challenge in 2017/18 and beyond. The Governing Body and Audit and Governance Committee have received comprehensive briefings throughout the year on the in-year financial position and pressures.

At the end of March 2017 as part of the quarter 3 Improvement and Assessment Framework meeting, NHS England North Midlands notified the CCG that it had recommended the CCG's leadership rating be moved from green to amber.

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

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically. The CCG has developed and continues to refine systems and processes to effectively manage financial risks and to secure a stable financial position.

The CCG makes full use of internal and external audit functions to ensure controls are operating effectively and to advise on areas for improvement. The CCG established an auditor panel in 2016/17 to oversee the procurement process for the appointment of external auditors making a recommendation to the Governing Body in December 2016.

Both internal and external auditors carry out independent reviews of systems and processes within the organisation. Recommendations and action plans are put in place following these reviews to ensure controls are safe and adequate, providing safeguard of assets and resources. Key risks highlighted in these reports are also added to the corporate risk register.

Financial governance

The Clinical Commissioning Group has sound financial governance arrangements in place. The Constitution documents the standing orders, scheme of reservation and delegation, and the prime financial policies supported by the detailed financial policies including the operational scheme of delegation reviewed and approved at the Governing Body meeting in March 2017.

The Governing Body has ensured that robust governance arrangements are in place and has established committees for audit and remuneration. The Clinical Cabinet has established a Finance and QIPP Group to monitor financial performance, investment and the delivery of QIPP schemes.

The Internal Audit Plan for 2016/17 contained a number of audits specifically related to financial management and governance. The outcomes of those audits were reported to the Audit and Governance Committee and provided significant assurance on the systems and processes in place.

Financial reporting

The CCG's financial plan was developed for 2016/17, and budgets set within this plan, and signed off by the Governing Body prior to the start of the financial year. The chief finance officer and his team worked closely with managers to ensure robust annual budgets were prepared and delivered. These budgets were communicated to managers and budget holders within the organisation.

Finance reports are presented to the senior management team, QIPP and Finance Group, Clinical Cabinet and Governing Body each month. Alongside the financial position, performance against statutory duties, risks and actions to mitigate risks are reported and discussed.

The CCG operates within the prescribed running cost allowance for its central management costs. A vacancy control process has been established to ensure that the line managers undertake a comprehensive review of all posts prior to seeking authorisation to recruit from the chief officer.

Risk pooling

The financial risk pool that was agreed by the six Greater Nottingham and Mid-Nottinghamshire CCGs in 2014/15 continued to be operated in 2015/16 and 2016/17.

The operation of the 2016/17 Risk Pool Agreement is summarised as:

- high cost patients (a patient whose costs in the calendar year for acute secondary and critical care services within the scope of the CCG exceed £80,000)
- one-off 'major incidents' (events that (i) are expected to occur less frequently than once in every two years; and (ii) have been recognised by Public Health England and/or an appropriate local health authority as an outbreak or emergency); both would be risk shared at a City/County basis.

In addition, the five Nottinghamshire County CCGs have a financial risk agreement for continuing healthcare and non-NHS low secure/locked rehabilitation; and a high cost patient (non-acute) prescribing agreement that continue to be in place on the same basis as when they were established in 2013/14.

Cases where risk sharing of resources under this agreement took place were reported to the Governing Body in the finance report at each meeting.

Financial Recovery Plan – Programme Management Office

The four CCGs across Greater Nottingham have been working closely together since the end of the last financial year to identify programme areas and Quality, Innovation, Productivity and Prevention (QIPP) schemes where the most progress can be made in achieving financial recovery in 2017/18. A financial turnaround team with representation and expertise from across the four CCGs was pulled together on an informal basis to initiate this work in November 2016 and develop the Greater Nottingham CCGs Financial Recovery Plan. During quarter 4 of 2016/17 this work of the turnaround team has focused on:

- delivery of schemes to achieve 2016/17 financial balance for Rushcliffe, Nottingham West and Nottingham North and East CCGs

- supporting the requirements of NHS England's regional financial escalation meetings for Rushcliffe, Nottingham West and Nottingham North and East CCGs
- developing the Greater Nottingham QIPP plan for all 4 CCGs for 2017/18.

This work is now being more formally developed to ensure comprehensive delivery of the QIPP schemes with appropriate governance, assurance, and oversight to enable successful delivery of QIPP in 2017/18.

The Financial Recovery Plan is defined across 9 programme areas:

- Elective and cancer
- Primary care
- Community care
- Urgent care
- Mental health
- Estates
- Continuing healthcare/integrated personalised commissioning
- Prescribing
- Internal efficiencies

Each programme area has a senior responsible officer (SRO) working across Greater Nottingham. The clinical resource to support the QIPP plan is being discussed by the clinical leads.

The Programme Management Office process has been developed to ensure delivery of the Financial Recovery Plan and where possible aligning with Greater Nottingham Transformation structure and governance. The structure and governance enables the SROs to report on delivery of the programme areas and provide assurance on delivery against the QIPP plan.

NHS England is providing the CCGs with support to further develop and implement the QIPP plan for 2017/18. Thirty five days support has been provided by Arden Gem Commissioning Support Unit and Price Waterhouse Coopers in quarter 4 and focused on:

- the development of individual QIPP schemes to support 2017/18 QIPP programme
- supporting the development of project initiative documents and service specifications
- identifying and refining key performance indicators to provide an indication of how well individual milestone plans are being implemented
- reviewing key risks which could prohibit successful implementation and developing actions to prevent or mitigate potential impact.

Delegation of functions

The CCG has not delegated any functions either internally or externally.

Counter fraud arrangements

The CCG chief officer and chief finance officer are jointly responsible for ensuring adherence to the NHS Protect Anti-Crime Strategy for countering fraud, bribery, and corruption and the application of the related NHS Protect Standards for Commissioners. The chief finance officer is also responsible for the completion of a self-assessment review toolkit (SRT) in relation to these Standards which is submitted annually to NHS Protect.

During 2016/17 the CCG's Fraud, Corruption, & Bribery Policy was reviewed by the CCG's CFS and made available to all staff. Counter fraud awareness has also taken place and regular updates including distribution of the publication "Fraudulent Times" are made available.

The CFS provides the CCG with a comprehensive annual risk assessment from which a work plan is developed to achieve compliance with the Standards for Commissioners.

The CFS attends meetings of the Audit and Governance Committee and provides comprehensive updates on progress towards completion of the annual work plan and compliance with the Standards for Commissioners.

The CCG was not subject to an NHS Protect Quality Assessment during 2016/17 and therefore did not receive any recommendations. However, the CFS has reflected recommendations made during quality assessments at other organisations within the work carried out for the CCG.

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:

In providing my opinion, it should be recognised that the organisation's current systems of control and arrangements for governance and the management of risk will need to continue to develop in the coming year, particularly reflecting on increasing cross-organisation and sector partnerships, as these arrangements will bring additional challenges in terms of the management of risk and ensuring that all partners understand the inter-relationships.

From my review of your systems of internal control, primarily through the operation of your Governing Body Assurance Framework (GBAF) in the year to date, and the

outcome of individual assignments also completed in the year, I am providing a **Significant Assurance** that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

My opinion is provided primarily on the basis of work undertaken within the Internal Audit Plan for the 2016/17 financial year and is limited to the scope of work that has been agreed with the CCG Executive Officers and as shared with the Audit & Governance Committee, both prior to the commencement of work, and as detailed within our final report. Any opinion level provided must, therefore, be considered in terms of the agreed review scope only and no inference may be assumed by the CCG or other users of my report, that this opinion extends to the adequacy of controls and processes outside the scope agreed.

In providing an opinion for the financial year, it is important to reflect on the environment in which the organisation has been required to function and the impact of an on-going need to meet quality challenges whilst reducing costs, along with responding to the sustainability and transformation agenda. This will undoubtedly impact on the operation of control, however, the system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure.

During the year, internal auditors issued the following audit reports:

Audit Assignment	Report Ref.	Status	Assurance Level/Comment
2015/16 Internal Audit Plan			
Better Care Fund	1516/NNECCG/05/R	Issued	Significant
Safeguarding Adults	1516/NNECCG/06/R	Issued	Significant
Data Management Arrangements (including Pseudonymisation and Anonymisation)	1516/NNECCG/07/R	Issued	Significant
2016/17 Internal Audit Plan			
Budgetary Control and Key Financial Systems	1617/NNECCG/02/R	Issued	Full
Information Governance	1617/NNECCG/03/R	Issued	Full
Collaborative Commissioning		Work in progress	
Managing Transformation		Work in progress	
Safeguarding Children		Issued	Significant
Procurement		Issued	Significant
Personal Health Budgets		Draft Report	
Conflicts of Interest	1617/NNECCG/05/R	Issued	n/a

Audit Assignment	Report Ref.	Status	Assurance Level/Comment
Head of Internal Audit Opinion	1617/NNECCG/01/R 1617/NNECCG/04/R	Issued	Significant
Patient Safety – Continuing Healthcare		Work in progress	

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

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

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body and the Audit and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

My review was also informed by:

- CCG assurance meetings with NHS England
- Delivery of audit plans by external and internal auditors
- NHS staff survey results
- 360° stakeholder survey

Conclusion

No significant internal control issues have been identified with the exception of any internal control issues that I have outlined in this statement, my review confirms that NHS Nottingham North and East Clinical Commissioning Group has a sound system of internal control. This supports the achievement of its goals, vision, values, policies aims, and objectives.

Sam Walters: Accountable Officer, May 2017

Remuneration and staff report

Remuneration report

Remuneration committee (not subject to audit)

We have established a Remuneration Committee, which is a key committee of the Governing Body. The committee has delegated responsibility to review and set the remuneration and terms of service of the directors. The committee, which comprises lay members, met on three occasions during the year. All three members attended the meeting. There were no changes to membership throughout the year.

Members of the Remuneration Committee are:

- Terry Allen (Chair)
- Janet Champion
- Mike Wilkins (from Dec 2016)

The chief officer attends meetings to advise the committee except where discussions are around her own remuneration.

Policy on the remuneration of senior managers (not subject to audit)

The chief officer, chief finance officer, deputy chief officer, director of transformation, and director of nursing and quality are the senior manager not directly employed under Agenda for Change terms and conditions and were appointed in accordance with HR guidance issued by the NHS Commissioning Board and remunerated in line with: *Clinical Commissioning Groups: Remuneration Guidance for Chief Officer (where the senior manager also undertakes the accountable officer role) and Chief Finance Officers* applicable from when the CCG became the employing body on 1 April 2013. The agreed remuneration for the posts does not include any performance-related pay and do not exceed £142,500 per annum.

Senior managers on Agenda for Change terms and conditions will be remunerated in line with any national changes and pay awards.

Our future policy will be to remain in line with guidance issued to date or any revised guidance issued by NHS England.

All senior managers are employed on substantive contracts with a minimum notice period of three months. We do not make termination payments which are in excess of contractual obligations. There were no such payments during the 2016/17 financial year.

Lay members and clinical leads on the Governing Body have contracts for service. The term of office, notice period, and grounds and arrangements for removal from office for these individuals are detailed in the CCG's constitution.

Senior manager remuneration (including salary and pension entitlements) (subject to audit)

2016/17						
Name and Title	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£000	£000	£000	£000	£000
Samantha Walters, Chief Officer	110-115				95-97.5	205-210
Sharon Pickett, Deputy Chief Officer	80-85				72.5-75	155-160
Hazel Buchanan, Director of Operations	60-65				15-17.5	75-80
Janet Champion, Lay Member Patient and Public Involvement	5-10					5-10
Mike Wilkins, Lay Member Primary Care	0-5					0-5
Ben Teasdale, Secondary Care Consultant	0-5					0-5
Terry Allen, Lay Member Financial Management and Audit	10-15					10-15
Dr Ian Campbell, GP Representative	15-20					15-20
Dr James Hopkinson, Clinical Chair	105-110				105-107.5	210-215
Dr Caitriona Kennedy, GP Representative	15-20					15-20
Dr Elaine Maddock, GP Representative	15-20					15-20
Dr Paramjit Panesar, Assistant Clinical Chair	105-110					105-110

2016/17						
Name and Title	**Salary (bands of £5,000)**	**Expense payments (taxable) to nearest £100**	**Performance pay and bonuses (bands of £5,000)**	**Long term performance pay and bonuses (bands of £5,000)**	**All pension-related benefits (bands of £2,500)**	**TOTAL (bands of £5,000)**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Jonathan Bemrose, Chief Finance Officer	45-50				27.5-30	70-75
Rebecca Larder, Director of Transformation	10-15				*	*
Andrew Hall, Director of Outcomes and Information	40-45				12.5-15	55-60
Nichola Bramhall, Director of Nursing and Quality	35-40				20-22.5	55-60
Maxine Bunn, Director of Contracting	20-25				22.5-25	40-45

2015/16						
Name and Title	**(a) Salary (bands of £5,000)**	**(b) Expense payments (taxable) to nearest £100**	**(c) Performance pay and bonuses (bands of £5,000)**	**(d) Long term performance pay and bonuses (bands of £5,000)**	**(e) All pension-related benefits (bands of £2,500)***	**(f) TOTAL (a to e) (bands of £5,000)**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Hazel Buchanan	55-60					Missing information
Samantha Walters, Chief Officer	110-115					125-130
Jonathan Bemrose, Chief Finance Officer	40-45					75-80
Sharon Pickett, Deputy Chief Officer	75-80					75-80
Andrew Hall, Director of Outcomes & Information	40-45					45-50
Maxine Bunn, Director of Contracting	25-30					30-35
Nichola Bramhall, Director of Quality and Patient Care	30-35					30-35

2015/16						
Name and Title	**(a) Salary (bands of £5,000)**	**(b) Expense payments (taxable) to nearest £100**	**(c) Performance pay and bonuses (bands of £5,000)**	**(d) Long term performance pay and bonuses (bands of £5,000)**	**(e) All pension-related benefits (bands of £2,500)***	**(f) TOTAL (a to e) (bands of £5,000)**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Rebecca Larder, Director of Transformation	40-45					Missing information
Emma Pooley (March 2015 – February 2016), Clinical Director	70-75					Missing information
Janet Champion, Governing Body Lay Member Patient and Public Involvement (start Jan 2016)	0-5					0-5
Mike Wilkins, Governing Body Lay Member Patient and Public Involvement (March 2015 to Jan 2016)	5-10					5-10
Terry Allen, Governing Body Lay Member – Financial Management and Audit	10-15					10-15
Dr Paramjit Panesar, Assistant Clinical Chair – Governing Body	70-75					70-75
Dr James Hopkinson, GP Representative – Governing Body	65-70					65-70
Dr Paul Oliver (March 2015 – February 2016 GP), Clinical Lead/Chair	70-75					70-75
Adrian Kennedy (March 2015 to June 2015), Governing Body Allied Healthcare Professional Representative	0-5					0-5

2015/16						
Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)*	(f) TOTAL (a to e) (bands of £5,000)
	£000	£000	£000	£000	£000	£000
Dr Mohammed Al-Uzri, Governing Body Secondary Care Consultant	5-10					5-10

The salaries of the members below were allocated over a number of CCGs. The allocation to Nottingham North and East Clinical Commissioning Group is shown above. Their total remuneration is shown below:

2016/17						
Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£000	£000	£000	£000	£000
Jonathan Bemrose, Chief Finance Officer	105-110				65-67.5	170-175
Rebecca Larder, Director of Transformation	95-100				*	*
Nichola Bramhall, Director of Quality and Patient Care	80-85				45-47.5	130-135
Andrew Hall, Director of Outcomes and Information	100-105				32.5-35	130-135
Maxine Bunn, Director of Contracting	75-80				87.5-90	165-170

2015/16				
Name	**Salary (bands of £5,000)**	**Other remuneration (bands of £5,000)**	**Bonus payments (bands of £5,000)**	**Benefits in kind (rounded to the nearest £00)**
	£000	**£000**	**£000**	**£00**
Jonathan Bemrose, Chief Finance Officer	105-110			
Rebecca Larder, Director of Transformation	95-100			
Nichola Bramhall, Registered Nurse and Director of Nursing and Quality	80-85			
Andrew Hall, Director of Outcomes and Information	95-100			
Maxine Bunn, Director of Contracting	65-70			

Pension benefits as at 31 March 2017 (subject to audit)

Name	(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 31 March 2017 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2016	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2017	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Samantha Walters, Chief Officer	5-7.5	5-7.5	30-35	80-85	458	83	541	16
Jonathan Bemrose, Chief Finance Officer	2.5-5.0	5-7.5	40-45	115-120	649	70	719	15
Rebecca Larder, Director of Transformation	*	*	*	*	*	*	*	*

Name	(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 31 March 2017 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2016	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2017	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Hazel Buchanan, Director of Operations	0-2.5		5-10.		88	12	100	9
Nichola Bramhall, Director of Nursing and Quality	2.5-5.0	0-2.5	30-35	80-85	456	43	499	12
Sharon Pickett, Deputy Chief Officer	2.5-5.0	10.0-12.5	30-35	100-105	567	90	657	12
Dr James Hopkinson, Clinical Chair	2.5-5.0	5-7.5	15-20	40-45	198	55	253	15

* The CCG believes that the employment dates for the information it has received from the Pensions Agency are incorrect.

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Compensation on early retirement of for loss of office (not subject to audit)

There were no compensation payments on early retirement of for loss of office.

Payments to past directors (not subject to audit)

In 2016/17 there were no payments to past directors.

Pay multiples (subject to audit)

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

NHS Nottingham North and East CCG's highest paid director is the chief officer. The banded remuneration of the chief officer in the financial year 2016/17 was £110-£115k (2015/16: £110-115k). This was 2.75 times (2015/16: 2.66) the median remuneration of the workforce, which was £41.373 (2015/16: £42,161).

Reasons for the change in ratio from the previous year are:

- an increase in overall staff numbers due to vacancies being filled and the development of the Multi-Specialty Community Provider
- inclusion of agency staff this year.

In 2016/17, no employees received remuneration in excess of the highest-paid member. Remuneration ranged from £19,217 to £111,100 (2015/2016: £19,027 to £111,100).

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.

Staff report

We have a small core team within the CCG of 53 employees (50.42 full time equivalents).

Staff numbers (subject to audit)

A breakdown of our team by staff group and gender is presented below:

Staff group	Number	Band	Full-time equivalent	Gender	
				Male	Female
Very senior managers	5*	VSM - 5	5	2	3
Senior managers	2	8D - 1 8C - 1	2	0	2
Employees	45		42.42	8	37
Agency	1		1	0	1
Total	53		50.42	10	43

*This figure includes 4 shared posts which cover three or four CCGs.

In addition, for economies of scale and to reduce duplication and costs, we have a number of shared teams for performance and information, finance, quality and patient safety and contracting. The Performance and Information team are employed by Rushcliffe CCG and the Contracting team are employed by Nottingham West CCG. NNE CCG hosts the Finance, Quality and Patient Safety and Transformation Teams being employed by NNE and included in our employee numbers above.

Our Governing Body comprises of 12 members which includes seven male and five female members.

More information about our Governing Body is provided in the Members' Report and on our website.

Staff costs (subject to audit)

The CCG's staff costs are shown in the table below. These figures include employer costs. They also include remuneration for all Governing Body members.

	Permanent employees	Other	Total
Admin	£1,724,875	£0	£1,724,875
Programme	£358,344	£27,209	£385,553
Total			£2,110,428

Sickness absence data

NHS Nottingham North and East CCG recognises the valuable contribution made by each employee to the delivery of its services and is committed to the promotion of employee health, safety and wellbeing. We are committed to acting as a fair and reasonable employer dealing with employees who suffer ill health or incapacity either of a temporary or permanent nature in a fair and compassionate way.

We encourage the attendance of all employees throughout the working week but recognise that a certain level of absence may be unavoidable due to ill health or other reasons.

The table below shows staff sickness absence for 2016/17:

	2015/16 number of days	2016/17 number of days
Total days lost	101	78
Total staff years	50	24*
Average working days lost	2	3.3

*the sickness figures are received by NHS England, the CCG does not think this is an accurate reflection.

Staff policies

We proactively supported our commitment to employees who have a disability through:

- operating the guaranteed interview scheme for candidates with a disability meeting the essential criteria.

We are not aware of any of our employees becoming disabled during 2016/17.

Expenditure on consultancy

Department	Actual 2016/17
Collaborative commissioning	30,758.22
CEO/board office	16,537.48
Contract management	39,530.86
Finance	11,741.18
Patient and public involvement	28,635.60
Total 2016/17 spend	127,203.34

Off-payroll engagements

Following the *Review of Tax Arrangements of Public Sector Appointees* published by the chief secretary to the treasury on 23 May 2012, clinical commissioning groups must publish information on their highly paid and/or senior off-payroll engagements.

Between 1 April 2016 and 31 March 2017, the CCG had no new off-payroll engagements for more than £220 per day which lasted more than six months.

Off-payroll engagements longer than six months

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

	Number
Number of existing engagements as of 31 March 2017	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

New off-payroll engagements

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

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

Off-payroll engagements/senior official engagements

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

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	9*

*All on payroll engagements (not including employees).

Parliamentary accountability and audit report

NHS Nottingham North and East CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report.

Signature of the accountable officer

I certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the NHS Act 2006 (as amended).

Signed:

Sam Walters
Accountable Officer

26th May 2017

Appendix 1

Annual accounts & independent auditors report 2016/17

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The Primary Statements:

Notes to the Accounts

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

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(1,658)	(1,091)
Other operating income	2	(1,829)	(1,100)
Total operating income		**(3,487)**	**(2,191)**
Staff costs	4	2,922	2,646
Purchase of goods and services	5	203,353	196,035
Depreciation and impairment charges	5	0	0
Provision expense	5	(31)	19
Other Operating Expenditure	5	60	57
Total operating expenditure		**206,304**	**198,757**
Net Operating Expenditure		**202,817**	**196,566**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**202,817**	**196,566**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**202,817**	**196,566**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2017		**202,817**	**196,566**

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

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Non-current assets:			
Property, plant and equipment	13	0	0
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		**0**	**0**
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	2,209	1,490
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	11	47
Total current assets		**2,220**	**1,536**
Non-current assets held for sale	21	0	0
Total current assets		**2,220**	**1,536**
Total assets		**2,220**	**1,536**
Current liabilities			
Trade and other payables	23	(8,112)	(7,445)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(104)	(136)
Total current liabilities		**(8,217)**	**(7,581)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(5,997)**	**(6,045)**
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		**0**	**0**
Assets less Liabilities		**(5,997)**	**(6,045)**
Financed by Taxpayers' Equity			
General fund		(5,997)	(6,045)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(5,997)**	**(6,045)**

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

The financial statements on pages 1 to 27 were approved by the Audit and Governance Committee on 24th May 2017 and signed on its behalf by:

Chief Accountable Officer

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	(6,045)	0	0	**(6,045)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 01 April 2016	**(6,045)**	**0**	**0**	**(6,045)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating expenditure for the financial year	(202,817)			(202,817)
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 Year	**(202,817)**	**0**	**0**	**(202,817)**
Net funding	202,865	0	0	202,865
Balance at 31 March 2017	**(5,997)**	**0**	**0**	**(5,997)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16				
Balance at 01 April 2015	**(5,420)**	**0**	**0**	**(5,420)**
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 01 April 2015	**(5,420)**	**0**	**0**	**(5,420)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(196,566)			(196,566)
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 Year	**(196,566)**	**0**	**0**	**(196,566)**
Net funding	195,941	0	0	195,941
Balance at 31 March 2016	**(6,045)**	**0**	**0**	**(6,045)**

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

Statement of Cash Flows for the year ended 31 March 2017

	Note	**2016-17 £'000**	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(202,817)	(196,566)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(719)	(40)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	667	652
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	(31)	19
Net Cash Inflow (Outflow) from Operating Activities		**(202,901)**	**(195,936)**
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		**(202,901)**	(195,936)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		202,865	195,941
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		**202,865**	**195,941**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(36)**	**5**
Cash & Cash Equivalents at the Beginning of the Financial Year		**47**	**42**
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		**11**	**47**

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

1.1 **Going Concern**

These accounts have been prepared on the going concern basis

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

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

1.2 **Accounting Convention**

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

1.3 **Acquisitions & Discontinued Operations**

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

1.4 **Movement of Assets within the Department of Health Group**

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

1.5 **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.

1.6 **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.

1.6.1 ***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:

- Gross Accounting

The Clinical Commissioning Group has entered into an arrangement with the other Nottinghamshire Clinical Commissioning Groups in adopting Gross Accounting in relation to transactions between DH Group Bodies, except transactions deemed to be in the nature of a "recharge". This is consistent with the requirements contained within IAS 8.

- Maternity Pathway Costs

The Clinical Commissioning Group prepays out Maternity Pathway Costs which span the end of the Financial Year.

Notes to the financial statements

1.6.2 **Key Sources of Estimation Uncertainty**

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

· Partially Completed Spells

The Clinical Commissioning Group includes estimations for partially completed spells which span the end of the financial year. The provider produces activity information to the Clinical Commissioning Group on which to base the estimation value.

1.7 **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.

1.8 **Employee Benefits**

1.8.1 **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.

1.8.2 **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.

1.9 **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.

1.10. **Property, Plant & Equipment**

1.10.1 **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.

Notes to the financial statements

1.10.2 **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.

1.10.3 **Subsequent Expenditure**

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

1.11 **Intangible Assets**

1.11.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group's business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.11.2 **Measurement**

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Notes to the financial statements

1.13 **Donated Assets**

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 **Government Grants**

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 **Non-current Assets Held For Sale**

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 **Leases**

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

1.16.1 **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.

1.16.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17 **Private Finance Initiative Transactions**

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The clinical commissioning group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.17.1 **Services Received**

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.17.2 **PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

Notes to the financial statements

1.17.3 **PFI Liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.17.4 **Lifecycle Replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.17.5 **Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme**

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

1.18.6 **Other Assets Contributed by the Clinical Commissioning Group to the Operator**

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.18 **Inventories**

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

1.19 **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.

1.20. **Provisions**

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

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

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

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.21 **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.

1.22 **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.

1.23 **Continuing healthcare risk pooling**

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

1.24 **Carbon Reduction Commitment Scheme**

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

Notes to the financial statements

1.25 **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.

1.26 **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.

1.26.1 **Financial Assets at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.26.2 **Held to Maturity Assets**

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.26.3 **Available For Sale Financial Assets**

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

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1.26.4 **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.

1.27 **Financial Liabilities**

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

1.27.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.27.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Notes to the financial statements

1.27.3 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.28 **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.

1.29 **Foreign Currencies**
The clinical commissioning group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

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

1.31 **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).

1.32 **Subsidiaries**

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.
Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.33 **Associates**
Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 **Joint Ventures**
Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 **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.

1.36 **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.

1.37 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Other Operating Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	40	0	40	13
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	1,658	48	1,610	1,091
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	1,789	5	1,784	1,088
Total other operating revenue	**3,487**	**53**	**3,434**	**2,191**

3 Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
From rendering of services	3,487	53	3,434	2,191
From sale of goods	0	0	0	0
Total	**3,487**	**53**	**3,434**	**2,191**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2016-17	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	2,328	2,294	33	1,819	1,819	0	508	475	33
Social security costs	276	276	0	231	231	0	45	45	0
Employer Contributions to NHS Pension scheme	318	318	0	261	261	0	57	57	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,922**	**2,889**	**33**	**2,312**	**2,312**	**0**	**611**	**577**	**33**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,922**	**2,889**	**33**	**2,312**	**2,312**	**0**	**611**	**577**	**33**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,922**	**2,889**	**33**	**2,312**	**2,312**	**0**	**611**	**577**	**33**

2015-16	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	2,142	2,085	57	1,912	1,909	3	231	176	54
Social security costs	210	210	0	180	180	0	30	30	0
Employer Contributions to NHS Pension scheme	294	294	0	248	248	0	46	46	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,646**	**2,589**	**57**	**2,340**	**2,337**	**3**	**307**	**252**	**54**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,646**	**2,589**	**57**	**2,340**	**2,337**	**3**	**307**	**252**	**54**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,646**	**2,589**	**57**	**2,340**	**2,337**	**3**	**307**	**252**	**54**

4.1.2 Recoveries in respect of employee benefits

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

4.2 Average number of people employed

	Total Number	**2016-17 Permanently employed Number**	**Other Number**	2015-16 Total Number
Total	**52**	**51**	**1**	**48**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Staff sickness absence and ill health retirements

	2016-17 Number	2015-16 Number
Total Days Lost	101	78
Total Staff Years	50	24
Average working Days Lost	**2**	**3**

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

Ill health retirement costs are met by the NHS Pension Scheme.

4.4 Exit packages agreed in the financial year

	2016-17 Compulsory redundancies		**2016-17 Other agreed departures**		**2016-17 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	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**

	2015-16 Compulsory redundancies		**2015-16 Other agreed departures**		**2015-16 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	0	0	3	20,448	3	20,448
£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**	**3**	**20,448**	**3**	**20,448**

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

Analysis of Other Agreed Departures

	2016-17 Other agreed departures		2015-16 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	3	20,448
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**3**	**20,448**

4.5 Pension costs

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

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

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

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

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their 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 appropriate employee and employer representatives as deemed appropriate.

For 2016-17, employers' contributions of £318,400 were payable to the NHS Pensions Scheme (2015-16: £293,600) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay.

5. Operating expenses

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	2,677	2,067	611	2,161
Executive governing body members	245	245	0	486
Total gross employee benefits	**2,922**	**2,312**	**611**	**2,647**
Other costs				
Services from other CCGs and NHS England	19,503	84	19,419	16,272
Services from foundation trusts	32,357	0	32,357	31,013
Services from other NHS trusts	83,573	32	83,541	79,210
Services from other WGA bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	23,552	0	23,552	22,927
Chair and Non Executive Members	0	0	0	0
Supplies and services – clinical	0	0	0	0
Supplies and services – general	1,407	36	1,371	3,228
Consultancy services	127	96	31	126
Establishment	520	161	359	658
Transport	3	2	1	40
Premises	1,085	104	981	1,132
Impairments and reversals of receivables	6	6	0	1
Inventories written down and consumed	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	45	45	0	54
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	23,066	0	23,066	22,671
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	17,709	0	17,709	17,924
Other professional fees excl. audit	105	105	0	24
Grants to Other bodies	0	0	0	0
Clinical negligence	1	1	0	1
Research and development (excluding staff costs)	9	0	9	13
Education and training	14	13	0	38
Change in discount rate	0	0	0	0
Provisions	(31)	0	(31)	19
Funding to group bodies		0	0	0
CHC Risk Pool contributions	287	0	287	718
Other expenditure	44	12	33	42
Total other costs	**203,382**	**698**	**202,684**	**196,111**
Total operating expenses	**206,304**	**3,010**	**203,295**	**198,758**

6.1 Better Payment Practice Code

Measure of compliance	**2016-17 Number**	**2016-17 £'000**	2015-16 Number	2015-16 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	2,622	45,035	1,815	34,819
Total Non-NHS Trade Invoices paid within target	2,611	45,028	1,805	34,680
Percentage of Non-NHS Trade invoices paid within target	**99.58%**	**99.98%**	**99.45%**	**99.60%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,012	140,805	1,953	127,247
Total NHS Trade Invoices Paid within target	2,007	140,783	1,906	126,866
Percentage of NHS Trade Invoices paid within target	**99.75%**	**99.98%**	**97.59%**	**99.70%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no late payments of commercial debt during the year (15/16: £nil).

7 Income Generation Activities

There were no Income Generation Activities during the year (15/16: £nil).

8. Investment revenue

There were no Investment Income during the year (15/16: £nil).

9. Other gains and losses

There were no Other Gains and Losses during the year (15/16: £nil).

10. Finance costs

There were no Finance Costs during the year (15/16: £nil).

11. Net gain/(loss) on transfer by absorption

Transfers as part of a 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.

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense	**Land**	**Buildings**	**Other**	**2016-17 Total**	Land	Buildings	Other	2015-16 Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	0	1,077	0	1,077	0	1,113	0	1,113
Contingent rents	0	0	0	0	0	0	0	0
Sub-lease payments	0	0	0	0	0	0	0	0
Total	**0**	**1,077**	**0**	**1,077**	**0**	**1,113**	**0**	**1,113**

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

12.1.2 Future minimum lease payments	**Land**	**Buildings**	**Other**	**2016-17 Total**	Land	Buildings	Other	2015-16 Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	0	0	0	0	0	-	-	0
Between one and five years	0	0	0	0	0	-	-	0
After five years	0	0	0	0	0	-	-	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

12.2 As lessor

12.2.1 Rental revenue	**2016-17**	2015-16
	£'000	£'000
Recognised as income		
Rent	0	0
Contingent rents	0	0
Total	**0**	**0**

12.2.2 Future minimum rental value	**2016-17**	2015-16
	£'000	£'000
Receivable:		
No later than one year	0	0
Between one and five years	0	0
After five years	0	0
Total	**0**	**0**

13 Property, plant and equipment

The CCG has no property, plant and equipment at the year end (15/16: £nil).

14 Intangible non-current assets

The CCG has no intangible non-current assets at the year end (15/16: £nil).

15 Investment property

The CCG has no Investment Property at the year end (15/16: £nil).

16 Inventories

The CCG has no Inventories at the year end (15/16: £nil).

17 Trade and other receivables	Current 2016-17 £'000	Non-current 2016-17 £'000	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS receivables: Revenue	517	0	562	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	1,224	0	572	0
NHS accrued income	176	0	136	0
Non-NHS and Other WGA receivables: Revenue	166	0	159	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	88	0	22	0
Non-NHS and Other WGA accrued income	38	0	22	0
Provision for the impairment of receivables	(6)	0	(1)	0
VAT	6	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	**2,209**	**0**	**1,490**	**0**
Total current and non current	**2,209**		**1,490**	
Included above:				
Prepaid pensions contributions	0		0	

17.1 Receivables past their due date but not impaired	2016-17 £'000	2015-16 £'000
By up to three months	52	198
By three to six months	7	0
By more than six months	1	1
Total	**60**	**199**

£3k of the amount above has subsequently been recovered post the statement of financial position date.

17.2 Provision for impairment of receivables	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	(1)	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	(5)	(1)
Transfer (to) from other public sector body	0	0
Balance at 31 March 2017	**(6)**	**(1)**

	2016-17 £'000	2015-16 £'000
Receivables are provided against at the following rates:		
NHS debt	0	0

18 Other financial assets

The CCG has no Other Financial Asssets at the year end (15/16: £nil).

19 Other current assets

The CCG has no Other Current Asssets at the year end (15/16: £nil).

20 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	47	42
Net change in year	(36)	5
Balance at 31 March 2017	**11**	**47**
Made up of:		
Cash with the Government Banking Service	11	47
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	**11**	**47**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2017	**11**	**47**
Patients' money held by the clinical commissioning group, not included above	0	0

21 Non-current assets held for sale

The CCG has no Non-Current Assets held for sale at the year end (15/16: £nil).

22 Analysis of impairments and reversals

The CCG has no impairments and reversals during the year (15/16: £nil).

23 Trade and other payables	**Current 2016-17 £'000**	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
Interest payable	0	0	0	0
NHS payables: revenue	1,249	0	994	0
NHS payables: capital	0	0	0	0
NHS accruals	1,131	0	1,139	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	3,697	0	4,549	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	714	0	652	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	38	0	33	0
VAT	0	0	0	0
Tax	36	0	41	0
Payments received on account	0	0	0	0
Other payables and accruals	1,247	0	37	0
Total Trade & Other Payables	**8,112**	**0**	**7,445**	**0**
Total current and non-current	**8,112**		**7,445**	

Other payables include £170,000 outstanding pension contributions at 31 March 2017 (15/16: £44k).

24 Other financial liabilities

The CCG has no Other Financial Liabilities at the year end (15/16: £nil)..

25 Other liabilities

The CCG has no Other Liabilities at the year end (15/16: £nil).

26 Borrowings

The CCG has no Borrowings at the year end (15/16: £nil).

27 Private finance initiative, LIFT and other service concession arrangements

The CCG has no Private Finance Initiative, LIFT or other service concession arrangements at the year end (15/16: £nil).

28 Finance lease obligations

The CCG has no Finance Lease Obligations at the year end (15/16: £nil).

29 Finance lease receivables

The CCG has no Finance Lease Receivables at the year end (15/16: £nil).

30 Provisions

	Current 2016-17 £'000	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	104	0	136	0
Other	0	0	0	0
Total	**104**	**0**	**136**	**0**
Total current and non-current	**104**		**136**	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**136**	**0**	**136**
Arising during the year	0	0	0	0	0	0	0	0	0	0
Utilised during the year	0	0	0	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	0	0	0	(31)	0	(31)
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	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	0
Transfer (to) from other public sector body under absorption	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**104**	**0**	**104**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	104	0	104
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**104**	**0**	**104**

31 Contingencies

Contingent liabilities	**2016-17 £'000**	2015-16 £'000
Mental Health risk share	164	0
	164	**0**

32 Commitments

32.1 Capital commitments

	2016-17 £'000	2015-16 £'000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	**0**	**0**

32.2 Other financial commitments

The NHS Clinical Commissioning Group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2016-17 £'000	2015-16 £'000
In not more than one year	0	0
In more than one year but not more than five years	0	0
In more than five years	0	0
Total	**0**	**0**

33 Financial instruments

33.1 Financial risk management

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

Because 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.

33.1.1 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.

33.1.2 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.

33.1.3 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.

33.1.3 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.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	693	0	693
· Non-NHS	0	203	0	203
Cash at bank and in hand	0	11	0	11
Other financial assets	0	0	0	0
Total at 31 March 2017	**0**	**908**	**0**	**908**

	At 'fair value through profit and loss' 2015-16 £'000	Loans and Receivables 2015-16 £'000	Available for Sale 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	698	0	698
· Non-NHS	0	182	0	182
Cash at bank and in hand	0	47	0	47
Other financial assets	0	0	0	0
Total at 31 March 2016	**0**	**926**	**0**	**926**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,380	2,380
· Non-NHS	0	5,488	5,488
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**7,869**	**7,869**

	At 'fair value through profit and loss' 2015-16 £'000	Other 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,133	2,133
· Non-NHS	0	5,195	5,195
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2016	**0**	**7,328**	**7,328**

34 Operating segments

The Clinical Commisisoning Group and consolidated group consider they have only one segment: Commisisoning of Healthcare Services

35 Pooled budgets

The Clinical Commissioning Group entered into a pooled budget arrangement for Integrated Community Equipment schemes om 1st April 2014 ending 31st March 2015 with Nottinghamshire county Council. Under the arrangements funds are pooled under section 75 of the NHS Act for Integrated Community Equipment Scheme activities.

The Pool is hosted by Nottinghamshire County Council. As a Commissioner of Healthcare Services, the Clinical Commissioning Group makes contributiuons to the pool. The Memorandum Account for the Pooled Budget is:

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	**110**	**94**
Income:		
Nottinghamshire County Council ASCH&PP	1,527	1,966
Nottinghamshire County Council CFCS	249	283
Nottinghamshire City Council ASCH & CYP	1,111	1,310
Bassetlaw CCG	477	419
Nottingham City CCG	1,154	1,289
Nottinghamshire County CCG's	2,937	2,655
Continuing Health care funding	210	233
Other income	82	-2
Total income	**7,857**	**8,247**
Expenditure:		
Partnership Management & Administration costs	615	536
Contract Management Fee	1,264	1,410
ICES Equipment	4,985	5,515
Continuing Healthcare Specialist Equipment	252	250
Minor Adaptations	210	419
Direct Payments	3	6
Total expenditure	**7,328**	**8,137**
Balance at 31 March 2017	**529**	**110**

The Better Care Fund (BCF) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care.
In 2015/16, the first year of the BCF, an additional £1.1bn was transferred from NHS England Area Teams for former Section 256 schemes to Clinical Commissioning Groups to create the total fund at £3.8bn. In 2016/17, the second year of the fund, the Clinical Commissioning Group contributed the value in the table below towards creation of a Better Care Fund pooled fund in Nottinghamshire of £56.130m.
Assessment of the operation of the Better Care Fund pooled fund identified that it does not constitute a joint arrangement and therefore the requirements of IFRS11 are not met and does not satisfy the criteria of a pooled budget.

2016-17	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
	NHS Bassetlaw	**NHS Mansfield & Ashfield**	**NHS Newark & Sherwood**	**NHS Nottingham North & East**	**NHS Nottingham West**	**NHS Rushcliffe**	**Nottinghamshire County Council**	**Total**
Balance b/f	0.0	0.0	0.0	0.0	0.0	0.0	1,672.0	1,672.0
Underspend from 15/16							-85.0	-85.0
Net	0.0	0.0	0.0	0.0	0.0	0.0	1,587.0	1,587.0
Contributions to the fund	7,554.5	12,597.0	8,019.7	9,243.7	6,265.8	6,974.0	5,475.4	56,130.0
Payments received from the fund	4,679.5	7,797.0	5,105.7	5,354.8	3,417.1	4,026.2	25,749.7	56,130.0
Scheme Expenditure								
CCG schemes	4,679.5	7,797.0	5,105.7	5,354.8	3,417.1	4,026.2		30,380.3
Protecting Social care							16,445.0	16,445.0
Disabled Facilities Grants							5,475.4	5,475.4
Care Act Implementation							386.0	386.0
Other LA Schemes							1,665.9	1,665.9
Total Scheme Expenditure	4,679.5	7,797.0	5,105.7	5,354.8	3,417.1	4,026.2	23,972.3	54,352.5
Net balance 2016/17	0.0	0.0	0.0	0.0	0.0	0.0	1,777.4	1,777.4
Balance c/f	0.0	0.0	0.0	0.0	0.0	0.0	3,364.4	3,364.4

2015-16	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
	NHS Bassetlaw	**NHS Mansfield & Ashfield**	**NHS Newark & Sherwood**	**NHS Nottingham North & East**	**NHS Nottingham West**	**NHS Rushcliffe**	**Nottinghamshire County Council**	**Total**
Balance b/f	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Contributions to the fund	7,532.0	14,274.0	8,769.0	9,115.0	6,180.0	6,780.0	5,168.0	57,818.0
Payments received from the fund	4,736.0	9,552.0	5,973.0	5,059.0	3,249.0	3,880.0	25,369.0	57,818.0
Scheme Expenditure								
CCG schemes	4,736.0	9,552.0	5,973.0	5,059.0	3,249.0	3,880.0		32,449.0
Protecting Social care							16,167.0	16,167.0
Disabled Facilities Grants							3,204.0	3,204.0
Care Act Implementation							357.5	357.5
Other LA Schemes							3,968.5	3,968.5
Total Scheme Expenditure	4,736.0	9,552.0	5,973.0	5,059.0	3,249.0	3,880.0	23,697.0	56,146.0
Net balance 2015/16	0.0	0.0	0.0	0.0	0.0	0.0	1,672.0	1,672.0
Balance c/f	0.0	0.0	0.0	0.0	0.0	0.0	1,672.0	1,672.0

36 NHS Lift investments

The CCG has no NHS LIFT investments at the year end (15/16: £nil).

37 Related party transactions

Details of related party transactions with individuals are as follows:

IAS 24 applies to material transactions between NHS bodies and related parties. Related Party transactions for the CCG relate to payments made to GP Practices which have a GP who sits on the CCG Governing Body.

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
Park House Medical Centre	1,069	0	28	0
Stenhouse Medical Centre	1,360	0	55	0
The Calverton Practice	1,190	0	51	0
The Ivy Medical Group	513	0	17	0
Trentside Medical Group	1,241	0	49	0
The Peacock Practice	639	0	65	0

Details of related party transactions with other bodies are as follows:

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

• NHS England;	20,374	1,458	1,078	709
• NHS Foundation Trusts;	32,414	305	1,075	22
• NHS Trusts;	83,743	177	227	1,186
• Health Education England	0	0	0	0
• NHS Special Health Authorities	4	0	0	0
• NHS Property Services/Community Health Partnerships	1,079	0	0	0

38 Events after the end of the reporting period

There are no events after the end of the reporting period.

39 Third party assets

The CCG held no Third Party Assets (15/16: £nil).

40 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2016-17 Target	**2016-17 Performance**	2015-16 Target	2015-16 Performance
Expenditure not to exceed income	210,192	206,304	200,558	198,757
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	206,705	202,817	198,368	196,566
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	3,422	2,957	3,228	2,913

41 Impact of IFRS

There has been no impact of IRFS on the CCG during the year (15/16: £nil).

42 Analysis of charitable reserves

The CCG held no Charitable Reserves (15/16: £nil).

43 Losses and special payments

43.1 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 2016-17 Number	**Total Value of Cases 2016-17 £'000**	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £'000
Administrative write-offs	1	6	0	0
Fruitless payments	0	0	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**	**6**	**0**	**0**

43.2 Special payments

	Total Number of Cases 2016-17 Number	**Total Value of Cases 2016-17 £'000**	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	0	0	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**0**	**0**	**0**	**0**

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

We have audited the financial statements of NHS Nottingham North & East CCG for the year ended 31 March 2017 on pages 1 to 27 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Members of the Governing Body of NHS Nottingham North & East CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2104. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on pages 75 to 77, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

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

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

Scope of the audit of the financial statements

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

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

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

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

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

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

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on regularity

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

Opinion on other matters

In our opinion the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

We report to you if, in our opinion, the parts of the Remuneration and Staff Report subject to audit have not been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

In our opinion the parts of the Remuneration and Staff Report subject to audit have not been properly prepared in accordance with the relevant requirements because the CCG has decided not to include the pension figures for all of its senior managers. The reasons for this judgement are disclosed in the Remuneration and Staff Report on page 134.

Matters on which we are required to report by exception

We are required to report to you if:

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

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

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

Certificate

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

Tony Crawley
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
31 Park Row
Nottingham
NG1 6FQ

30 May 2017

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