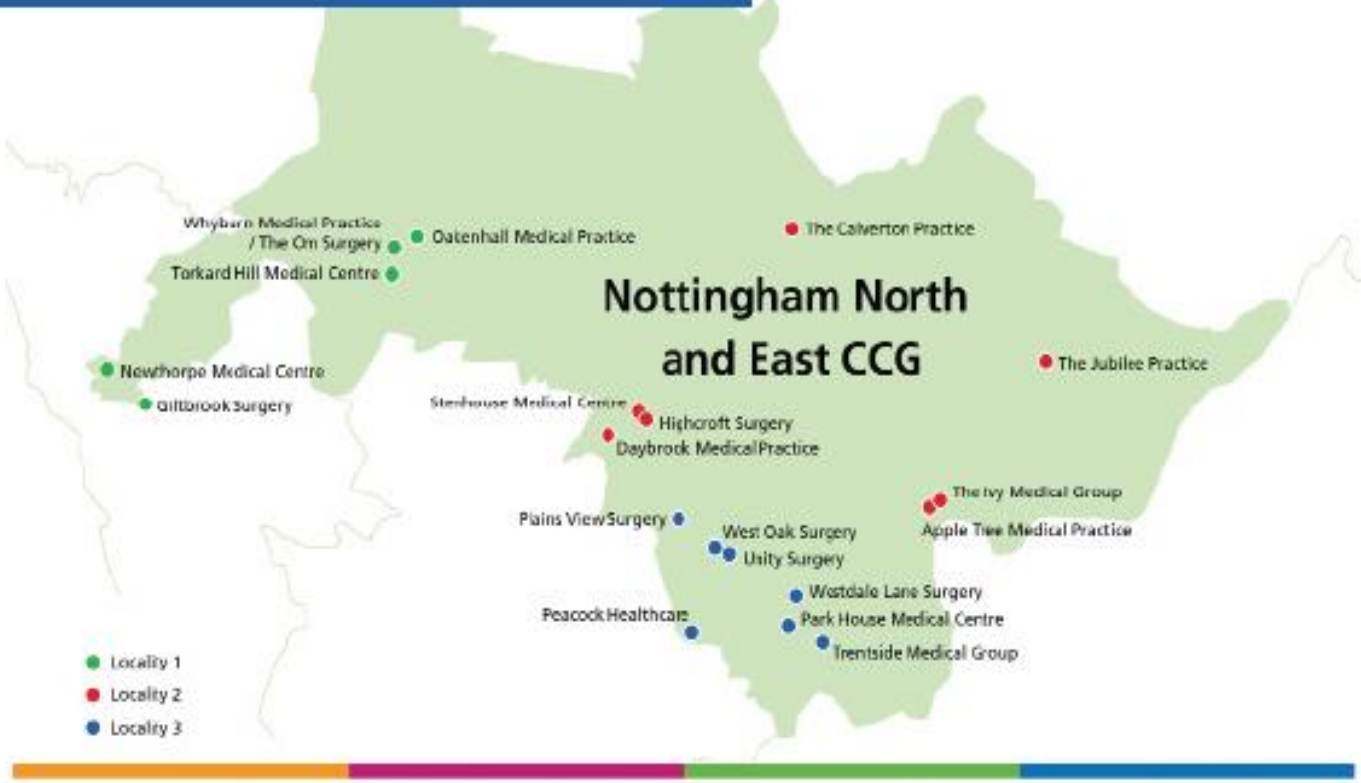
NHS
Nottingham North and East
Clinical Commissioning Group

Our Annual Report and Accounts 2017/18



NHS Nottingham North and East Clinical Commissioning Group Annual Report 2017/18

This is the Annual Report and Accounts for NHS Nottingham North and East Clinical Commissioning Group 2017/18. It includes information about the organisation and its activities during 2017/18.

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

For more details about any of the information included within this document please contact us:

Nottingham North and East Clinical Commissioning Group
Civic Centre
Arnot Hill Park
Arnold
Nottingham
NG5 6LU

Tel: 0115 883 1838

Email: nnest.enquiries@nhs.net

Website: www.nottinghamnortheastccg.nhs.uk

Twitter: @NHSNNE

Contents

Performance report

This document fulfils our duty to produce an annual report on how we have discharged our functions in 2017/18. It also highlights our achievements, as well as the challenges faced during 2017/18.

The form and content of this report has been agreed with the CCG's Audit and Governance Committee 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 the Annual Report and Accounts 2017/18 for NHS Nottingham North and East Clinical Commissioning Group (CCG)

The last 12 months have been characterised by intense preparation to ensure we are well placed to meet the significant challenges within the health and care system.

This year has been one of the most challenging for the NHS, in Nottinghamshire and nationally. The financial pressures we face are unprecedented, and are driven by continued growth and demand on hospital, and continuing healthcare services.

Despite these challenges, the CCG met all of its financial duties and we will continue to work on achieving further efficiencies. Our savings target (QIPP) increased to £12m this year, making the financial environment extremely challenging. Although we remain in formal financial recovery the development of the Greater Nottingham Financial Recovery Plan for 2017/18 provides a strong foundation for further work. There is more detail on this later in the report.

During 2017/18, the CCG continued to perform well, meeting or exceeding all the national targets for dementia diagnosis, the 18 weeks referral to treatment target and cancer services, including the number of patients with suspected cancer being seen by a consultant within 14 days and receiving their first treatment within 31 days following diagnosis. However, performance against waits in A&E continued to be below target.

We are constantly seeking to improve the quality of services we commission and have robust harm review processes and metrics to provide assurance in relation to quality impacts where operational performance is not achieved

Nottingham North and East has performed well in terms of the quality and safety of primary care services with 100% of our GP practices having achieved a CQC rating 'Good' or 'Good*' This achievement reflects the hard work and dedication of our doctors and their staff.

The journey towards an Integrated Care System (ICS) has been a key driver this year prompting changes to our governance arrangements. The Governing Bodies of the four Greater Nottingham CCGs have agreed to establish a Joint Committee with

delegated responsibilities for those work programmes and decisions which are best taken at Greater Nottingham level. The Joint Committee will be operational from April 2018, subject to NHS England approval.

Nottingham and Nottinghamshire are already among the leading areas in the country in terms of working together to provide better quality care by joining up GP, community, mental health, hospital and social care services. However, in order to deliver sustainable high-quality care to the populations we serve, we need to look beyond our own organisational boundaries to ensure we get the best value from sharing resources. This year, we began the process to align the four CCGs in Greater Nottingham and form a single staffing/ management structure.

I would like to thank our CCG staff during this transitional period for their professionalism and commitment. I would also like to thank our member practices and partners for their ongoing dedication and commitment; and our patients and communities who give their free time to help us develop our services.

Samantha Walters

Chief Officer

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 152,374. 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 accountable 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

This year the four Greater Nottingham CCGs, NHS Nottingham City, NHS Nottingham North and East, NHS Nottingham West and NHS Rushcliffe made the decision to come together under a single management structure and to establish a joint committee with delegated responsibilities for commissioning arrangements including work programmes and decisions which are best taken at Greater Nottingham level.

This commitment for joint working is driven by a range of factors but the focused work to develop an Integrated Care System (ICS) is a key reason for change. The CCGs will transition to the Greater Nottingham Clinical Commissioning Partnership early in 2018/19 once approved by NHS England.

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

Nottingham North and East (NNE) has a registered population of 152,374 (NHS Digital, 2016). Our population has a higher proportion of working age and older adults, with 25-64 year olds and over 65 year olds representing 52.6% and 19.1% of the population respectively. The proportion of over 65 year olds is 8.5% greater than

that of England average of 17.6%. The proportion of the 25-64 year olds is 1.15% higher than England's average of 52%. Conversely, the proportions of 0-15 year olds and 16-24 year olds is lower (ONS, 2014). See figure 1 for a representation of the age structure of the NNE population.

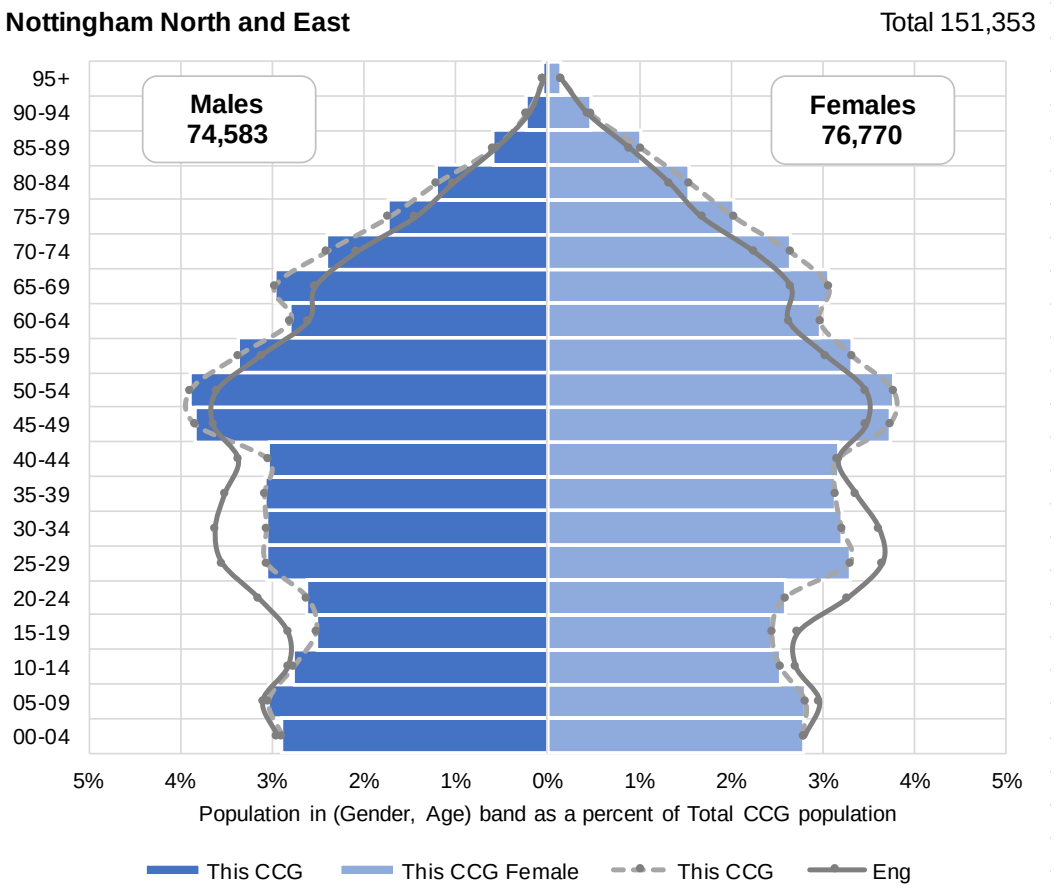


Figure 1. Population pyramid for NNE (NHS Digital, 2016)

Deprivation and Health Inequalities

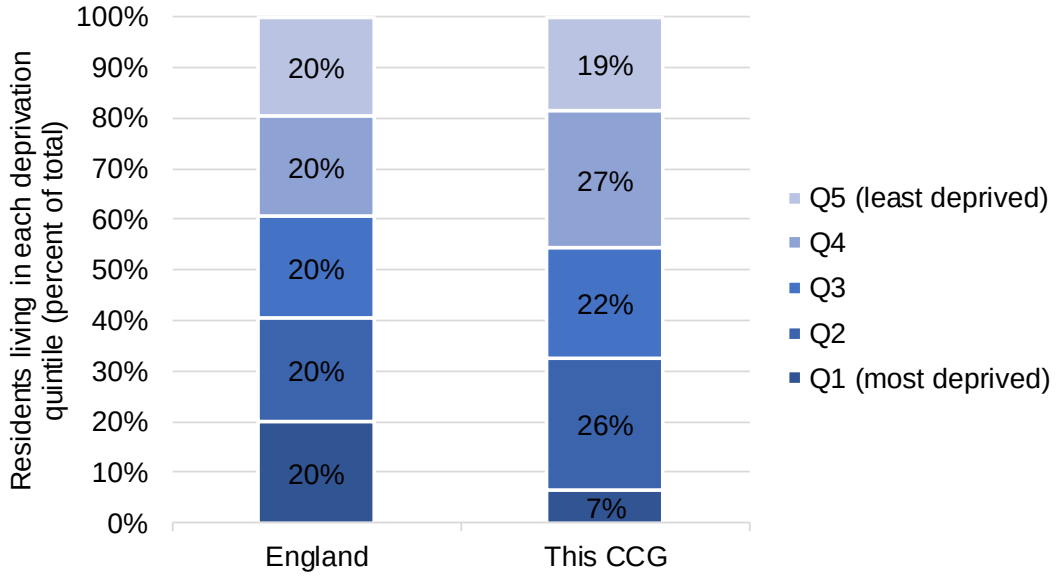
In terms of deprivation and its IMD score (Index of Multiple Deprivation), NNE, with a score of 17, is better than the England average of 22 (England worst 51, best 6). This is reflected in many health and wellbeing indicators that will follow (Nottinghamshire Insight/DCLG, 2015).

Unemployment stands at 1.6% compared to the 1.8% England average (NOMIS, 2017).

Overcrowding stands at 3.9% compared to the 8.7% England average (ONS Census, 2011).

The proportion of children in low income families stands at 17.2% compared to the 18.6% England average (PHE/Local Government Association, 2013).

Figure 2 highlights the differences in deprivation between NNE and England, and Figure 3 shows a map of the CCG area with colour coded indices of deprivation.



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

Figure 2. Population living in national deprivation quintiles

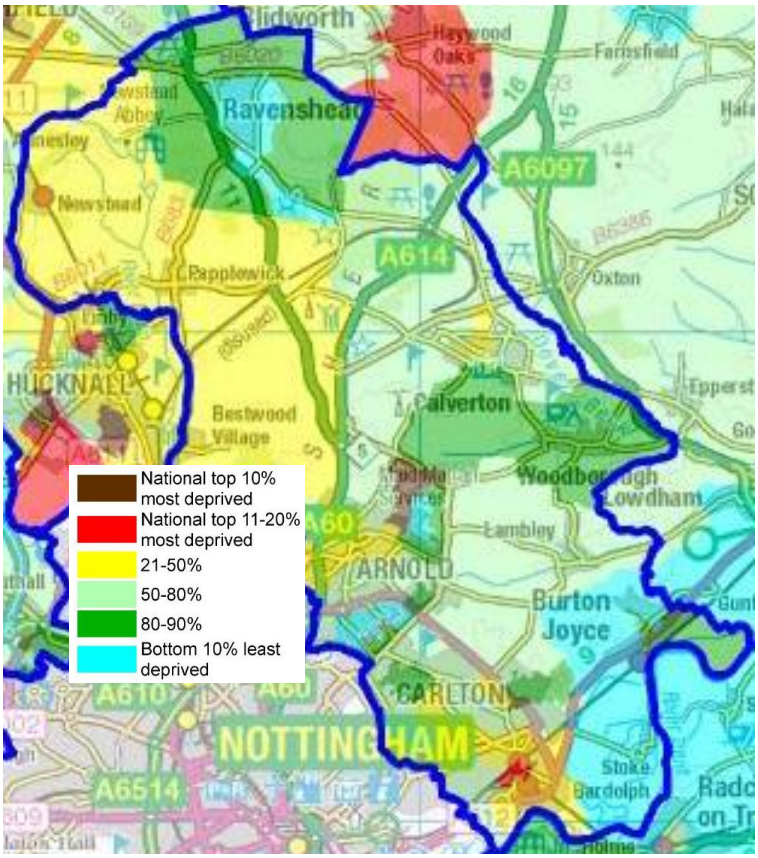


Figure 3. Map of Deprivation – national ranking of super output area (Nottinghamshire Insight, 2015)

The charts below show life expectancy for men and women in the local authority (Gedling) which makes up the largest proportion of the registered population. Each chart is divided into deciles (tenths) by deprivation, 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. Life expectancy is 8.4 years lower for men and 7.6 years lower for women in the most deprived areas of Gedling than in the least deprived areas (PHE Fingertips/DCLG 2015).

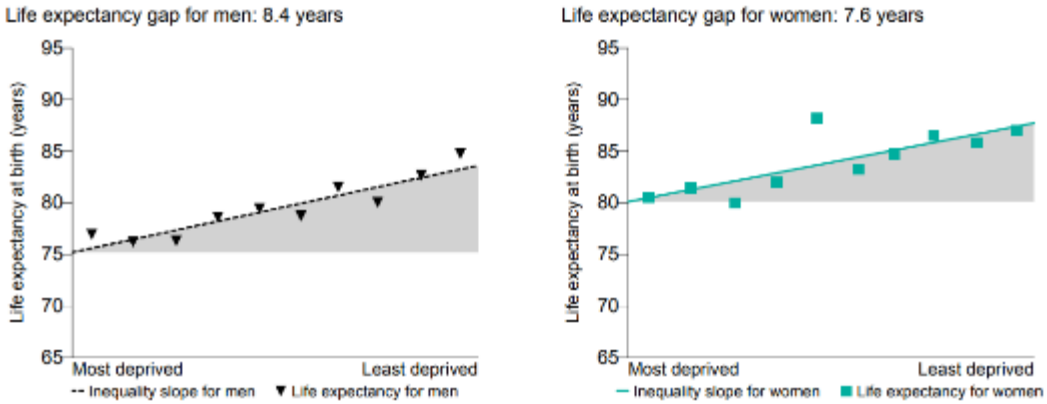


Figure 4. Inequalities: Life Expectancy versus Deprivation

Health conditions and health inequalities

As expected with lower levels of deprivation, NNE displays mostly good health outcomes as compared to the England average.

Notably, emergency hospital admissions for all causes are low with a standardised admissions ratio (SAR) of 92.6 compared to the 100 England average (HES, 2016).

Emergency admissions in children under 5s stand at 8.9% compared to the 14.9% England average (HES, 2016).

Hospital admissions for injuries in under 5s and under 15s stand at 91 and 71 compared to the 139 and 108 England averages respectively (rate per 10, 000, HES, 2016).

Hospital admissions for asthma in children under 19 years stand at 64 compared to the 198.6 England average (rate per 100,000, HES, 2015).

The rate of obesity in children of 10-11 years is low at 17.1% compared to the 26.9% England average (National Child Measurement Programme/NHS Digital, 2015).

However, numbers for registered patients with a limiting long term illness or disability are high, standing at 19.5% compared to the 17.6% England average (ONS Census, 2011).

Incidence of prostate cancer is also high, with a standardised incidence ratio (SIR) of 109 compared to the 100 England standard (PHE/NCIN 2015).

Elective hospital admissions for knee replacement are high, with a standardised admissions ratio (SAR) of 116 compared to the 100 England standard (HES, 2016).

Deaths from all causes and in all ages are also high, with a standardised mortality ratio (SMR) of 104.7 compared to the 100 England standard (PHE/ONS, 2015).

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.

Key risks include the following:

The CCG is unable to deliver against plan due to continually increasing activity, unexpected costs and an inability to maintain QIPP savings.

The fragility of the system impacts on the capability of the CCG to deliver against its financial duties.

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.

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.

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.

There is a risk that pressures and fragility within the system impact on the CCG's capability to deliver against targets.

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 services.

Due to the CCG alignment, turnaround and other major priorities, maintaining grip at an NNE level may be compromised impacting on the short term priorities and delivering as a CCG.

Lack of succession planning in the leadership team and the Governing Body impacts on the capability to evidence robust leadership.

There is a risk that the urgent requirements to support financial recovery becomes the dominant force therefore impacting on decisions being made and a resultant failure to deliver transformational change.

Key issues over the year relate to the Treatment Centre procurement, A&E performance, the cyber attack, primary care services, financial pressures.

More details on key risks and issues 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 2017/18. 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	95%	95.12%
A&E 4 Hour Standard	95%	84.01%
Last Minute Cancelled Elective Operations – 28 day rebooking (Nottingham University Hospitals)	0	24
CCG IAF Six Priority Areas		
Cancer 2 Week Wait	93%	94.82%
Cancer diagnosis and treatment commencement within 62 days	85%	85.80% (normal 62d)
Dementia Diagnostic Rate	67%	71.69%
Maternal Smoking at Delivery	10.4%	12.3%
Quality and Patient Experience		
Clostridium difficile	43	32 Cases
MRSA Blood Stream Infection (BSI)	0	0 Cases
Financial Performance		
Keep within revenue resource limit	£216,418,000	✓
Achieve planned surplus	177,000	✓
Cash balances within agreed limit	<£273,600	✓
Remain within running cost allowance	£3,242,000	✓
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

Personal health budgets and integrated personal commissioning (IPC)

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.

Nottinghamshire IPC has far exceeded the target set by NHS England of 707 personal health/integrated budgets by March 2018. At the end of Q 3 across all 5 CCGs we have a total of 2048 budgets. The majority of the budgets are being achieved through the offer of a personal health budget to give carers a break from their caring role.

Our current efforts are focussed on increasing our integrated budgets to people who have joint funding from health and social care. This is being achieved through setting health and social care staff a 90 Day Challenge to undertake integrated support planning and budgets. This resulted in: positive joint working between health and social care, with workers reporting “they enjoyed it” and good feedback from service users on the approach. Thirty integrated support plans and budgets have been put in place. The next challenge is how to scale up the approach across Nottinghamshire, so that everyone with a joint funded budget has an IPC approach.

Protected characteristics and health inequalities

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 of death 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.

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, the acute hospital trusts and local authorities 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 North and East CCG along with, 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 2017/18 has included further development of an action plan to support the commitment to the five pledges within the charter.

During 2017/18 the CCG has worked with stakeholders to improve services which have had a direct impact on patients of protected characteristics in a positive way, some of the successes include:

- Identification of a CCG Autism Champion
- Reduction of smoking prevalence in pregnancy from 11.9% to 10.7%
- Cancer screening initiative for adults with a learning disability

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.

Equality Impact Assessment (EQIA)

A process has been introduced that brings together equality and quality impact considerations into a single Equality and Quality Impact Assessment (EQIA). This provides a streamlined process and prevents equality and quality risks from being considered in isolation.

The EQIA is an assessment of whether proposed changes could have a positive, negative or neutral impact on people's different protected characteristics, as defined by the Equality Act 2010. It also considers the impacts on people from relevant inclusion health groups (e.g. carers, homeless people, people experiencing economic or social deprivation).

The EQIA also assesses impacts in line with the CCGs' duty to maintain and improve the three elements of quality (patient safety, patient experience and clinical effectiveness) and considers the following:

- Access to services (including patient choice)
- Transfers between services (whether between specialities, care settings, or during a person's life course)
- Safeguarding adults
- Safeguarding children
- Dignity and respect (including privacy)
- Person-centred care
- NICE requirements
- Shared decision-making
- Health inequalities

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.

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 highlighted that BME staff were under-represented at senior levels, band 9 and VSM and at Governing Body voting level.

The E&D Forum has reviewed the WRES reports completed by providers and has actively monitored action plans.

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. Following the grading, equality objectives and an action plan were set collectively for the individual organisations. Since that time the Forum completed a further self-assessment of the EDS2 supported by a patient engagement event and agreed the following objectives for 2017/18:

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

Patient and public communications and engagement report 2017/18

How we involve the patients and the public

Patients are at the heart of everything we do and it's important that they are involved not just in decisions about their care, but also in the decisions that shape the health services delivered locally.

Communicating and engaging with our patients and local people is central to achieving our aims to deliver the health services Greater Nottingham patients' need, within the funding available to us.

During 2017/18, 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 and examples of this can be found in each of the Greater Nottingham CCG Annual Reports

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.

We also strive to engage with hard to reach groups. We work in partnership with Healthwatch, our neighbouring CCGs in Nottinghamshire, community health providers 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. We also measure all our equalities and diversity data from patient engagement campaigns.

2017/18 was an unusual year as we faced two periods of purdah resulting in the need to carefully consider how to manage new communications and engagement campaigns. As a result, we used this time to ensure our engagement and communications principles and processes were robust enough to face the level of service change we expect to be implementing in 2018/19 through our financial recovery programme.

This was also the year when we started the conversation with the Greater Nottingham public around the aims and objectives of the Greater Nottingham Transformation Partnership - more detail about which can be found below.

Our processes

In 2017/18, we implemented an updated and robust EQIA process across the Greater Nottingham patch. In response to the Financial recovery Plan, this EQIA process has been invaluable particularly when assessing QIPP and financial recovery schemes.

The approach has been to manage the communications and engagement on a scheme-by-scheme basis, with a consistent approach applied each time, starting with a screening process.

The process for determining the scale of communications and engagement work required has been based on the following:

- The **scale** of the change
- The **impact** of the change on patients
- The likely level of **controversy**

Schemes broadly fall into one of three categories of approach depending on the above factors. These are:

- Informing – Communicating the changes to people
- Engaging – Targeted engagement with affected people or their representatives
- Consulting – Formal consultation with affected groups and the wider public

Commissioners must ensure that arrangements for involvement are fair and proportionate. The Gunning Principles have been applied in assessing the category of involvement. This process has meant that we have a robust engagement approach to our Greater Nottingham QIPP and financial recovery schemes.

Greater Nottingham Integrated Care System patient and public engagement

All four Greater Nottingham Clinical Commissioning Groups have supported the development of a communications and engagement plan for the Greater Nottingham Transformation Partnership.

On Wednesday 1 November, across the Greater Nottingham Transformation Partnership, we had the first of a series of local events to raise awareness around the development of an integrated care system for Greater Nottingham. There are four planned over 2017/18 and they are open events for any member of the public, patient or group to attend.

The events follow a Q&A format and focus on the challenges facing the health and care system in Greater Nottingham and our plans to address these. They also include table top discussions when members of the public get the opportunity to discuss in more detail the information from the presentations and how they might impact on their experience of health and social care.

The events are run by the CCGs on behalf of the Greater Nottingham Health and Care partners, providing an opportunity to engage with people as a system.

The second event was held in Radcliffe on Trent in February. Feedback from each event helps to formulate the plans for the next. All feedback from the table top discussions and the Q&A feedbacks back into the GNTP plans.

Nottingham North and East Clinical Commissioning Group patient and public engagement

Patients are at the heart of everything we do and it's important that they are involved not just in decisions about their care, but also in the decisions that shape the health services delivered locally. We work to empower patients to shape services and the care that they receive and this is supported by robust Patient and Public Involvement Governance structures.

Over the last year, we have continued to make significant steps to develop a robust approach to communications and engagement and have worked with our patient representatives and stakeholders to develop relationships and deliver communications and engagement activity which has had an impact on both strategy and public perception.

We aim not only to involve as many patients as possible but also to actively seek out the views of those most affected by service change and those hard to reach communities.

We build our engagement approach around understanding patient experience and listening to patients in the environments where they are most comfortable. Our engagement manager regularly participates at local support and community groups.

Governance and assurance information

We have robust governance arrangements which includes patients being involved with all aspects of our commissioning decisions.

Patient and Public Involvement Committee

We have a Patient and Public Involvement 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 is central to decision making.

Feeding into this group are:

The PPI QIPP group

The PPI QIPP 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 Transformation Partnership. 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 our local 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 may be 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 our 2017/18 engagement activity and the impact of participation

Weekend and extended hours engagement campaign

In line with NHS England's 'General Practice Forward View', we are working towards implementing extended hours and seven day local GP services across the Nottingham North and East area during 2018/19.

To support this, and to ensure we deliver the services patients need, we carried out a range of engagement activities with local people throughout the Summer to establish what they wanted from an extended GP service and to look at ways we can further improve access.

In June 2017, we launched a three-month patient engagement campaign to discover local views on General Practice (GP) extended hours access. Using a printed and online survey, we followed a multi-channel approach to patient engagement promoting via GP Practices, Summer locality events, social media and media relations. 506 patients responded.

What patients told us about GP access:

- 91% of respondents say there is a need for weekend GP services and 96% say there is a need for extended weekday hours.
- Feedback indicated that there is a certain amount of flexibility in planning services over the weekend and extended weekday hours.
- Public transport links and options will play a big part in the extended services being successful
- Most respondents said that they did not require support to see a GP or nurse at the weekend. However, comments were made about needing support due to disability or mobility issues and several respondents predicted they may need support in the future. We need to bear in mind the ageing population and take note that this need may increase and consider it in any plans.
- The feedback regarding Skype/Facetime, online consultations and symptom checker shows us there's a split between those that are keen to embrace these technologies to access services and those that are not. There are many comments highlighting concerns and safety issue around this.
- Throughout the planning of extended services, patients, carers and the public indicated they wanted to involved and engaged, and where that it is not possible that they are kept informed.

How are we acting on patient feedback?

We have established a working group, which includes patient and GP representation and have looked at the patient engagement feedback in detail. The intelligence within the engagement report was presented to the Primary Care Commissioning Committee in order that this could be used as part of wider decision making. Plans are now in progress to design the new extended hours service which we hope will be in operation by October 2018. We intend to involve patients in the development of this service and will look at how best to deliver it bearing in mind patients' wishes around a hub model.

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

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

This was an engagement campaign that actually took place in January/ February 2017 and, as such, was included in the 2016/17 Annual Report. However, as part of the decision and feedback on this engagement activity, we promised to return to patients six months later to examine the impact of the changes on patients.

Background

The three South Nottinghamshire NHS Clinical Commissioning Groups (Nottingham North and East, Nottingham West, and Rushcliffe) undertook a six-week patient and stakeholder engagement (Dec16/Feb17) 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.

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. Feedback from the public engagement, stakeholders and financial and clinical evidence was collated and the following was 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 people to 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.

While we know that these changes save the three CCGs on average around £30,000 a month, we didn't know what the impact on the patients has been.

So, in November 2017, we embarked on a self care roadshow around all our 20 GP Practices. We set up displays in waiting rooms and, along with promoting Winter self care messages, and repeat prescribing habits, we also took the opportunity to talk to patients about the impact of the new Over The Counter medicines recommendations.

Eighty four per cent of the 168 people we talked to said they hadn't noticed any difference since the recommendations had changed. Patients were mostly positive about the changes and were pleased with the savings that had been made.

The engagement report can be found on our website.

Big Health Debate: waste medicines

As part of the self-care roadshow practice tour, we also took the opportunity to talk to people about medicine waste - asking a series of questions to examine their understanding of repeat prescribing processes and to also understand patients' repeat prescribing habits.

The questionnaire aim was to find out about patient's experiences and habits around prescribing so we can begin to address why so much money is spent on medicine that is wasted.

The findings included

- More patients are beginning to use on-line services to order their repeat prescriptions but the majority still go in person to the GP practice. Could may be due to lack of understanding or awareness of access to on-line services and it would therefore be interesting to correlate this data with the number of patients registered to use on-line services at each of the practices.
- The majority of respondents only receive medication that they have requested; this is reassuring as it shows that people are aware and taking responsibility to only order what they require when requesting repeat medicines.
- Majority of respondents said yes that their doctor or pharmacist explains why they are prescribed each of their medicines which would suggest that patients are being encouraged to take responsibility for managing their illness and long term conditions.

- Over half of the respondents said their usual pharmacy doesn't offer them a medicines review to discuss their medicines. This may be because patients don't have regular contact with their pharmacy or that patients don't see the importance of a health review unless their condition deteriorates or changes.

We will be looking at repeat prescribing in more detail as part of our FRP challenge and the feedback from this engagement activity will feed into a wider engagement plan. In tandem with this, we also created a set of pdfs and digital communications collateral and shared it with our PPGs for use on practice noticeboards, community boards, web and social media.

Integrated Personal Commissioning (IPC) Engagement

The three south Nottinghamshire CCG engagement teams led on the design, implementation, support and monitoring of an IPC Co-Production Group that was a vital part in establishing IPC in Nottinghamshire. IPC is a partnership programme between NHS England and the Local Government Association (LGA). It is a nationally led, locally delivered programme that is supporting healthcare empowerment and the better integration of services across health, social care and the voluntary and community sector.

The focus of this work was to ensure patients and carers with lived experience of personal, integrated and personal health budgets were at the centre of the work. Much time was invested in contacting and engaging with local groups and communities to encourage involvement.

Leading on this strategy and in conjunction with the NHS England Lived Experience advisor and Self Help UK who were commissioned to facilitate the IPC Co-Production group, a strategy for the Co-production group was developed. This strategy outlines the role of the IPC Co-production group in Nottinghamshire, the context in which it will sit and a structure for how to establish and develop this group. The IPC Co-Production group will be part of promoting, actively informing decisions and designing the implementation of IPC across Nottinghamshire

Now the strategy is fully implemented the IPC Co-production group is thriving through monthly meetings run by Self-Help UK.

Events

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

We also hosted out Annual Public meeting at the Bonnington Theatre in Arnold, which looked back at our year, presented our Annual

Accounts and looked at plans for the future.

The engagement team also regularly attends local community meetings and presents on NHS news and engagement at groups like the Hucknall Partnership Group, locality PPG groups, Hucknall

Carers, Renew 34 etc. Well attended. Variety of people attended. Much of the meeting was dominated by group lobbying to stop privatisation of NHS.

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

Some of the issues raised during these events demonstrated the importance of having the right services locally, 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.

We have also supported the Accountable Care System events as outlined in the Greater Nottingham section.

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.

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, 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.

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

Additional communications campaigns

In addition to the communications campaigns which supported the engagement activity, we have also run a number 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, regular e-bulletins via Mailchimp and surveys via Survey Monkey.
- Media management of GP Practice issues
- 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 month and we also manage the NHS South Notts Facebook page. 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 over the counter medicines, big health debate and urgent and emergency care.
- Over the year, we have delivered regular branded – NNE Patient Connect - bulletins to the patients on our distribution list to let them know about involvement opportunities and our local events.
- 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 set up 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, two in Spring, to promote our services and get key messages out to every resident in Gedling.
- 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 for our GPs and CCG staff.

Key 2017/18 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'.

Waste Medicines

Working with PPGs, we developed collateral to promote responsible ordering of repeat medicines. W

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. In 2017/18 we created collateral to specifically target BME and elderly patients.

Helping you to help yourself - Self care

We continued to build on our self care campaign, which was launched in March 2017 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'.

Other campaigns

- Care management plans
- Video case studies to promote community –based services
- 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

Compliance with Statutory Guidance on Patient and Public Participation in Health and Care

In April 2017 NHS England published revised statutory guidance for CCGs and NHS England commissioners. In addition, further to the publication of this revised guidance NHS England developed a new approach to the assessment of patient and public participation as part of its statutory annual assessment of CCG performance. This assessment relates to the ten key actions listed within the guidance and involved a desktop review of each CCG based on the following information:

- Corporate Annual Reports
- CCG websites
- Documents and information published on CCG websites

The assessment took place in July 2017 and resulted in an overall **Green** RAG rating with improvements recommended in three areas: Practice; Feedback and Evaluation; and Equalities and Health Inequalities.

The CCG are reviewing processes to ensure they are compliant with the guidance "Planning, assuring and delivering service change for patients" which was released March 2018.

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)
- Find us on Facebook: /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 2018:

- 94.802% of patients with suspected cancer were seen by a consultant within 14 days of referral by their GP (national standard 93%)
- 97.69% of patients received their first treatment within 31 days following a diagnosis of cancer (national standard 96%)
- 85.80% 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:

- Implement National Optimal pathways for Lung and Prostate Cancer, which are tumour types where additional focus is required
- GP direct access to FIT test implemented in Greater Nottingham

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 year to 31 March 2018:

- 3.13% 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)
- 66.31% of patients who had completed treatment were moving to recovery (national standard 50 per cent)

Early Intervention in Psychosis (EIP)

This indicator focusses on improving access to evidence based care in EIP services. People who receive the right treatment at the right time from an EIP service can go on to lead full, hopeful and productive lives. The standard requires that more than 50% of people experiencing a first episode of psychosis will be treated with a NICE recommended care package within two weeks of referral.

In the year to 31 March 2018 the achievement figure is:

- 83.33% of people referred were treated within two weeks

Children and Younger Peoples Eating Disorders (CYPED)

Over 1.6 million people in the UK are estimated to be directly affected by eating disorders, with Anorexia Nervosa having the highest mortality amongst psychiatric disorders. Research shows that areas with dedicated community ED services (CEDS) had better identification from primary care; lower rates of admissions with non-ED generic CAMHS admitting 2.5 times those from the community ED service.

Family-based therapies conducted on an outpatient basis are effective and have excellent long-term outcomes (NICE 2004). The relapse rates for those who have responded well to outpatient family therapy are significantly lower than that following inpatient care and there is some evidence that long-term inpatient admission may have a negative impact on outcome, as well as being more costly. It is on this basis that the Autumn Statement, 2014 announced the provision of additional funding of £30million/year for 5 years, to support the training and recruitment of new staff in addition to those already within services, to ensure that children and young people with an Eating Disorder get expert help early, enabling them to be treated in their community with effective evidence based treatment.

Our current performance in the year to 31 March 2018:

- 75.00% of children and Young People (up to the age of 19) with eating disorders (routine cases) waited 4 weeks or less from referral to start of NICE-approved treatment (national standard is 95% from April 2020)

Dementia

In April 2017, the 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 2017/18 was 67%.

At 31 March 2018 the achievement figure is:

- 71.69% 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	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual	Trajectory	Actual
CCGs (non-secure)	29	28	29	31	28	29	26	25
NHS England (secure)	43	44	40	39	36	40	31	43
Total (all ages)	**72**	**72**	**69**	**70**	**64**	**69**	**57**	**68**
+/- Trajectory	**0**		**+1**		**+5**		**+11**	

For CCG commissioned (non-secure) beds discharge dates for individuals already in receipt of inpatient care have slipped which has prevented discharges taking place. There has been a variety of causal factors preventing discharges including availability of community based placements (both housing and support providers) the requirement to obtain Ministry of Justice and Parole Board approval for discharge

which has caused delays, the failure of a unit to deregister as a hospital within Quarter 3 and awaiting beds for patients to step up to a higher security setting.

For NHS England commissioned (secure beds) discharge dates for individuals already in receipt of inpatient care have slipped which has prevented discharges taking place.

A recovery action plan has been submitted to improve performance.

Maternity

The National Maternity Review '*Better Births, Improving outcomes of maternity services in England: A Five Year Forward View for maternity care'* published in 2016 recommended that Local Maternity Systems (LMS) be formed to provide place-based planning and leadership for transformation of maternity and neonatal services.

In March 2017 the Nottinghamshire's Local Maternity System (LMS) Board was constituted to cover Nottingham and Nottinghamshire CCGs and six work streams led by commissioners, providers and public health to lead the transformational change to 2020/21 (Choice and Personalisation; Commissioning; Safe and Effective Care; Engagement, IT and Workforce).

In 2017/18 the National Maternity Programme team, overseeing 44 Local Maternity Systems of which Nottinghamshire is one, has collectively achieved:

- LMS Boards on Sustainability and Transformation Partnership (STP) footprint to lead and deliver transformation in maternity services in every part of the country;
- Since 2010, a 16% reduction in stillbirths, 10% reduction in neonatal mortality and 20% reduction in maternal deaths;
- Piloted continuity of carer for over 3,000 women;
- Increased capacity for specialist perinatal care, with over 5,000 more women accessing services and 4 new mother and baby units funded, including Hopewood in Nottingham, a new Mother and Baby Unit and outpatient facility for Perinatal Mental Health Services due to open in 2018.

NHS Constitution Standards

We worked hard throughout the year to meet the national targets that were set. Specific detail on our performance during 2017/18 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 2017/18 we met or exceeded all the national targets for elective waiting times set by the Department of Health.

In the year to 31 March 2018:

- 95.12% of patients who were still waiting for their treatment had been waiting less than 18 weeks (national standard 92%)
- 108 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 2018:

- 84.01% 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.

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 2018/19.

Ambulance – East Midlands Ambulance Service

In the year to 31 March 2018:

- The average response time for calls assigned as Category 1 (Life threatening illnesses or injuries) was 9 minutes and 45 seconds (national standard 7 minutes)
- The average response time for calls assigned as Category 2 (Emergency calls) was 45 minutes and 05 seconds (national standard 18 minutes)
- The 90th centile response time for calls assigned as Category 1 (Life threatening illnesses or injuries) was 17 minutes and 31 seconds (national standard 15 minutes)
- The 90th centile response time for calls assigned as Category 2 (Emergency calls) was 40 minutes and 18 seconds (national standard 40 minutes)

Ambulance service performance data is at East Midlands level. Performance was under close scrutiny throughout 2017/18 and we will continue to work with our provider organisation and co-ordinating commissioner, NHS Hardwick CCG, to improve performance in this area through 2018/19. Please see the Governance Statement further on in this report for more detail.

Cancelled elective operations – Nottingham University Hospitals

In the year to 31 February 2018, 24 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 2018/19.

NHS continuing healthcare (CHC)

The following table shows the CCG performance against the CHC indicators in the CCG Improvement and Assessment Framework (IAF) and Quality Premium:

Indicator	Latest Data Period	England Average	NNE
CCG IAF indicator: number eligible for CHC per 50,000 population	Q2 2017/18	54.07	63.79
Quality Premium Indicator: % assessments in acute setting. National Target **<15%;** Local trajectory **20% or less**.	Data from February 2018		20%
Quality Premium Indicator: % decision communicated within 28 days of assessment. Target **80%**; Local trajectory **70%**	Data from February 2018		100%

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 ongoing health needs. The CCG has implemented an out of hospital discharge to assess pathway which it is anticipated will support achievement of this standard. Monthly trajectories have been set to achieve the <15% target by March 2018.

The CCG has achieved the national target of >80% for eligibility decision making within 28 days which is a significant improvement in year. Weekly pre-panels and panels are held to ensure timely CCG decision making and communication. In addition the CHC provider has access at all times to the Director of Personalisation (or their Deputy in her absence) by email or telephone to enable decisions to be made, preferably same day, or as a minimum within two working days for decisions that are required outside of panel.

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 CityCare finance, contracting and quality representatives is meeting fortnightly to oversee implementation.

In December 2016 NHS England announced the launch of the NHS Continuing Healthcare Strategic Improvement Programme. A collaborative engagement method is at the centre of the programme's approach. The NHS England team has worked 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 WebEx sessions are held to share learning and develop future policy.

Children's Wheelchairs

The aim to improve wheelchair services was outlined in NHS England's *Business Plan for 2014/15 – 2016/17: Putting Patients First*. The stated objectives were to improve the experience and outcomes for wheelchair users by supporting the implementation of the action plan from the national Wheelchair Summit; piloting the wheelchair tariff and supporting improved commissioning.

This indicator places an emphasis on timely delivery of equipment and provision of service to children and young adults below the age of 18 years old. Not receiving equipment in a timely manner severely limits independence, mobility and quality of life of affected individuals.

In the year to 31 March 2018,

- 90% of children received equipment in less than 18 weeks of being referred to the wheelchair service (national standard is 92%).

Quality in primary medical care

The quality of care provided by GP practices in Nottingham North and East has been predominantly rated 'Good' with 2 achieving 'Outstanding' and 1 being rated as 'Requires Improvement' overall by the Care Quality Commission (CQC). Q4 quality dashboard overall RAG ratings were predominantly green with 2 achieving a green* rating (no adverse indicators) and 2 achieving an amber rating. The one practice rated as 'Requires Improvement' by the CQC is receiving support from the CCG to address concerns raised and the 2 with an amber quality dashboard rating have actions in place to address the adverse indicators.

Practice name	CQC Outcome	Quality Assurance Framework RAG Q3 2017/18
Calverton Practice	Outstanding	Green
Park House Medical Centre	Good	Green

Practice name	CQC Outcome	Quality Assurance Framework RAG Q3 2017/18
Om Surgery	Requires Improvement	Green
Newthorpe Medical Centre	Good	Green
Giltbrook Surgery	Outstanding	Green
Plains View Surgery	Good	Green
Daybrook Medical Practice	Good	Green
Trentside Medical Group	Good	Green
Torkard Hill Medical Centre	Good	Green
Apple Tree Medical Practice	Good	Green
Unity Surgery	Good	Green
Westdale Lane Surgery	Good	Green
Whyburn Medical Practice	Good	Green
Oakenhall Medical Practice	Good	Green
Stenhouse Medical Centre	Good	Green
Ivy Medical Group	Good	Green
Jubilee Practice	Good	Green
West Oak Surgery	Good	Green
Highcroft Surgery	Good	Amber
Peacock Healthcare	Good	Amber

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 28 February 2018 against limits (subject to validation):

Organisation	*Clostridium difficile*			MRSA Blood Stream Infection (BSI)		Escherica Coli (*E.Coli)*	
	Full Year Limit	Actual to end Feb 2018	Pre/Post 72 Hours	Full Year Limit	Actual to end Feb 2018	Full Year Limit	Actual to end of Feb 2018
NNE CCG	47	32	16 pre/16 post	0	0	139	131
NUH	91	85	All post	0	2**	204***	181

**includes 1 unexplained acquisition

*** includes only Trust apportioned cases not all cases tested through the laboratory

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. During 2017/18 there was a national supply issue with the antibiotic Tazocin which meant that alternatives that are not as *C.diff* sparing had to be used which may account for the higher numbers in some CCGs this year.

The Secretary of State has launched a new ambition to reduce healthcare associated gram negative bloodstream infections (BSI) and inappropriate prescribing for urinary tract infections (UTIs) in primary care. Whilst this is not a target as such, it comes with a financial incentive in the form of a CCG Quality Premium, which places responsibility for reduction across the whole health economy with CCGs. To achieve this, a 10% reduction from the baseline in 2015/16 is required over the period 2017-18 with an expectation that a 50% reduction will be met by 2021. The initial focus is

on reducing *E-coli* infections as these represent 55% of all gram negative bloodstream infections, with 75% of cases considered to be of community onset with the most common source being Urinary Tract Infections (UTIs). During 2017/18 information in relation to risk factors present in *E. Coli* cases has been collected, to date there are no significant emerging themes other than age and co-morbidity

CCG Performance

Comparison with other similar organisations is helpful to gain contextual detail on trajectories against performance targets. Categorisation of CCGs by RightCare has been linked to the Office of National Statistics (ONS) clusters. Nottingham North and East and Nottingham West CCGs are located within the manufacturing towns group. Rushcliffe is located within the prospering smaller towns group.

The CCGs continue to compare favourably to RightCare peers and no concerns in relation to diagnosis, treatment or antimicrobial prescribing have been identified in post infection reviews.

The CCG met the zero tolerance targets for MRSA blood stream infections.

The CCG met the target for a 10% reduction in *E.Coli* BSI. Early national work has identified that risk factors may include an ageing population, increased antibiotic usage, urinary tract infection and increases in rates are multifactorial. The case reviews should enable exploration of local risk factors and determine key actions which may prevent future cases. Local improvement initiatives to date include a local hydration campaign 'What Colour Is Your Wee', new antibiotic prophylaxis guidelines for Recurrent Urinary Tract Infections in Adults and the recent implementation of the 'Dip or Not to Dip Project' across care homes.

NUH Performance

In Q4 there were 30 cases assigned to NUH which meant that at the end of Q.4 there were 101 cases which exceeded the trajectory of the 91 cases for 2017/18.

C. *diff* toxin positive assessments identified lapses in the quality of care in 22 cases year to date. 24 cases had identified lapses in care which include:

- Inappropriate antimicrobials
- Delayed diagnosis
- Delayed treatment

A further case of MRSAb was identified in Q4 but this was a contaminant on admission and attributed to NUH following blood culture and positive screening. A full PIR was not required for this case due to it being a contaminant; there were no issues around the sampling technique. This means there were 2 cases for 2017/18 which compares favourably to the previous year when five cases were reported.

Serious incidents

A total of 195 SIs were reported during Q1 – Q4 (2017-18) although due to the timescale of the Serious Incident framework some are still undergoing ratification to determine that they are true SIs. The main categories of serious incidents reported are grade 3 or 4 pressure ulcers and maternity incidents.

The number of SIs reported in Q.4 of this year is 47 (compared to 53 in Q.4 of the previous year and 46 in the previous quarter (Q.3 - 2017/18). The highest category is avoidable stage 3 pressure ulcers, which relate mainly to NUH and Local Partnerships - Physical Health Division (LP), although there is a reducing trend year on year as a consequence of the sustained learning and action from investigations of providers. The reporting of maternity related Serious Incidents continues at an increased rate compared to the previous year, which is a positive indicator of NUH's commitment to improve maternity governance and implement improvement initiatives as a result of investigations. All maternity SI investigation reports continue to be reviewed for quality at a regular MDT panel which is attended by members of the Clinical Maternity Network.

One notable SI category is diagnostic incident (including failure to act on test results), of which there were 4 incidents in Q.4 for NUH. In addition to individual learning from these SIs being explored via investigation NUH provided additional assurance at the QSP in the form of a risk assessment, linking SIs to mitigating action to address failures to act on diagnostic tests.

The CCG continues to hold a panel review of incidents not declared as SIs to provide scrutiny of SI conversion decisions by providers. At the last panel (held on 30.1.18) for NUH there were 8 incidents reviewed which had been randomly selected by the CCG and of these none were deemed to be SIs. The same is indicated by panel reviews of LP incidents.

Never events

Never Events are a subset of Serious Incidents that are considered wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. For a full list of Never Events go to:

www.england.nhs.uk/patientsafety/never-events/

There has been 1 Never Event reported in Q4: wrong site surgery – intra-ocular injection to wrong eye (NUH) and this is being investigated to identify omissions in care and action required to prevent future occurrences. YTD there have been 3 NEs reported across providers as follows: NUH incident above, wrong site surgery – premolar tooth removed in error (LP) and carpal tunnel release instead of trigger

finger release (Woodthorpe Hospital)). This is a significant improvement on the previous year when eight Never Events were reported.

Safeguarding

During 2017/18 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 adults 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.

An internal audit of children's safeguarding processes was undertaken and reported in Quarter 1 of 2017/18. This provided **Significant Assurance**.

The CCGs have recently with the support of NHSE purchased extended licences for the Safeguarding Assurance Tool (SAT) which will enable a further period of evaluation of the system to collate safeguarding assurance evidence.

During 2018/19 the CCG will work with other safeguarding partners to locally implement the recommendations arising from the Wood Review and the revised Working Together to Safeguard Children guidance which is expected in May 2018.

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 2017/18. PALS include general enquiries and low level concerns where the referrer does not wish to make a formal complaint.

CCG PALS	2017/18 Total
Anonymous/Out of Area	230
NHS Nottingham North and East	117
NHS Nottingham West	331
NHS Rushcliffe	152
Cross South Nottingham CCGs	66

CCG PALS	2017/18 Total
Totals	**896**

The Patient Experience Team received a high number of enquiries relating to a number of changes in service pathways or commissioning decisions undertaken during 2017/18 for example stroke rehabilitation, pain management, restriction to prescribing of gluten free products, over the counter medications and enforcement of patient transport eligibility criteria. Enquiries tended to be related to the transition to the new provider/ pathway and the effective communication to patients. The team liaised with PALS colleagues at the relevant providers to resolve these issues.

Complaints

The following table shows the CCG complaints received during 2017/18. 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	2017/18 Total
NHS Rushcliffe	19
NHS Rushcliffe primary care	7
NHS Nottingham West	19
NHS Nottingham West primary care	7
NHS Nottingham North and East	29
NHS Nottingham North and East primary care	20
Other	4
TOTAL	**105**

The main themes identified were in relation to Continuing Healthcare (retrospective claims) and the changes to Pain Management services (see above). Complaints information is considered at the Primary Care Quality Groups.

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 2017/18 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 e-healthscope so that this intelligence can be triangulated with other sources of data to support quality monitoring and assurance.

Quality Priorities 2017-19

The table below provides an update on progress against the quality priorities identified for 2017-19:

Priority	Progress in 2017/18	Actions in 2018/19
Improving four-hour A&E access performance and ambulance response times by implementing system transformation to reduce attendances and improve timely discharge	The Discharge to Assess pathway and additional community capacity was introduced in October 2017. Whilst this has not had a significant impact on A&E performance there has been a significant increase in the numbers of supported discharges from NUH and a significant reduction in the number of CHC assessments undertaken in hospital. There has also been a significant reduction in ambulance handover times (the best in the region) which has released capacity to respond to calls. The reinforcement of the 10 minute GP call back has also reduced unnecessary conveyances by providing alternative pathways. Despite continued system pressure there have been only two 12 hour breaches in 20171/18. Harm review processes and metrics continue to provide assurance in relation to quality impacts where operational performance is not achieved.	To continue to embed the Discharge to Assess pathway. To support the development of the care home sector to maximise appropriate use by upskilling staff and providing early intervention support to struggling homes. Continued focus on reducing non-conveyance (supported by the national CQUIN). Continued focus on maintaining ambulance handover times. Continued implementation of harm review processes and metrics to monitor the impact of A&E and ambulance performance. This

		will need to extend to cancelled elective activity which was necessary during system pressure.
Reducing cancer and diagnostic waits by ensuring that capacity and demand is matched and efficient systems are in operation	There has been significant improvement in the 2 week wait standard and some improvement in the 31 day and 62 day targets. There has been a significant reduction in the number of 104 day breaches and harm review processes are now established across all tumour sites. To date no incidents of harm have been identified in 2017/18.	Continued monitoring of capacity and demand. Continued implementation of harm review processes to monitor the impact of delays.
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	As at 19 March 2018 there are 26 inpatients in Nottinghamshire CCG commissioned services against a year end trajectory of 26. However the number of inpatients in NHSE commissioned secure services has exceeded the trajectory and therefore this will not be met overall as a system. Care and Treatment Reviews (CTRs) have been undertaken and an 'at risk of admission' register has been maintained. During 2017/18 new services have been commissioned aimed at reducing admissions and expediting discharges for example Intensive Community Assessment and Treatment Team (ICATT), case management by the Community Forensic Team and an emergency respite service.	Continue to ensure CTRs are completed and the 'at risk of admission' register is maintained. Robust case management to ensure admissions are avoided and discharges are expedited. Evaluation of the new services introduced in 2017/18 to monitor impact/ effectiveness.
Improving staff health and wellbeing by ensuring that initiatives are	During 2017/18 all NHS providers (and some independent providers) had a CQUIN aimed at improving staff health and well-being by implementing initiatives that support	The staff health and well-being CQUIN is a two year CQUIN which extends into

implemented that support musculo-skeletal (MSK), mental health (MH) and healthy eating	MSK, MH and healthy eating. All providers are on track to achieve the CQUIN milestones for 2017/18.	2018/19.
Supporting safe and proactive discharge by developing transfer to assess services and improving provider to provider communication and collaboration	The Discharge to Assess pathway and additional community capacity was introduced in October 2017. There has been a significant increase in the numbers of supported discharges from NUH and a significant reduction in the number of CHC assessments undertaken in hospital. During 2017/18 the acute and community providers had a CQUIN aimed at improving discharge pathways and provider to provider communication. All relevant providers are on track to achieve this CQUIN by year end. In the 2018/19 planning guidance this CQUIN was removed for acute providers, there remains an option to have a local CQUIN relating to discharge for community providers.	To develop an improved transfer of care document and process to increase the reliability of information on which transfer decisions are made. Work is currently underway to determine the most effective way to utilise a local CQUIN, potential options are to use this incentive to facilitate the above work on the transfer of care document and/ or to support upskilling of community/ care home staff to maximise utilisation of community capacity.
Reducing impact of serious infections (in particular sepsis) by ensuring appropriate use of early warning tools, staff training and antibiotic therapy	There has been a national CQUIN focussed on identifying and treating sepsis and reducing antimicrobial resistance. During 2017/18 a sepsis audit was undertaken in all GP practices across the three South Nottinghamshire CCGs. This provided good assurance in relation to awareness of the NHS England educational resources	Implementation of NEWS2 across all relevant providers. Identifying sepsis leads in all GP practices. Undertaking training sessions in Protected Learning Time

	including the NEWS tool and the management of suspected cases.	sessions in primary care. Implementation of year 2 of the sepsis/ reducing antimicrobial resistance CQUIN.
Improving services for patients with mental health needs who attend A&E.	There has been a national CQUIN focussed on improving services for patients with mental health who attend A&E. Relevant providers are on track to achieve the 2017/18 milestones.	Implementation of year 2 of this CQUIN.
Reducing avoidable emergency admissions by ensuring effective advice and guidance is available to referring clinicians and improved GP access.	There has been a national CQUIN focussed on reducing avoidable emergency admissions by ensuring access to Advice and Guidance for referrers. Relevant providers are on track to achieve the 2017/18 milestones.	Implementation of year 2 of this CQUIN.
Maximising choice by ensuring that all first outpatient referrals are able to be received through e-Referral Service	Achieving 100% e-Referrals by end Q4 2017/18 was a CQUIN this year. Relevant providers are on track to achieve the 2017/18 milestones.	This was only a year 1 CQUIN. However performance against the standard will continue to be monitored and any variances addressed with the relevant provider.
Preventing ill health by risky behaviours (alcohol and tobacco in particular)	This has been a CQUIN for Community and Mental Health providers in 2017/18. The community providers are on track to achieve the milestones related to undertaking screening,	Implementation of year 2 of this CQUIN for community and MH providers. Introduce the CQUIN for acute providers.

	offering brief intervention and onward referral/ medication in 2017/18. The Mental Health provider is likely to only partially achieve the milestones for tobacco and are not expected to achieve the CQUIN for alcohol.	Work with the Mental Health Trust to improve the uptake of screening, offering brief intervention and onward referral/ medication for both tobacco and alcohol.
Improving the assessment of wounds that have not healed within four weeks by implementing full wound assessments	This has been a CQUIN for community providers in 2017/18. The community providers are on track to achieve the milestones in 2017/18.	Implementation of year 2 of this CQUIN.
Improving access to and transitions between mental health services for children and young people	This has been a CQUIN for Mental Health providers in 2017/18. The MH provider is on track to achieve the milestones in 2017/18.	Implementation of year 2 of this CQUIN.
Increasing personalised care and support planning by staff training to support increased patient activation	There has been a national CQUIN focussed on increasing personalised care in 2017/18. The relevant providers are on track to meet the 2017/18 milestones for this CQUIN.	Implementation of year 2 of this CQUIN.
Increasing the uptake of personal health budgets (PHBs) and integrated personal commissioning (IPC)	Nottinghamshire has exceeded the target for PHBs in 2017/18. Nottinghamshire is an early adopter of IPC and has case studies referenced by the National Director of Personalisation. During 2017/18 PHB guidance has been developed and adopted.	Continued expansion of the PHB/IPC offer outside of CHC.

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	There has been a national CQUIN focussed on this in 2017/18. The relevant providers are on track to meet the 2017/18 milestones for this CQUIN. The reinforcement of the 10 minute GP call back has also reduced unnecessary conveyances by providing alternative pathways.	Implementation of year 2 of this CQUIN.
Reducing clinical variation by using intelligence to identify opportunities for improvement	We have used intelligence from sources such as Rightcare to identify and address areas of clinical variation which is considered during practice visits and at clinical cabinets. We have seen some improvement in reducing clinical variation in particular in relation to first outpatient referrals.	Review of refreshed Rightcare packs to identify further areas of focus.
Improving early cancer and dementia diagnosis by appropriate staff training and access to diagnostics and specialist services	All three South Nottinghamshire CCGs exceeded the target for dementia diagnosis in 2017/18. A new pathway for suspected cancers where the symptoms are non-specific and could therefore be a number of tumour sites has been introduced with the aim of speeding up diagnosis and preventing onward referrals. Additional capacity for lung diagnostics commissioned.	Continued focus on dementia diagnosis rates. Continued focus on ensuring that cancer diagnostic capacity meets demand.
Reducing mortality and improving quality of life for people with long term conditions	Providers have implemented 'Learning from Death' programmes which mandates clinicians to review deaths using a subjective judgement review process to ascertain if there is learning which could prevent future deaths. The Learning Disability Mortality Review process has also been	Continue to learn from deaths, share learning and implement changes that could prevent future deaths.

	implemented in Nottinghamshire.	
Improving the care, experience and choice for pregnant women by implementing the recommendations in 'Better Births'.	During 2017/18 Nottinghamshire established a Local Maternity Services (LMS) Transformation Board. The LMS transformation plan which focusses on patient safety, choice and continuity was submitted to NHS England in October 2017. Feedback has been received and the plan is undergoing further development.	Finalise LMS plan and recruit to NHS England funded posts to support implementation. Development of a set of Nottinghamshire wide system quality indicators.

Our achievements during 2017/18

Diabetes

During 2017/18 the CCG developed upon a number of schemes and pathways aimed at improving prevention, diagnosis, treatment, and outcomes for patients with diabetes. These include the following:

- The first Nottinghamshire diabetes management plan to support patient self-care.
- National Diabetes Prevention Programme which is a structured education programme aimed at preventing the onset of Type 2 diabetes in those identified as at risk.
- Developments to the Hypoglycaemic Pathway to ensure that primary care and/or the Diabetes Specialist Nursing Service are made aware of patients who have had 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.
- The review of the Diabetes Insulin, Initiation & Management Service within primary care to ensure a more equitable service for all practices, which has seen a significant improvement in uptake.
- Development of a clinical template to standardised clinical care.

NHS Diabetes Prevention Programme (NHS DPP)

In 2017/18 NNE were successful in becoming a Wave 2 site for the NHS DPP, which is an evidence-based behavioural programme that aims to reduce type 2 diabetes through focusing on healthy weight, increasing physical activity and improving the diet of those individuals identified as being at high risk of developing Type 2 diabetes.

Learning disabilities

Through a 'local Enhanced Service' NNE has 12 practices (60%) signed up and engaged with a cancer screening initiative for adults with a learning disability. The aim is to improve the uptake of Bowel, Breast and Cervical cancer and AAA (Abdominal Aortic Aneurysm) screening.

Respiratory

NNE has led and coordinated the Greater Nottingham Respiratory Group, which has seen several improvements in respiratory care. These include the following:

- The development and implementation of the first bronchiectasis management; plan across Nottinghamshire/STP foot;
- Implementation of the micro-spirometry guidelines;
- COPD Upskilling training for NNE practice nurses;
- Development of clinical templates (F12) for both COPD and Asthma.

Cost effective prescribing

The pressure of financial recovery continued to have an impact across the CCG throughout 2017/18. The CCG's Medicines Management Team have continued to work closely with GP practices to reduce prescribing spend by promoting cost effective prescribing and utilising the prescribing decision support software (Optimise-Rx) to provide individualised patient-centred advice on the best clinical and cost effective drug choices. Issues with out of stock medicines and no cheaper stock obtainable (NCSO) has made any work around cost effective prescribing particularly challenging. Despite this, the overall spend against prescribing budget during 2017/18 has decreased from by 5.53% when compared with spend over the same period for 2016/17. Nationally prescribing costs have decreased by 0.37% over the same period.

Medicines Management Quality and Safety

Optimise Rx is still utilised not only for cost-effective drug choices but for best clinical choices too. A member of the team still acts as designated medicines safety officer (MSO) representing the CCG as part of the Nottinghamshire and Derbyshire Medicines Safety Officers Network. The MSO has developed a series of clinical reports for practices using SystemOne. These reports are updated monthly and it is the intention that they will act as a useful resource for GP practices to help action Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts.

Other ongoing MSO work includes the splenectomy re-audit. This work includes identifying patients who are not up to date with the appropriate vaccinations and therefore are at risk of invasive infections and severe harm.

The CCG's team of pharmacists continue to 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.

There is still considerable activity with the Medicines Management Facilitators and their work. This has included cost saving work but also significant work on improving the quality of systems and processes and thereby impacting positively on safety within practices.

Care Homes Prescribing

There has been plenty of activity with prescribing work in care homes. The Oral Nutritional Supplement (ONS) project is in the process of being rolled out across all care homes and this will be audited quarterly. This will be supported by the delivery of an education and training programme to care home staff, including supporting information to promote Food First within care homes.

Throughout the year there has been ongoing input into 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 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. The care home pharmacist is looking to now develop an IT template.

The Dip or Not to Dip project was launched within Care Homes within NNE (with the support of the Community Nursing team). This involved delivering an education and training session to care home staff and implementing a urinary tract infection (UTI) assessment tool to improve the diagnosis of possible urinary infections in residents >65 years old within care homes, and improving the appropriate use of antibiotics in these patients.
The primary outcomes from Q3 2017-18 in the pilot group (locality 3) are really encouraging:

- 65% reduction in antibiotics prescribed for UTI in pilot areas compared to same period the previous year(90 to 31)
- 62% reduction in number of residents prescribed antibiotics for UTI (75 to 28)
- Reduction in dipstick testing for diagnosis of UTI in care homes
- Reduction in number of residents on long term antibiotics
- Reduction in admissions for UTI

There is still ongoing work around waste reduction of medicines in care homes and the medication review programme with GP practices which is being re-evaluated.

It is anticipated that there will be some work around respiratory medicines with the support of the CCG respiratory support nurse throughout the following year.

Leadership

Quality of leadership

We have strong governance and committee structure arrangements that underpin the organisation which were assessed by NHS England as **Fully Compliant** for probity and corporate governance in the 2016/17 annual performance assessment published in July 2017. More detail on our arrangements can be found in the Governance Statement.

During the year we have been working towards establishing a single management structure and joint commissioning committee across the four Greater Nottingham CCGs with delegated authority from each Governing Body. This is driven by a number of commissioning issues facing the CCGs including the development of new models of care, significantly increasing financial pressures, increased challenges around performance of the health system and stretched capacity to deliver all of the commissioning functions.

At the end of the last financial year, NHS England commissioned a Capacity and Capability Review of a number of CCGs including Nottingham North and East CCG. The review concluded that there was insufficient senior management capacity within individual CCGs in Greater Nottingham to deliver the challenges ahead particularly in relation to the significant cost reduction programme to ensure that financial stability was achieved and maintained in the medium term.

Efficiencies and economies of scale from a shared management structure under the leadership of a single accountable officer across the four Greater Nottingham CCGs were also highlighted in the report. Good progress has been made with the appointment of the Accountable Officer in September 2017 and an overall restructure to a single management team. The restructure includes a senior executive team including a Chief Finance Officer, Chief Nurse, Chief Commissioning Officer and Chief Operating Officer. The Accountable Officer is also supported by a Programme Director for Transformation and a Turnaround Director.

Strong clinical leadership has been at the forefront of these changes with the Clinical Leads directly inputting into the structures. The memberships of each of the four CCGs supported the alignment and approved the necessary changes to the CCGs' constitutions throughout February and March 2018.

More detail on leadership can be found in the Governance Statement.

The CCG's local relationships

360 Stakeholder Survey

The CCG participated in the CCG 360 Stakeholder Survey for 2018 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, the Health and Wellbeing Board, other local CCGs, providers and patient groups. The CCG had an overall response rate to the survey of 61%. The survey is an important tool, providing valuable feedback, that is used to inform action plans and build on relationships.

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 2017/18 for Nottingham North and East CCG there were two reported health and safety incidents both related to scalding from a new water boiler. The equipment was checked by maintenance staff and staff informed to take extra care.

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
94%	98%

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 2017/18 we received 198 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 health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004 (CCA 2004) and the NHS Act 2007 (as amended). The CCA 2004 specifies that responders will be either Category 1 (primary) or Category 2 responders (supporting agencies). NHS England, acute and ambulance service providers, Public Health England and Local Authorities are Category 1 responders and CCGs are Category 2 responders.

As a Category 2 responder, the CCG supports Category 1 responders and is part of a wider EPRR framework that includes local health providers, EMAS, NHS England and Public Health which is called the Local Health Resilience Partnership. The CCG also works closely with other agencies and partners including the Local Authorities, police and fire services through the Local Resilience Forum. In order to carry out its responsibilities, the CCG has relevant plans and a 24/7 on call structure in place. A self-assessment is carried out each year by the CCG (as with all NHS Category 1 and Category 2 responders) in order to provide assurance on compliance against core standards for EPRR. For 2017/18 the Level of Compliance for the Nottinghamshire CCGs was **Substantial**.

Business continuity

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

of the plan is required annually, usually tested by way of an exercise. However, it was activated on 12 May 2017, following the WannaCry Ransomware cyber-attack that threatened local IT infrastructure.

The activation and review highlighted that the plan required further development to ensure it was effective in the event of all disruptions. One plan across the South Nottinghamshire CCGs has now been developed that incorporates learning from the incident, ensures consistency in approach and is more aligned to the future shared management structures

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. Since becoming a CCG, NNE has supported approximately 25 research projects through excess treatment costs. Throughout 2018/19 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 2017/18, 88 patients had been recruited to participate in research and 16 out the 20 GP practices in the area had participated. Research topics include:

- The Proactive Health Care in Care Homes (PEACH) Study
- Format of patient education for different sociodemographic groups
- Understanding variation in referral decisions in primary care

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 further developed information systems to facilitate sharing of innovative ideas and service improvements;
- 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 2017/18 included:

For clinical staff	For practice managers
Acute Kidney Injury / Chronic Kidney Disease, Abnormal LFTs and Gastro pathway	Safeguarding
Sepsis, updated community antimicrobial guidelines and Neurological Conditions	Making Reasonable adjustments for patients with learning disabilities and Patient Safety Incidents, Reporting, Investigating, Learning and Sharing
Mental Health and Perinatal Psychology	
Community MSK and Patient Safety Incidents, Reporting, Investigating, Learning and Sharing	
Notts Fracture Liaison Service and Patients with frailty	

Organisational development

The CCG held development time outs for the staff and leadership team. A review was 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 were held on building resilience and working mindfully, responding effectively to change, Maximising productivity and understanding team dynamics and effective team working.

All staff were given an opportunity to apply for the Mary Seacole Programme for Aspiring First Time Leaders. The Mary Seacole Local Programme is a six-month leadership development programme designed by the NHS Leadership Academy and offered locally to help develop leaders across the system.

New e-learning modules on the Electronic Staff record (ESR) were added to replace existing modules to ensure content was up to date and provided better interaction for users. Two new e-elarning modules were added "Data Security Awareness" and "Conflicts of Interest".

Sustainability and Transformation Plan

Creating a Sustainable Health and Care System in Greater Nottingham

Health and social care organisations in Greater Nottingham have been working closer together with a shared vision for delivering more joined-up care for local people.

This involves all of the four Clinical Commissioning Groups – Nottingham City, Nottingham West, Nottingham North and East, and Rushcliffe – working with hospitals, GPs, councils and other health teams to transform the way we plan and provide care.

All of this is being led by the Greater Nottingham Transformation Partnership and is part of the wider Nottinghamshire Sustainability and Transformation Partnership (STP), which aims to improve the physical and mental health and wellbeing of people in our area, while simplifying and streamlining the way that people get care and support.

The key principles are:

- We want people to lead healthy lives and to be independent and well
- If someone needs help, advice or support, they should easily be able to find out how and where to get it.
- Where possible, this help and support should be close to home, with hospitals only for those who need to be there.

Why we have to change

Our population is growing, people are living longer with more health problems, and our patients do not always get the consistent quality of care we would wish for them. The rising cost of health and social care is becoming unsustainable.

It is not simply about putting more money into the system. Some parts of the NHS work brilliantly for our patients, but others do not. We have a complicated system with care delivered by different, fragmented organisations that do not always work together in a joined-up way.

We believe an integrated system can join up all of the different NHS organisations and the social care delivered by local councils. Patients will get better, more joined-up care, often closer to home in their communities. We will be better able to keep pace with our growing and ageing population and fix some of the current problems we have in our NHS, while making it sustainable for the future.

Our local NHS has a history of innovation that we can build on. We believe we can continue to find new ways of working together that will be better for our patients and meet the needs of our growing and ageing population within our available budget.

Importantly, this will not change the fundamental principles of the NHS: it will still be free at the point of use and available to all.

Moving forward

Greater Nottingham was announced by NHS England in Summer 2017 as one of eight ‘accelerator’ sites to explore new ways to join up health and social care as part of a more integrated system.

Transformation funds were made available by NHS England to allow the accelerator sites to employ special teams to focus on the changes needed. Learning can then be shared with other NHS organisations nationally.

Greater Nottingham used part of the funding to get expert advice from other parts of the world that have successfully integrated health systems to benefit patients. This advice has helped put together the ‘building blocks’ of what is needed to join up health and social care.

We are starting to move towards bringing all of the Greater Nottingham Clinical Commissioning Groups together under a single Accountable Officer.

The next step is to understand how we might bring together the different providers of health and social care.

Feedback and discussion

All of this has been underpinned by ongoing engagement with patients and citizens to make sure we are getting regular feedback about our work.

These include three large public events attended by more than 300 people in November 2017, February 2018 and March 2018 – building on the public conversations held as part of the initial STP launch. All of the discussion has been fed into the different workstreams for transformation.

All of this has been done in close collaboration with HealthWatch and the Greater Nottingham Citizens Advisory Group – as well as regular conversations with patient groups.

Next steps for transformation

Our learning from the last year is being put into a business case for options for how we will progress towards the next stage of an integrated care system. This will help us to understand what we can do ourselves and what we might need help to do (‘build or buy’).

The organisations who make up our partnership will agree on the preferred option – this will be published at public board meetings.

We will work to further understand how our health care providers can best come together Sustainability

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.

Nottingham North and East CCG is an active member of the Health and Wellbeing Board.

The consultation for the second Nottinghamshire Joint Health & Wellbeing Strategy was launched by the Health and Wellbeing Board at their meeting on 6 September 2017 and ran until 29 October 2017.

The consultation aimed to invite views from professionals from service providers and voluntary sector organisations, members of the public and wider partners and covered four key areas:

- Vision - what the HWB wants to achieve
- Approach - how the HWB will work
- Strategic Ambitions – broad themes for work
- Priorities for action - specific areas of work to improve health and wellbeing

The CCG was part of the Nottinghamshire CCGs formal response to the consultation.

The Joint Health and Wellbeing Strategy for Nottinghamshire 2018-2022 was agreed in December 2017. The Health and Wellbeing Board will develop a delivery plan during 2018 as it discusses each of the ambitions and priorities set out.

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.

Sustainability

Environmental sustainable development

Sustainability in this context is about the smart and efficient use of natural resources, to reduce both immediate and long term social, environmental and economic risks. The cost of all natural resources is rising and there are increasing health and wellbeing impacts from the social, economic and environmental costs of natural resource extraction and use. The most widely accepted definition for sustainable development comes from the 1992 Rio Earth summit, which defines it as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs".

The CCG recognises that the activities associated with commissioning and delivering healthcare services can have an adverse impact on the environment, which in turn can have negative health implications. Therefore, the CCG understands the importance of reducing its environmental footprint and minimising the negative environmental impacts of delivering its services.

From an operational perspective the CCG understands that quality healthcare delivered by sustainable providers at the right time and in the right place reduces the use of resources and improves environmental sustainability. The CCG leads by example and seeks to work in a way that has a positive effect on the communities for which we commission services. As an example, we have established strategic commissioning partnerships with Nottingham City, Nottingham West CCG and Rushcliffe CCG.

We also expect a commitment to the principles of environmental sustainability from our providers, this is because most of the CCGs environmental & social impact occur through our commissioning. For our commissioned services we use the 'sustainability comparator' established by the Sustainable Development Unit to measure the performance of our service providers (https://www.sduhealth.org.uk/policy-strategy/reporting/organisational-summaries.aspx).

The mandate for sustainability reporting

For the NHS, sustainable development has been recognised at a national level as an integral part of efficiently delivering high quality healthcare. To this end, the Department of Health Group Accounting Manual (DoH GAM) states that all NHS bodies are required to produce a sustainability report for inclusion in their Annual Report. This sustainability report has been prepared in accordance with HM Treasury's Public Sector Annual Reports: Sustainability Reporting Guidance 2016/17 and guidance from the Sustainable Development Unit (SDU).

Summary of environmental performance

The table below summarises the environmental performance of the CCG for the 17/18 financial year and the pre-ceding four years across a variety of sustainability metrics. The CCG has been able to include new data this year that wasn't previously reported, this is due to improved data capture and reporting. This new data allows a greater understanding of the CCGs performance and will be reported for all subsequent years.

The grand total carbon emissions for the CCG have decreased slightly (42.44 t CO2e) compared with the 2016/17 financial year (46.32 t CO2e). In comparison to the baseline year (2013/14) the CCG has been able to reduce its total carbon emissions by 13.20%.

Energy in buildings

Energy consumption within buildings has increased from 75,783 kWh last year to 85,647 kWh this year, however the associated CO2e emissions have decreased from 30 t CO2e to 25 t CO2e. The primary reason for this reduction is the change in the conversion factor used to convert electricity consumption into carbon emissions. In 2016/17 the conversion factor was 0.41205 kg CO2e per kWh, but in 2017/18 this was reduced to 0.35156 kg CO2e per kWh. This change reflects the changing energy mix used in the production of electricity, specifically the recent move away from fossil fuels and towards renewables in the form of domestic solar, on-shore wind and off-shore wind. This trend of reduction has been ongoing since 2014/15 where the electricity conversion factor was 0.49426 kg CO2e per kWh. Conversely the conversion factor for natural gas remains unchanged, however the CCG did not previously report a disaggregated figure for gas consumption.

Sustainability metric		2013/14	2014/15	2015/16	2016/17	2017/18
Grand total GHG emissions (t CO_2e)		48.89	50.28	48.29	46.32	42.44
t CO_2e per WTE		1.19	1.12	1.05	1.02	0.81
Energy in buildings	kWh	77,230	80,379	82,370	75,783	85,647
	Carbon emissions (t CO_2e)	28	31	30	30	26
	Electricity consumption (kWh)	Not reported				33,990
	Gas consumption (kWh)	Not reported				51,657
Water consumption	m^3	636	704	702	706	715
	Carbon emissions (t CO_2e)	0.58	0.64	0.74	0.7	0.65

	m^3 / WTE	15.48	15.68	15.26	15.55	13.60
Transport	Total distance travelled (miles)	48,754	43,805	45,232	44,906	44,091
	Total expenditure (£)	20,297	18,237	25,330	25,147	21,858.15
	Carbon emissions (t CO_2e)	18	16.1	16.4	16.2	13.26
Grey fleet	miles	Not reported				36,066
Taxi	miles	Not reported				171
Train	miles	Not reported				3,927
Waste	Recycling (tonnes)	0.809	0.89	1.11	0.67	1.11
	Landfill (tonnes)	7.29	7.29	7.29	7.29	7.29
	Carbon emissions (t CO2e)	1.468	1.47	1.474	1.475	2.53
Headcount	WTE	41.08	44.89	45.99	45.41	52.57

Water consumption

Water consumption has increased slightly, from 706 m3 in 2016/17 to 715 m3 this year. However, when the water consumption data is normalised against WTE figures the CCG has slightly increased its water use efficiency to 13.60 m3 per WTE.

Transport

Regarding transport, the total number of miles travelled by CCG staff has decreased slightly from 44,906 miles in 2016/17 down to 44,091 miles in 2017/18. This is the first year that the CCG has reported the individual components to the total miles travelled (grey fleet, taxi & train). From this data grey fleet mileage (business travel where staff use their own car) is the largest contributor to the total number of business miles travelled. The mileage data for taxi and train journeys was estimated from expenditure using the Sustainable Development Unit carbon emissions tool. This is because the CCG does not directly collect mileage data for these forms of travel, unlike grey fleet mileage. In line with the reduction in total business miles the CO_2e emissions resulting from travel (13.26 t CO_2e) have also reduced when compared with last year (16.20 t CO_2e) & the baseline year (18.00 t CO_2e).

Scoped emissions

The CCG is required to report its carbon emissions as scope 1, 2 & 3 totals, the table below contains this information.

Scope	Total emissions (t CO_2e)	Carbon sources
Scope 1	11.65	Gas consumption
		Water consumption
Scope 2	15	Electricity consumption
Scope 3	15.8	Grey fleet mileage
		Taxi travel
		Train travel
		Waste production

Financial Management: Capability and Performance

The 2017/18 financial year for NHS Nottingham North and East was a challenging year, with a planned savings target (QIPP) of £12.4 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 challenging. The CCG also saw additional financial pressures as a result of national drug shortages on low cost generic supply.

The CCG had entered into formal financial recovery in 2016/17, and the governance structure established in 2016/17 was further strengthened during 2017/18 with the Financial Recovery Programme Management Office (PMO) covering all four CCGs in Greater Nottingham - NHS Rushcliffe, Nottingham City, Nottingham West and Nottingham North and East CCGs. More detail on this can be found in the Governance Statement later in this report.

The CCG commenced the year with a requirement to achieve in year breakeven (Control Total of £0). This has been amended to a requirement to deliver an in year surplus of £177,000. This value effectively represents the return of prescribing savings that have been held nationally. The CCG has been required to hold back an amount (£932,000) to contribute towards a national 'risk reserve', however, the CCG has been allowed to release this into the position without having to increase the in-year surplus in order to offset the financial pressure of the low cost generic supply.

With the engagement of our GP colleagues and practices, a number of areas under financial pressure have been addressed through the Greater Nottingham PMO and this work has contributed to the CCG meeting its financial duties for the year, including delivery of the revised Control Total. Some non-recurrent measures were used in achieving the 2017/18 position. This gives the CCG an underlying position of £5.2 million deficit at the end of the financial year. The duties are summarised below:

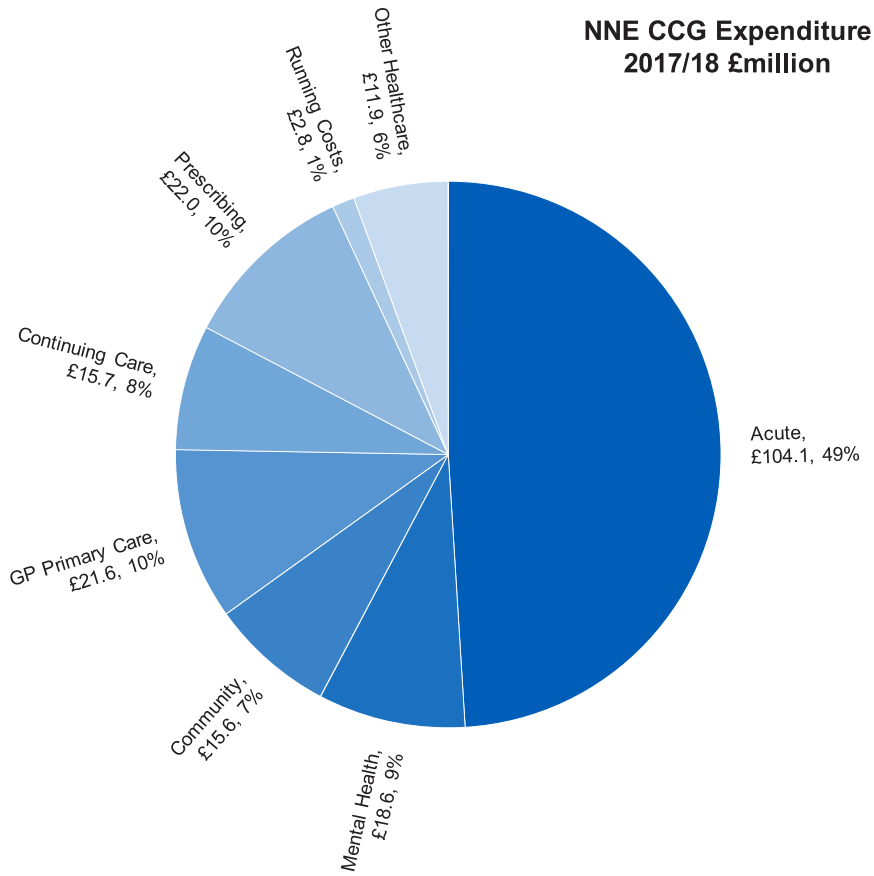
Delivery of 2017/18 Financial Duties

Financial Duty	Target	Delivery
Keep within revenue resource limit	£216,418,000	✓
Achieve Control Total Surplus	£177,000	✓
Cash balances within agreed limit	<£273,600	✓
Remain within running cost allowance	£3,242,000	✓
Achieve BPPC targets	>95%	✓

The Better Payment Practice Code (BPPC) requires the CCG 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). The chart below shows where we spent our resource:

Expenditure



The ‘Other Healthcare’ section includes development costs of the Greater Nottingham Integrated Care System, which have been funded from NHS England

Delivery of the QIPP target was a key area for the PMO to oversee. The overall £12.3 million target was met, £10 million recurrently delivered through programme savings and the under delivery of £2.3 million is offset by non-recurrent mitigations.

Savings Delivery by Programme

Programme Area	Description	Savings (£000s)
Planned Care	Services for pre-arranged health care either in a community setting or in the hospital.	£5,549
Prescribing	Services relating to the authorisation and usage of a medicine or treatment.	£1,765
Continuing Healthcare	Services related to a package of care for people who have significant ongoing healthcare needs.	£1341
Internal Efficiencies	Internal review of organisation resources.	£486
Urgent Care	Improved management of non-elective admissions.	£877
Community Care	Services enabling people to remain living in their own homes and to retain as much independence as possible.	
Mental Health	Services relating to a person’s condition with regard to their psychological and emotional well-being.	
Total		**£10,018**

Financial Governance

The internal financial governance framework includes the Finance and QIPP Group, which meets monthly and oversees the financial recovery programme of the CCG. This has been strengthened throughout the year to support the transition to the Greater Nottingham Clinical Commissioning Partnership with the introduction of the Greater Nottingham Finance Group, alongside the financial recovery groups supported by the Greater Nottingham Financial Recovery Programme Management Office (PMO).

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

The detailed accounting policies approved by the Audit Committee comply with the NHS Group Accounting Manual and International Financial Reporting Standards (IFRS). 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.

2018/19 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 £6.1 million (3.09%) increase in its recurrent revenue allocation. This additional growth is required to finance the underlying deficit, demographic and other activity growth pressures, national requirements such as the Mental Health Investment Standard (MHIS), inflation and cost pressures. With these requirements totalling £19.4 million, the CCG has a 2018/19 QIPP target of £13.3 million (6.2% of allocation) in order to deliver the NHS England business rules.

This QIPP target is significantly higher than savings delivered in previous years and represents a significant financial risk. Achievement will be reliant upon the transformation and system changes that the health economy confirmed as part of the Sustainability and Transformation Partnership (STP).

The key metrics for the 2018/19 financial year are as follows:

2018/19 Financial Plan Metrics

Metric	£
Business rules (plan meets all business rule requirements)	
Surplus – deliver Control Total (in year breakeven)	Breakeven
Running cost allowance	3,238,000
Contingency – 0.5% requirement	1,070,000
Mental Health investment Standard met	YES
£3/head Primary Care fund met	YES
Resultant plan	
Total Revenue Allocation (excluding carried forward surplus)	212,052,000
In year Surplus / (Deficit)	0
Recurrent underlying Surplus / (Deficit)	725,000
QIPP	13,311,000

The development of the Greater Nottingham Financial Recovery Plan for 2017/18 and subsequent delivery provides a strong basis for continued delivery in 2018/19. This includes improved processes for Financial Recovery, senior leadership, strengthened monitoring, highlight reporting and escalation, strengthened governance and clearer line of sight to Governing Bodies and increased PMO capacity.

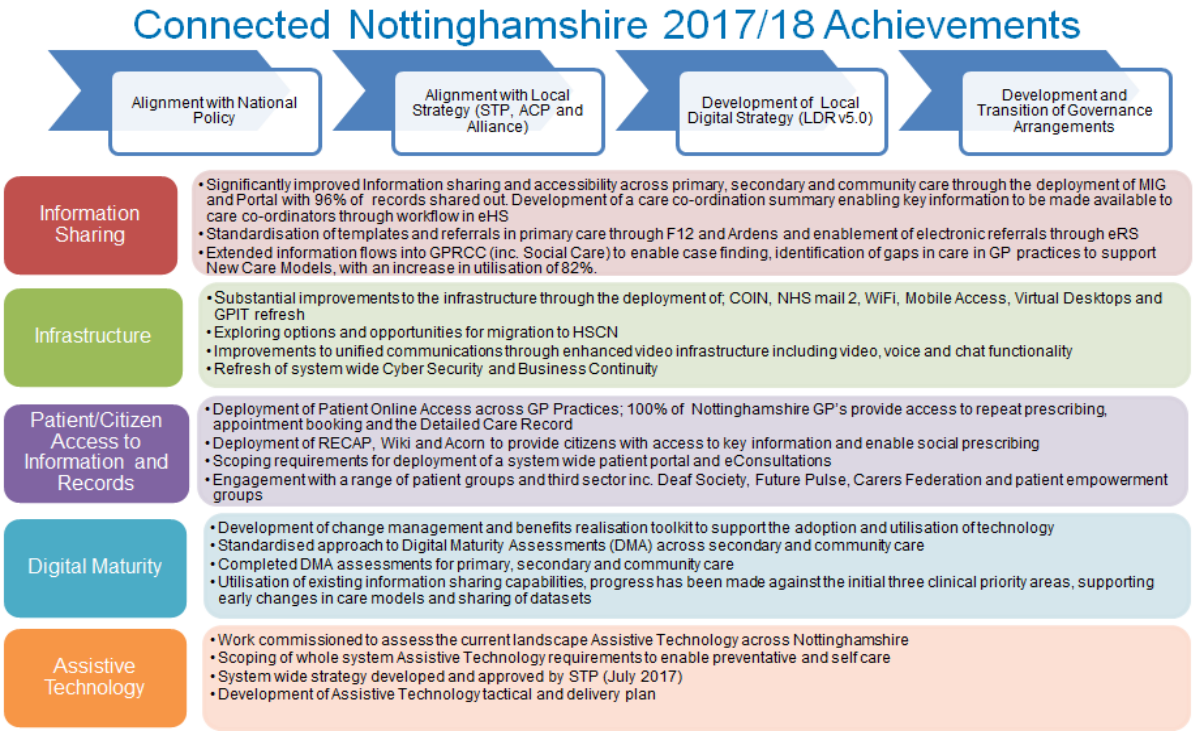
The 18/19 Financial Recovery Programme includes over 70 schemes managed across 9 Programme Areas with senior leadership. The Greater Nottingham PMO will continue to lead the development of the plan and prioritise mobilisation for delivery.

Paper-free at the point of care

Connected Nottinghamshire is a digital programme that was set up in 2013 to improve sharing of health and social care information between organisations to enhance patients' experience of care, support business transformation and encourage collaborative working between health and social care IT providers with the aim of a fully digital and interoperable health and care system by 2020.

Nottinghamshire's Sustainability and Transformation Partnership (STP) has identified Technology Enabled Care (TEC) as one of its high impact work streams and the programme is responsible for the development of TEC plans to support the Integrated Care System (ICS) and Integrated Care Partnerships (ICP) through Nottinghamshire strategic digital plans known as the Local Digital Roadmap (LDR).

The programme reports directly through a programme board, with the Greater Nottingham Chief Finance Officer (CFO) acting as the senior responsible owner (SRO). The Board reports to the ICS and Local Health and Wellbeing Board and has strong links in to Nottingham City and Nottinghamshire County Councils.



Strategic Planning Activities: during 2017/18 a number of strategic planning activities have taken place to ensure continued alignment with national policy and direction, to take into account changes in legislation and to ensure alignment with Nottinghamshire Sustainability and Transformation Partnership.

The programme has reviewed and updated its delivery plans to ensure changes to local and national strategic plans and policy are reflected in the digital strategy. There has also been a period of development of the programme governance structure to enable post implementation transition to business as usual.

Analytics at point of care: GP Repository for Clinical Care (GPRCC) project is now in its third phase. The focus of the first phase of GPRCC was to develop the technology required to combine data sources for direct patient care, the second phase has extended how the data is used to support practices to perform their clinical audits, view system performance outcomes measures and get more from Public Health services through the use of the aggregate GPRCC2 data. The third phase has seen the increase of data flows into GPRCC including Social Care and the increase in endpoints with care co-ordinators able to access a care co-ordination summary through workflow which has assist in, and, improved MDT management.

Access to direct care information: with greater collaborative working across areas of care, shared access to all direct care information is essential. For this reason technology referred to as 'Portal' technology is required. Nottinghamshire made a decision to support the provision of this service by Nottingham University Hospitals using the CareCentric set of technologies. From 2017-2020 this will form the main information exchange for sharing of direct care information across all Nottinghamshire health and care providers. Phase 1a and 1b which includes; data feeds extracted from, and, access provided to these feeds to Sherwood Forest Hospital Trust, Nottingham University Hospitals and Nottinghamshire Healthcare Trust. Phase 1a also included access to key GP data though a view within the portal. Early benefits realisation management has seen over 90 hours of clinical time saved since deployment of this technology.

Sharing of GP records: significant progress has been made in this area. Most notably via the Medical Interoperability Gateway (MIG) with all GP practices in Nottinghamshire agreeing their patients' key medical items are available to be viewed, only when needed, by clinicians in all care settings at the point of care to improve informed decision making. An additional End of Life dataset is now available through MIG to support clinicians treating this cohort of patients. Phase three of MIG was deployed in 2017/18 increasing access across community care.

Consent management: the enhanced data sharing model (eDSM) is the model that has been introduced for TPP SystmOne sites which enables the safe sharing of patient information to support patient care on a consent basis; this has further been improved in February 2018 to include an access verification process. As of January 2018 96% of patient records in SystmOne practices are available to be viewed via systems such as the Medical Interoperability Gateway (MIG) by clinicians in various settings such as Integrated Urgent Care, thereby greatly improving the speed of informed decisions and better patient experiences and outcomes.

Improved Infrastructure: Public WiFi has successfully been deployed across 100% of the GP estate enabling agile, multidisciplinary and federated working.

Work has been undertaken to improve remote communications through the deployment of video, voice and instant chat capabilities to support virtual meetings, multidisciplinary and multisite teams to work effectively and efficiently and enable them to know when someone is available and to be able to communicate with them.

Patient access to GP records and enhanced patient online services: 100% of Nottinghamshire practices are technically enabled for Patient Online Access. Average patient registrations are currently at 25% with some practices achieving as much as 50% of patients registered for online services such as appointment booking, ordering repeat prescriptions and access to their detailed care record.

A number of activities have taken place to explore opportunities to provide enhanced patient online services, including e-consultation functionality which will enable the development of a patient online strategy and delivery plan in 2018/19.

Assistive Technology: during 2017/18 a review was commissioned to assess the current assistive technology landscape across Nottinghamshire. This review resulted in the development of a system wide assistive technology strategy and tactical delivery plan support preventative and self-care.

Midlands Accord: in order to support the digital agenda on a larger scale Nottinghamshire has been working with other Local Digital Roadmap footprints across the Midlands which have enabled the development of the 'Midlands Accord'. The Midlands Accord is a concept of a co-operative across the health and care community spanning the whole of the Midlands geographical area, with an aspirational goal of a mature digital economy across health and social care in order to reduce the inefficiencies and improve patient experience.

Estates strategy

Having the right infrastructure in place in primary and community settings is crucial for the successful delivery of the Sustainability and Transformation Partnership (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.

During 17/18 good progress was made in a number of areas:

- **Hucknall:** the CCG has commissioned an outline business case to provide a new health centre for the town which is under pressure from extensive housing developments locally.
- **Netherfield:** the CCG approved in principle the outline business case for a new surgery building
- **Calverton:** Further funding was secured to extend the surgery and improve the quality of the existing rooms. Work will start very early in the new financial year.

- **Carlton:** Funding was approved to increase the capacity of two premises in the area to accommodate the growing number of patients registering with the practices
- Maximising utilisation in our existing premises
- Vacant space: identifying premises we no longer require

We continue to work with Gedling and Ashfield Borough Councils to ensure we have sufficient capacity for new housing developments.

Better Care Fund

In Nottinghamshire a Better Care Fund (BCF) plan has been developed between the six Nottinghamshire 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

During 2017/18 partners worked together to monitor implementation of schemes and progress against national conditions and key metrics. The key metrics demonstrate the progress made in 2017/18 in Nottinghamshire up to 31 March 2018:

Standard (to Q3 2017/18)	Target	Performance
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	66,097	66,214
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	565.6	500
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85%	85.05%

Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month)	Q1 607.0 Q2 613.7 Q3 613.7 Q4 597.0	673.79 Q3
Percentage of users satisfied that the adaptations met their identified needs	100%	95% Q2
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).	18%	18%

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.

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:

Samantha Walters
Accountable Officer
24 May 2018

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 2017/18

Member	Role
Dr James Hopkinson	Chair and Clinical Lead
Sam Walters	Chief Officer
Jonathan Bemrose	Chief Finance Officer
Dr Paramjit Panesar	Assistant Clinical Lead
Dr Ian Campbell	GP Member
Dr Caitriona Kennedy	GP Member
Dr Elaine Maddock	GP Member
Dr Ben Teasdale	Secondary Care Consultant
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
Paul Mckay	Observer

The Governing Body membership is supported by one observer who is an Officer from the Local Authority. The Observer is a fully active participant 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 2018, 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 2017/18

Member	Role
Terry Allen	Lay Member Financial Management and Audit
Janet Champion	Lay Member Patient and Public Involvement
Mike Wilkins	Lay Member Primary Care

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 2017/18 there has been no 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 Sam Walters to be the Accountable Officer of Nottingham North and East CCG.

The responsibilities of an accountable officer are set out under the NHS Act (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;
- Keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction;
- Such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error;
- Safeguarding the CCGs 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 NHS Act 2006 and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the NHS Act 2006; and
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the NHS Act 2006.

Under the NHS Act 2006, NHS England has directed each CCG 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 CCG 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
- Assess the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

To the best of my knowledge and belief, and subject to the disclosure set out below, I have properly discharged the responsibilities set out under the NHS Act 2006,

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; and

- 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.

Signed:

Samantha Walters
Accountable Officer
24 May 2018

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 2017, 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.

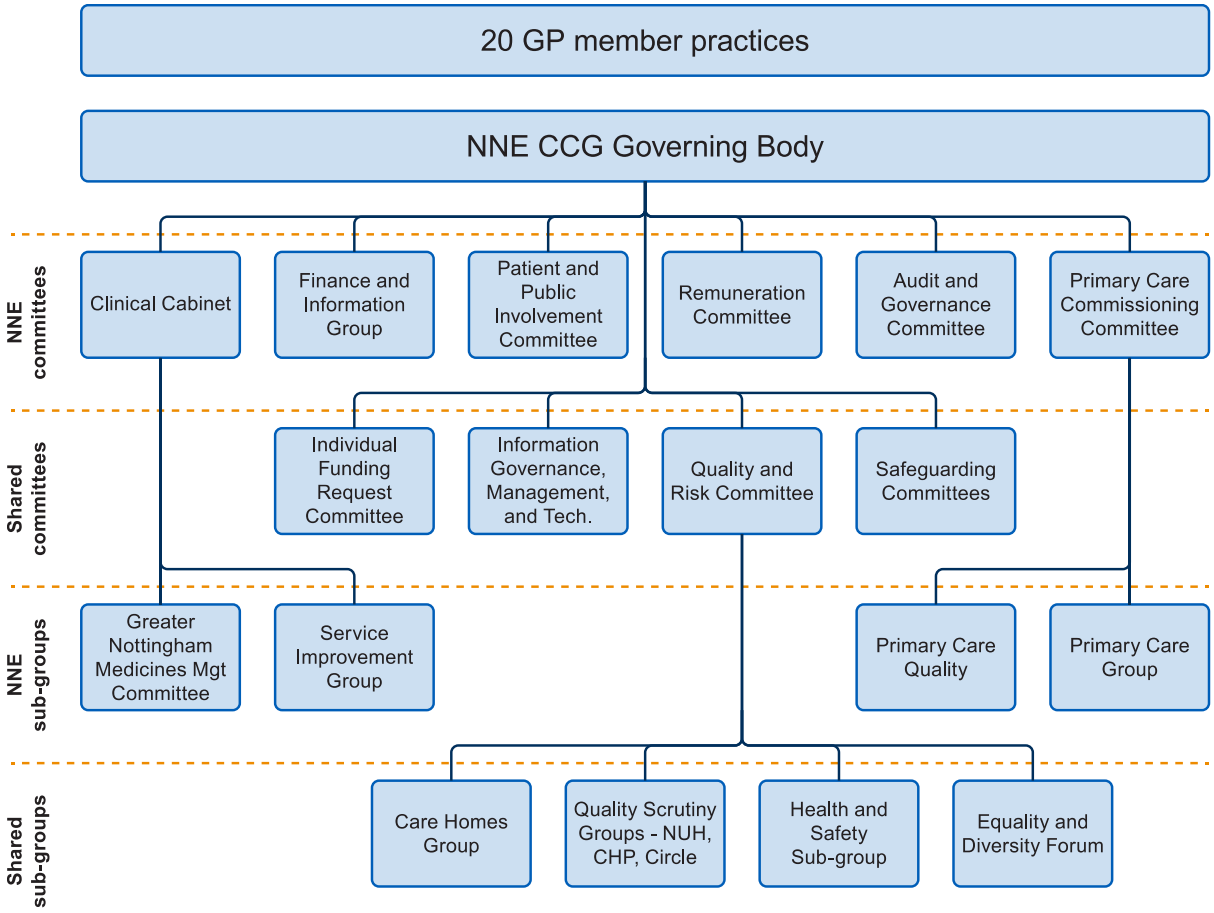
Governance arrangements and effectiveness

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 including sub-groups (March 2018)

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 2017/18 to discuss reserved matters including changes to the CCG Constitution, CCG alignment and Joint Committee across Greater Nottingham.

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.

Governing Body member	Governing Body position	Total/ possible
Dr James Hopkinson	Chair and Clinical Lead	8/8 1 Deputy
Sam Walters	Chief Officer	8/8 1 Deputy
Jonathan Bemrose	Chief Finance Officer	8/8
Dr Paramjit Panesar	Assistant Clinical Lead	8/7 1 As Chair
Dr Ian Campbell	GP Member	8/7
Dr Caitriona Kennedy	GP Member	8/8
Dr Elaine Maddock	GP Member	6/8
Dr Ben Teasdale	Secondary Care Consultant	5/8
Nichola Bramhall	Registered Nurse/Director of Nursing and Quality	8/8 1 Deputy
Terry Allen	Lay Member Financial Management and Audit	7/8
Janet Champion	Lay Member Patient and Public Involvement	7/8
Mike Wilkins	Lay Member Primary Care	4/8

Governing Body Attendance

Committees

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. The committees include the CCG's own as well as joint committees and joint working arrangements. Later in 2017/18 the CCG's Audit and Governance Committee met in common with NHS Nottingham West, NHS Rushcliffe and NHS City CCGs.

The following are the CCG's own committees:

- Audit and Governance Committee
- Finance and Information Group
- Remuneration Committee
- Primary Care Commissioning Committee
- Clinical Cabinet
- Patient and Public Involvement Committee

The following committees are either joint committees or have joint working arrangements. They were originally stablished under a Memorandum of Understanding to allow for 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

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 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. The committee has delegated authority to review and approve the annual report and annual accounts.

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.

Since October 2017, the committee has met as a committee in common with NHS Nottingham West and Rushcliffe CCGs. This has proved to be an efficient and effective way of undertaking audit committee business. In line with the Greater Nottingham Commissioning Partnership, the final meeting of the 2017/18 year also included NHS Nottingham City CCG.

Highlights of work

In early 2017/18 the committee approved the CCG's Annual Report and Accounts 2016/17 on behalf of the Governing Body, 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 a deep dive report on the Cyber-attack which took place in May 2017 and the lessons learned from this.

In addition, the committee approved the internal audit and counter fraud work plans including the counter fraud self-review tool submissions for 2018/19. This latter submission showed the CCG's score as 'green' overall. The Audit and Governance Committee approves resources and maintains an overview of progress.

The Committee deferred the review of the Integrated Risk Management Policy pending the development of a Greater Nottingham Policy in early 2018/19. The committee reviewed the quarterly and annual conflicts of interest self-certification submissions.

Membership and 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	5/5

Audit and Governance Committee Attendance

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.

Highlights of work

- Reviewed progress against QIPP and financial recovery plan
- Received and discussed the monthly financial performance report
- Received and discussed monthly activity reports

- Considered relevant financial, activity and information issues affecting the CCG
- Reviewed contract challenges
- Reviewed savings on rebate schemes
- Assessed financial risk and recommended mitigating actions to the Governing Body
- Considered topic specific issues as required

Membership and attendance

Committee member	Committee position	Total/ possible
Terry Allen	Lay Member Financial Management and Audit - Chair	10/10
Hazel Buchanan	Director of Operations	6/10
Maxine Bunn	Director of Contracting	9/10 (4 Deputy)
James Hopkinson	GP Clinical Lead	9/10
Ian Livsey	Deputy Chief Finance Officer	10/10 (1 Deputy)
Sergio Pappalettera	Contract & Information Manager	10/10
Sharon Pickett	Deputy Chief Officer	9/10
Sam Walters	Chief Officer	1/10

Finance and Information Group Attendance

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.

Highlights of work

NNE Remuneration Committee

- VSM pay and 1% pay award
- Chief Finance Officer remuneration
- Chief Officer remuneration
- Director of Operations remuneration
- Deputy Chief Officer remuneration

Remuneration Committee in Common

- Interim Accountable Officer remuneration
- Chief Nurse and Director of Quality remuneration
- Chief Commissioning Officer remuneration
- Chief Operating Officer remuneration
- Chief Finance Officer remuneration
- Tier 2 Directors remuneration

Membership and attendance

In 2017/18 the committee met on three occasions as a Committee in Common with NHS Nottingham West and Rushcliffe CCG and twice as an individual committee.

Remuneration 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	1/2
Mike Wilkins	Lay Member Primary Care	5/5

Remuneration Committee Attendance

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

- Adoption of the Greater Nottingham GP Forward View (GPFV) Plan as the CCG's Primary Care Strategy.
- Reviewed progress against the GPFV action plan
- Received and reviewed quarterly Primary Care Quality Dashboards
- Reviewed and monitored the primary care risk register
- Approved practice merger proposal
- Considered requests on changes to GP practice boundaries
- Considered requests for list closures
- Approved the GP Enhanced Delivery Scheme and other Enhanced Services for 2018/19

Membership and attendance

Committee member	Committee position	Total/possible
Mike Wilkins	Lay Member – Primary Care	4/5
Terry Allen	Lay Member – Financial Management & Audit	5/5
Janet Champion	Lay Member – Patient and Public Involvement	5/5
Caitriona Kennedy Parm Panesar	GP Representatives	5/5
Ian Livsey	Deputy Chief Finance Officer	5/5 2 Deputy
Esther Gaskill	Head Of Quality, Patient Safety & Experience	5/5 1 Deputy
Sharon Pickett	Deputy Chief Officer	5/5 1 Deputy

Primary Care Commissioning Committee Attendance

The Clinical Cabinet

The Clinical Cabinet has 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

- Financial Recovery Schemes
- The Nottinghamshire Area Prescribing Committee (NAPC) mandate
- Investment in children's mental health services in line with the expectations within the Five Year Forward View for Mental Health and Future in Mind programme.
- Investment in Early Intervention in Psychosis (EIP).
- Consultant Rheumatology capacity from Nottingham University Hospitals (NUH) to undertake the clinical triage of all GP rheumatology referrals.
- Appointment of a community MSK provider to triage rheumatology referrals and provide spinal/ back triage before 31 December 2017.
- Procurement of a new community MSK model for 2019/20 and investment in current Trauma and Orthopaedics provider to develop conservative management/ pre-rehab service/s for 2018/19.

- Faecal Immunochemical Test (FIT) Proposal
- Non-specific Cancer Symptoms Pathway (NCSP)

Membership and attendance

Practice	Total/ possible	Practice	Total/ possible
Apple Tree Medical Practice	3/8	Stenhouse Medical Centre	7/8
Daybrook Medical Practice	2/8	Torkard Hill Medical Practice	7/8
Giltbrook Surgery	4/8	Trentside Medical Practice	7/8
Highcroft Surgery	6/8	Unity Surgery	5/8
Jubilee Practice	0/8	West Oak Surgery	2/8
Newthorpe Medical Centre	5/8	Westdale Lane Surgery	7/8
Oakenhall Medical Centre	4/8	Whyburn Medical Practice	6/8
OM Surgery	6/8	Practice Manager	5/8
Park House Medical Centre	5/8	Practice Nurse	0/8
Plains View Surgery	6/8	Peacock Medical Practice	1/8
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	6/8 (2 x dep chair)
Jonathan Bemrose Chief Finance Officer	8/8 (2x dep)	Sharon Pickett Deputy Chief Officer	8/8 (3x dep)
Patient and Public Representatives- Kathryn Sanderson Jeff Burgoyne	 5/8 8/8	Dr John Tomlinson Jonathan Gribbin Public Health	3/5 1/3
Dr James Hopkinson Clinical Lead and Chair	8/8 (2 x dep)	Sam Walters Chief Officer	4/8 (1 x dep)
Paul McKay Local Authority	0/6		

Clinical Cabinet Attendance

Patient and Public Involvement Committee

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 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

- Primary Care Access
- GP Practice Patient Survey
- Financial Recovery Engagement Plans
- PPI Governance Structure

Membership and attendance

Committee member	Committee position	Total/ possible
Janet Champion	Lay Member Patient and Public Involvement - Chair	6/6
Patient/Public Representation	6 Patient/Public Representatives	6/6
Hazel Buchanan	Director of Operations	5/6
Helen Horsfield	Patient Experience Manager	6/6 (2 Deputy)
Sharon Pickett	Deputy Chief Officer	3/6
	GP Governing Body Member	4/6

Patient and Public Involvement Committee Attendance

Information Governance, Management and Technology (IGMT) Committee

Key responsibilities

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 including the introduction of the General Data Protection Regulations (GDPR).
- 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 including implementation of the Cyber Security action plans following the WannaCry Ransomware cyber-attack.
- 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.

- Agreeing 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.

The IGMT Committee approved the following documents in 2017/18:

- IGMT Committee Terms of Reference
- Information Governance Management Framework
- Information Governance Leads meeting Terms of Reference
- Information Security Policy
- Confidentiality and Data Protection Policy
- Electronic Remote Working Policy
- Internet and Electronic Mail Policy
- Bring Your Own Device
- Data Management Strategy
- Data Quality Policy
- Access to Patient or Staff Information by Using a Smart Card

Membership and attendance

IGMT Committee Member	Committee Position	Total/ Possible
Andy Hall	Director of Outcomes and Information and Senior Information Risk Owner (SIRO) Rushcliffe CCG (Chair)	4/4
Gina Holmes (up to January 2018)	Information Governance Lead, Mansfield and Ashfield CCG and Newark and Sherwood CCG	3/3
Ruth Lloyd (from January 2018)	Head of Governance, Mansfield and Ashfield CCG and Newark and Sherwood CCG	1/1
Paul Gardner (up to June 2017)	Head of Information Governance, Nottingham City CCG	1/1
Loretta Bradley (from October 2017)	Head of Information Governance, Nottingham City CCG	2/2
Nichola Bramhall	Caldicott Guardian South Nottingham CCGs	3/4 + 1 deputy
Mike O'Neil	General Practitioner Nottingham West CCG and Senior Information Risk Owner (SIRO) Nottingham West	2/2
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	0/4 + 1 deputy
Sarah Bray (up to September 2017)	Senior Information Risk Owner (SIRO) for Mansfield and Ashfield CCG and Newark and Sherwood CCG	1/1
Jonathan Shuter (from September 2017 until January 2018)	Senior Information Risk Owner (SIRO) for Mansfield and Ashfield CCG and Newark and Sherwood CCG	2/2
Mick Cawley (from January 2018)	Senior Information Risk Owner (SIRO) for Mansfield and Ashfield CCG and Newark and Sherwood CCG	1/1
Terry Allen (from September 2017)	Governing Body Lay Member for Nottingham North and East CCG	2/2
Jaki Taylor	Director of NHIS	3/4 + 1 deputy

IGM&T Committee Attendance

Quality and Risk Committee

Key responsibilities

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 2017/18 this included harm impact reviews undertaken at Nottingham University Hopsitals, Circle and East Midlands Ambulance Service as a result of continued failure to achieve ED/ cancer access targets and ambulance response times. ED quality indicators and nursing metrics introduced last year were also reviewed.

- 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. During 2017/18 quarterly H&S incident reports and EDS2 action plan updates were received by the committee. 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 2017/18 one risk has been archived (Circle endoscopy washer issues). Two new risks have been added (Circle endoscopy washer issues and Capacity to undertake learning disability mortality reviews). A number of risks have reduced in year (quality monitoring in primary care, harm associated with cancer breaches, deprivation of liberty safeguards). One risk has increased (potential harm as a result of ED performance). All other risks have stayed the same.
- A log of Equality Quality Impact Assessments (EQIA) has been received by the Committee. During 2017/18 an integrated Equality and Quality Impact Assessment process has been introduced jointly with Nottingham City CCG incorporating a screening tool, a full assessment and a review panel. EQIAs associated with the Financial Recovery Programme have been reviewed by the panel and outcomes have been shared with the QRC.
- 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 were received. During 2017/18 these included a inspection reports for BMI The Park Hospital, Queen's Medical Centre Urgent and Emergency Care Services and East Midlands Ambulance Service.
- 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

- Joint CCG Service Development Reports were received to aid sharing of good practice and update the Committee on local developments.
- Shared Medicines Management Team Work Programme Updates were received to assure the Committee regarding the work of this team.
- NHS Protect Security Management Standards Self-Review Tool; 360 Assurance SMS Workplan and Quarterly Reports were received to assure the committee in relation to CCG requirements.

During 2017/18 the following reports were also received to enhance assurance:

- Escherica Coli Reduction Action Plan this provided assurance that the CCGs are meeting the requirements to work with partners to analyse primary care risk factors and implement strategies to reduce infection rates e.g. 'to dip or not to dip' and 'what colour is your wee?' campaigns.
- Mazars Review/National Learning Disability Mortality Review this report was received along with plans regarding local implementation.
- Local Maternity System Update a report was provided detailing the local transformation plans for maternity services.

Membership and attendance

Quality and Risk Committee member	Committee position	Total/ possible
Janet Champion	Lay Member, NNE CCG (Chair of QRC)	4/4
Susan Bishop (to December 2017)	Lay Member, NW CCG	1/3
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)	4/4
Hazel Buchanan	Director of Operations, NNE	4/4
Craig Sharples (to July 2017)	Head of Quality, Governance and Engagement NW CCG (Chair of E&D Sub-Group)	0/1 + 1 Deputy
Lynne Sharp	Head of Governance and Integration, RCCG (Chair of H&S sub-group)	3/4
John Tomlinson (to December 2017)	Consultant in Public Health	3/3

Quality and Risk Committee member	Committee position	Total/ possible
Kerrie Adams (from February 2018)	Senior Commissioning Manager, Notts County Council	1/1
Max Booth	Patient Representative, RCCG	2/4
Michael Rich	Patient Representative, NW CCG	3/4
Dr Ben Teasdale	Secondary Care Consultant	2/4
Dr Ram Patel	General Practitioner, RCCG	3/3
Dr Paramjit Panesar	General Practitioner, NNE CCG	3/4
Esther Gaskill	Head of Quality, Patient Safety and Experience, South Notts CCGs	3/4
Jean Gregory	Head of Quality and Adult Safeguarding, South Notts CCGs (Chair of Care Homes sub group)	3/4

Quality and Risk Committee Attendance

Safeguarding Committee Children and Adults

Key responsibilities

Representation from the six Nottinghamshire CCGs continued to oversee the systems and processes in place to ensure the safeguarding of children and adults. The committee responded to matters referred to it by the Nottinghamshire CCG Governing Bodies, Nottinghamshire Safeguarding Children and Adult Boards and the CCG Safeguarding Operational Working Group.

Throughout 2017-18 the Safeguarding Committee met quarterly until October 2017. On all occasions the Committee was quorate.

Highlights of work

- Received the findings from 360 Assurance internal audits of CCG Safeguarding Children and Adult arrangements and monitored subsequent action plans in response.
- Received reports on plans in response to safeguarding concerns in local care homes.
- Monitored progress and issues arising from local and national inquiries into historical abuse in children's homes including Operation Equinox and the National Independent Inquiry into Child Sexual Abuse.
- Monitored progress and subsequent learning and improvement in relation to six Serious Case Reviews (child) 1 safeguarding Adult Review and 5 Domestic Homicide Reviews.
- Received reports in relation to progress in response to health services for Children in Care of the local authority.

- Oversaw the CCGs' position and responses in relation to Domestic and Sexual Abuse.
- Received reports in relation to CCG implementation of the Learning Disability Review Process (LeDeR).
- Received a benefit analysis of the NHS England Safeguarding Assurance tool pilot.
- Made recommendations in relation to future provision of the Multi Agency Safeguarding Hub (MASH) health team.
- Monitored and reported safeguarding and children in care risks.
- Received reports on the Nottinghamshire Children in Care Service Improvement forum, the action plan and associated working groups.
- Oversaw the response to Looked After Children (LAC) health assessment performance data.
- Oversaw the LAC Out of Area and Other Local Authority Children pathways being devised.
- Agreement of the Unaccompanied Asylum Seeking Children CCG pathway.

The following were approved by the Committee in 2017/18:

- Updated Safeguarding Policy.

Membership and 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)	3/3 (1 Deputy)
Nichola Bramhall	Director of Nursing and Quality, South Notts CCGs (Vice Chair)	1/3
Jean Gregory	Head of Quality and Adult Safeguarding, South Notts CCGs	2/3
Rosa Waddingham	Deputy Chief Nurse, for Newark and Sherwood and Mansfield and Ashfield CCGs	2/3
Sue Barnitt	Head of Quality and Patient Safety for Newark and Sherwood and Mansfield and Ashfield CCGs	3/3
Cathy Burke	Nurse Consultant Safeguarding (Designated Professional Adults and Children) for Bassetlaw CCG	3/3
Rachel Bussey (from January 2018)	Adult Head of Nursing for Bassetlaw VVG	1/1

Committee member	Committee position	Total/ possible
Val Simnett	Designated Nurse Safeguarding Children for 5 Nottinghamshire CCGs	3/3
Nicola Ryan	Deputy Chief Nurse for Bassetlaw CCG	3/3 (2 Deputy)
Dr Fiona Straw	Designated Doctor Safeguarding Children, South Nottinghamshire CCGs	1/3
Dr Becky Sands	Designated Doctor Safeguarding Children, North Nottinghamshire CCGs	Maternity Leave
Kathryn Higgins	Designated Nurse Children in Care for 5 Nottinghamshire CCGs	3/3
Dr Victoria Walker	Designated Doctor Children in Care , North Nottinghamshire CCGs	3/3
Dr Melanie Bracewell	Designated Doctor Children in Care, South Nottinghamshire CCGs	2/3
Dr Nadya James	Designated Doctor, Safeguarding	1/3
Dr Jane Selwyn	General Practitioner	2/3
Kerrie Adams	Public Health Manager (children lead) nominated by the Director of Public Health, Nottinghamshire County Council	1/3
Patricia Higham	Lay member	3/3

Safeguarding Committee Attendance

Individual Funding Request Panel

Key responsibilities

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

- There were 102 Individual Funding Request applications processed in accordance with the IFR Policy eligibility criteria. This increased number of applications compared to previous years is as a result of the Mid Notts CCGs no longer routinely funding a host of procedures that were previously included in the Commissioning Policy for Cosmetic Procedures (All Ages). Those procedures include, breast reduction, asymmetry, removal of lipomas, blepharoplasty, septo-rhinoplasty.
    - The IFR Panel considered three (3) requests, all of which were screened and deemed appropriate for full panel consideration.
    - One request was declined by the panel on the grounds of affordability and cost effectiveness and two were approved as clinical exceptionality was demonstrated.
    - 67 cases were screened in line with the policy, all of which were declined for consideration by the IFR Panel at the screening stage as they did not demonstrate clinical exceptionality. Five requests were redirected as they were not appropriate for consideration by the IFR panel: two to the mental health commissioning team, one to the Nottingham North and East podiatry prior approval process and one to the Mid Notts CCG prior approval process.
    - Sixteen IFR application cases were returned. In the main this was due to the forms being incomplete, or illegible.
    - Nine requests were approved at the screening stage, as the requested treatment is routinely commissioned and available within NHS Tariff costs - second opinions, post cancer treatment etc.
    - Two requests for funding are currently pending, awaiting further clinical information from the requesting clinician
- During 17/18 the IFR Panel reviewed four previously approved cases for clinical benefit.
- There were no patient complaints received in response to IFR applications where funding was declined at the screening stage during 2017-2018. The Patient Experience and Complaints Manager for Nottingham North and East, Nottingham West and Rushcliffe Clinical Commissioning Groups dealt with one complaint, in conjunction with the IFR Manager, which was declined by the IFR panel in 2017-18. The request for funding is currently being reviewed by the CCG designated Officer, to consider if the IFR panel took into account

and weighed appropriately all relevant evidence when applying the CCGs decision making framework.

- The IFR Team dealt with 17 requests received from the European Cross Border Healthcare Team who manage requests for NHS funding for treatment abroad.
- No MP enquiries were received in support of IFR applications that were declined at the screening stage during 2017-2018.
- During 2017-2018 the IFR team dealt with a number of Freedom of Information (FOI) requests. The requests received were in relation to IVF, and oculoplastic surgery.
- A quarterly IFR report was tabled at each of the IFR panel meetings during the year which detailed all requests for funding including commissioned and non-commissioned procedures for example IVF, assessment for Asperger's, European Healthcare Requests for Treatment Abroad.

Membership and attendance

Individual Funding Request Panel Member	Committee Position	Total/ Possible
Peter Robinson	Chair (Lay Representative)	5/5
Usha Gadhia	Nominated Deputy Chair (Lay Representative)	2/5
Jonathan Gribbin	Consultant in Public Health, Public Health Nottinghamshire County	5/5
Vicky Bailey (up to October 2017)	Chief Officer, NHS Rushcliffe and NHS Nottingham West CCG	1/4
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	3/5
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
Jane Urquhart	IFR Manager – NHS Mansfield and Ashfield CCG	4/5
Elaine Moss (from February 2018)	Chief Nurse, NHS Mansfield & Ashfield and NHS Newark & Sherwood CCG	1/1
Sally Seeley (from February 2018)	Director of Quality & Personalisation Greater Nottingham CCGs	1/1

Laura Catt	Prescribing Interface Advisor Shared Medicines Management Team	5/5

IFR Panel Attendance

East Midlands Affiliated Commissioning Committee (EMACC)

Key responsibilities

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

- Development of commissioning policies for (i) Orthotic Functional Electrical Stimulation (for foot drop of neurological origin), and (ii) Surrogacy (involving assisted conception). Both of these collaborative policies have been approved by EMACC for implementation by its member CCGs.

- Work has been undertaken to review the evidence and develop the following commissioning policies: (i) Hip Arthroscopy; (ii) Gamete Cryopreservation; which will be considered for approval by EMACC.

- A further work programme of policies to be developed by EMACC has been agreed. Work has commenced on these policies with EMACC again employing a Lead Area Model where each geographical area leads on at least one policy. In addition, EMACC has agreed to co-ordinate a review of the East Midlands Policy for the Management of Individual Funding Requests (IFRs) following the publication of NHS England's Commissioning Policy for IFRs.

- After each EMACC meeting, copies of meeting minutes and a communique are sent to CCGs for members of their Governing Bodies, for information.

Membership and attendance

Committee member	Committee position	Total/ possible
Dr Doug Black	Independent Chair	2/2
Jonathan Gribbin	Public Health Lead and Chair of Clinical Priorities Steering Group	2/2
Sally Seeley	Nottinghamshire Clinical Representative	1/2 + deputy
Dr Ben Milton	Derbyshire Clinical Representative	1/2
Steve Hulme	Derbyshire Representative	1/2
Andy Rix	Lincolnshire Representative	2/2
Dr Vindi Bhandal Dr Sunhil Hindocha	Lincolnshire Clinical Representative	0/2
Caroline Trevithick	Leicestershire Representative	1/2
Sarah Prema	Leicestershire Representative	1/2
Dr Sanjay Gadhia	Northamptonshire Representative	0/2

Committee member	Committee position	Total/ possible
Kathryn Moody Alison Kemp	Northamptonshire Representative	1/2 + deputy
Andy Roylance	Commissioning Manager	2/2

EMACC Attendance

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.

Following considerable changes in the membership of the Governing Body in 2016/17, the past year has provided an opportunity to focus on strategic development. Self-assessment of the Governing Body was carried out in 2017/18, supported by a capacity and capability review by an external organisation that covered leadership, governance and processes, financial position and recovery. Personal Development Plans for Governing Body members have been aligned to the outcomes of the capacity and capability review. Development sessions have focused on CCG integration, the accountable care system, financial turnaround, risk management and risk appetite.

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.

This Governance Statement is intended to demonstrate how the CCG has regard to the principles set out in the code that are considered appropriate for CCGs during the financial year ending 31 March 2017 and up to the date of signing this statement.

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

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 and through CCG committees. 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 review of risks at all meetings as relevant, use of a combined equality and quality impact assessment and privacy impact assessment of policies and service procurements and developments. These impact assessments are reviewed by the respective groups ie the Equality and Quality Impact Assessment Panel and Information Governance Group 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.

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

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.

- The Risk Assurance Framework fitness for purpose is reviewed by the Audit and Governance Committee. In addition the Governing Body also reviews the Risk Assurance Framework regularly throughout the year.
- 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 Risk Assurance Framework as its risk management tool for strategic objectives. This document is reviewed on a regular basis by the executive team members and reported to the Audit and Governance Committee and the Governing Body.

To ensure effective monitoring of delivery against the strategic objectives the CCG has risk registers that cover corporate, financial, clinical, information and safeguarding risks. Significant risks are discussed through the Governing Body agendas and as a result, the impact on strategic objectives is reviewed.

The table below represents the position at the end of March 2018.

Risk ID	Risk Narrative	Initial Risk Rating			Current	Target Risk Rating
		Impact	Likelihood	Score	Mar-18	
R01	The CCG is unable to deliver against plan due to continually increasing activity, unexpected costs and an inability to maintain QIPP savings.	5	5	25	20	15
R02	The fragility of the system impacts on the capability of the CCG to deliver against its financial duties.	5	3	15	15	10
R03	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	10
R04	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	6
R05	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	6
R06	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	12
R07	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 services.	4	3	12	12	6
R08	Due to the CCG alignment, turnaround and other major priorities, maintaining grip at an NNE level may be compromised impacting on the short term priorities and delivering as a CCG.	4	3	12	20	8
R09	Lack of succession planning in the leadership team and the Governing Body impacts on the capability to evidence robust leadership.	4	2	8	4	2
R10	There is a risk that the urgent requirements to support financial recovery becomes the dominant force therefore impacting on decisions being made and a resultant failure to deliver transformational change.	5	3	15	20	6

Amendments to existing risks identified during the year

Financial Plan 2017/18

The level of financial challenge for 2017/18 was unprecedented and the risk of non-delivery of financial plans remained high on the Risk Assurance Framework due to increasing activity, unexpected costs and inability to deliver QIPP savings. This had the potential to lead to further rationalisation of services in future years and other workforce efficiency savings which would impact on quality and experience of services for patients.

In collaboration with NHS Nottingham City, NHS Nottingham North and East and NHS Nottingham West CCGs a Financial Recovery Plan (FRP) for 2017/18 was developed. Delivery of the FRP was led by senior managers across the organisations and overseen by the Programme Management Office (PMO). Progress against the FRP was formally monitored through a Greater Nottingham Financial

Recovery Group and CCG Governing Bodies. South Nottinghamshire CCGs attended NHS England deep dive meetings to discuss risks to delivery of financial plans for 2017/18 throughout the year. More detail on the FRP can be found later in this Governance Statement.

Emergency Department

Performance of the national target of 95% of patients waiting less than four hours to receive an assessment and treatment was not achieved consistently throughout the year at Nottingham University Hospitals Trust (NUH). This is due to continued pressure on acute A&E services, an exceptionally high level of demand for respiratory beds due to flu over the winter months, shortage of clinical staff in the department, the responsiveness of other services in supporting the department and the flow of patients through the wider urgent care system.

Performance in 2017/18 was however, stronger than in the previous year with incremental improvement. The Accident and Emergency Delivery Board, which has representation from all system partners from both health and social care, now meets weekly to oversee improvement in performance and review operational challenges over the winter period.

To support the flow of patients through the hospital an Integrated Discharge Team, was established in October 2017 to support patients returning home or being transferred for ongoing rehabilitation and care in the community. Additional community beds were also opened to support the increase in demand for beds seen over the winter months. Whilst this is yet to impact upon A&E performance, it has led to a significant increase in the numbers of patients who need a supported discharge from hospital, as well as a significant reduction in the number of Continuing Health Care assessments being undertaken in hospital. Despite continued system pressure there have been only two 12 hour breaches during 2017/18. Harm review processes and metrics continue to provide assurance in relation to quality impacts where operational performance is not achieved. November 2017 reported a 3.8 percent improved position from the previous two months for Delayed Transfer of Care, however, this was still above target. A proactive nursing recruitment drive has resulted in a significant reduction in Emergency Department nursing vacancies, most new team members commenced in October 2017.

The number of inpatients at Queens Medical Centre campus remains high presenting challenges to maintain hospital flow, impacting on availability of ward assessment beds. In 2018/19, the Accident and Emergency Delivery Board will continue to meet to oversee improvements in performance and service redesign. There will be a revised system action plan further to the learning from last winter; focus on increasing the number of weekend discharges achieved across all pathways; continued medical and staff recruitment and review of future community capacity.

Downgraded Risks

Ambulance Service

Locally during the course of the year there has been a significant reduction in ambulance handover times which are now the best in the region releasing capacity to respond to more calls. In addition, the reinforcement of the 10 minute call back from GPs to an ambulance responder has also reduced unnecessary conveyances to hospital by providing alternative pathways.

Nationally, NHS England rolled out new ambulance standards trialled in the Ambulance Response Programme.The changes focus on making sure the most appropriate response is provided for each patient first time. Early recognition of life-threatening conditions, particularly cardiac arrest, is crucial.. A new set of pre-triage questions identifies those patients in need of the fastest response. Call handlers are also given more time to assess 999 calls that are not immediately life-threatening, which enables them to identify patients' needs better and send the most appropriate response, freeing up more vehicles and staff to respond to emergencies.

Performance against the new standards is at Nottinghamshire level and is monitored by NHS Hardwick CCG.

Cancer

Throughout the year there has been a significant improvement in the Cancer 2 week wait standard and some improvement in the 31 day target resulting in both targets being met year to date at the time of writing this report. The 62 day targets has also improved but performance remains slightly under the 85% target

There has been a significant reduction in the number of 104 day breaches and harm review processes are now established across all tumour sites. To date no incidents of harm have been identified in 2017/18.

Continuing Healthcare (CHC)

Building on the work started in 2016/17 to control cost pressures associated with continuing healthcare, a significant number of actions were implemented in 2017/18 under the oversight of the CHC Turnaround Group. These included:

- implementation of a cap on one to one hourly rates of £12 per hour
- review of one to one provision, high cost packages and fast track referrals to ensure appropriateness
- raising awareness of fast track eligibility amongst referrers
- management of accruals
- implementation of a Decision Support Tool 'lite' process for stable patients
- exploration of the West Norfolk screening model.

The effectiveness of these actions was monitored via the recovery action plan in place at the fortnightly Turnaround Group and the risk was de-escalated from the

Assurance Framework for management and oversight by the Finance and QIPP Group in May 2017.

New Risks

Quality governance issues within Maternity

Quality governance issues at NUH are impacting on delivery of services within Maternity. This is due to issues with leadership, workforce and processes and could lead to safe, effective and quality maternity care not being provided.

Nottingham City and Nottinghamshire County CCGs quality representatives met in April 2017 to strengthen and clarify commissioner processes, around safety, quality and the transformation agenda. This included reviewing the quality schedule for maternity and oversight arrangements. NUH have developed a new Standard Operating Procedure to strengthen timely escalation of incidents and there has been enhanced senior leadership at NUH including the appointment of Director of Midwifery. Case summaries are reviewed and where appropriate cases escalated to Serious Incidents and learning from reviews incorporated into overarching action plan which is monitored at six weekly meetings with NUH.

A Quality Risk Profile Tool was used to assess the safety and quality of the service with partners including NHS England, NHS Improvement, CQC, Public Health Commissioners and HealthWatch in May 2017. This assessment concluded that the service was safe but that further quality improvements were required. The CCGs quality team has worked with the provider to oversee implementation and evaluation of an improvement action plan. The assessment using the Quality Risk Profiling tool was repeated in January 2018 and the outcome of this was that the service is safe and there is no evidence to suggest that a risk review meeting or risk summit is required. There are some areas for further improvement including medical leadership and engagement and wider learning from incidents. The Trust remains on enhanced surveillance for maternity with 8 weekly meetings with commissioners to review progress against their improvement plan.

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 risks 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 members 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 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 provide 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 in the NHS (June 2017) 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.

The CCG has carried out the annual internal audit of conflicts of interest and has received an opinion of “Significant Assurance”.

Data management assurance

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. The CCG is a member of a Data Management Group which agrees the tactical and strategic priorities of the data management team.

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 2017/18.

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.

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.

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.

Control issues

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. The key consideration during this part of the recovery was to ensure all Practices had a minimum number of machines to access their clinical systems. Throughout the attack information was provided to NHS England on the status of each Practice and the availability of clinical services.

Working with partners, which includes providers, the CCG undertook a post recovery phased de-brief in co-operation with our supplier, Nottinghamshire Health Informatics Services. The CCG and it's supplier have developed and implemented action plans produced from lessons learnt. In order to ensure that plans and supporting actions are relevant, robust and progressing, an external review has been carried out.

Primary Care services

NHS England has issued CCGs with delegated authority for commissioning primary medical services the service auditor report (SAR) for Capita – the provider of GP payment processes and support. In 2016/17 the SAR gave an Adverse Opinion in respect of the operation of controls. As a result CCGs implemented alternative assurance arrangements as discussed with external auditors. For 2017/18, an interim SAR has been published, covering the period 1 October 2017 to 31 December 2017. The opinion noted in this interim report is Qualified, so still not providing adequate assurance, albeit improved. As a result, the CCG arrangements for obtaining the additional assurance, as implemented last year, have continued.

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.

Performance

Performance against the A&E Department four hour waiting times and ambulance standards were highlighted as ongoing issues in the month nine governance statement. These risks were closely monitored throughout the year through the A&E board and relevant CCG governance arrangements. More detail on each individual risk can be found earlier in this report in the Risk Assessment section.

Financial Pressures

The Governing Body and Audit and Governance Committee received briefings throughout the year on the financial pressures facing the CCG in-year. Whilst the CCG achieved all of its financial duties in 2017/18, this was achieved through the use of non-recurrent funding. The underlying financial position is deteriorating, presenting a significant challenge in 2018/19 and beyond.

Procurement

The contract for services at the Nottingham Treatment Centre was retendered by the Greater Nottingham Clinical Commissioning Partnership in January / February 2018.

The contract was for three years with the potential to extend to a total of five years, covering a range of services including outpatients, surgical theatres and dedicated diagnostic facilities such as scans and x-rays.

Service specifications were developed with local GPs and specialist clinicians, with advice from public health professionals and relevant professional bodies. The procurement value reflected changes in the local health system such as the expansion of alternative community services as well as tariff adjustments to accord to national policy.

The Invitation to Tender was reissued shortly after publication, with changes in response to concerns raised by one of the bidders.

As part of the revised bidding process providers were required to submit transformation plans to demonstrate how they could reduce activity in line with wider transformation plans. These plans could include innovations in clinical practice, improving the quality and responsiveness of service user care and reducing unwarranted clinical variation.

Circle Nottingham Ltd confirmed their intention to withdraw from the competitive process in March 2018, citing concerns around the sustainability of services.

Bids from other providers were received and commissioners completed the evaluation and moderation process on these bids.

Circle Nottingham Ltd subsequently issued two sets of proceedings against NHS Rushcliffe Clinical Commissioning Group (as the lead commissioner) at the end of March on the basis of procurement law and by way of judicial review.

Resolution of legal challenge and one-year extension to Treatment Centre contract

In May 2018 the Greater Nottingham CCGs and Circle Nottingham Ltd reached an agreement to protect patients' interests and ensure no disruption to services by ending the legal challenge on negotiated terms. This agreement was to extend the contract for Circle to provide services at the Treatment Centre by one year.

The agreement removed the risk that legal issues would impact on service provision averting the threat of disruption to services for patients.

The CCGs have now initiated a new procurement project and aim to award a new contract to the successful bidder in 2019. The CCG have encouraged all interested providers and bidders from the first process to continue with their interest in the

provision of services at the treatment centre to ensure this new procurement leads to the best service provision for the future.

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.

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 2018.

The Governing Body has ensured that robust governance arrangements are in place and has established committees for Audit and Remuneration. The Greater Nottingham Programme Management Office was established in April 2017 to lead the financial recovery work. As part of the integrated governance arrangements a joint Finance, Contracting and Procurement Sub-Committee is being established.

The Internal Audit Plan for 2017/18 contained a number of audits specifically related to financial management and governance. The outcomes of those audits were reported to the Audit Committee and provided significant assurance on the systems and processes in place.

Financial reporting

The CCG's financial plan was developed for 2017/18, 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 Executive 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.

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 2017/18.

The operation of the 2017/18 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.

Financial Recovery Plan – Programme Management Office

The demands for healthcare services remain significant and have contributed to increasing financial pressure on commissioning spend. Part of this is driven by demographic change as our population increases and is living longer. The areas of greatest pressure are in urgent and emergency care, treating and caring for those with long term conditions and continuing healthcare.

The Greater Nottingham CCGs have worked together since 2016 to ensure that we continue to meet healthcare needs by commissioning an appropriate range, pattern and style of healthcare from providers of healthcare including acute hospital care, community and mental health services. The CCGs are committed to commissioning services which are high quality as well as being clinically and financially sustainable. The effective use of our allocated funds is an important focus for the work of all staff in the CCGs and is coordinated and managed as part of a single programme of work.

The Greater Nottingham Programme Management Office was established in April 2017 with a small team to lead and focus this work across the CCGs and to provide a dedicated resource to help in identifying areas where the greatest progress can be

made in achieving financial stability. The team manages this programme with additional support to provide an external view and challenge. The combined allocation of the Greater Nottingham CCGs and the savings requirement is outlined in table below:

	NNE (£000s)	Rushcliffe (£000s)	Nottingham West (£000s)	Nottingham City (£000s)	Total (£000s)
Allocation	£207,534	£157,513	£133,057	£483,533	£991,637
Total Saving Requirements	£12,359 (5.9%)	£7,972 (5%)	£6,968 (5.2%)	£17,306 (3.6%)	£44,605 (4.9%)

The programme is defined across nine Programme Areas:

- Planned care
- Urgent care
- Community care
- Primary care
- Continuing healthcare
- Medicines management
- Mental health
- Internal efficiencies
- Estates

Each Programme Area is led by a Senior Responsible Officer on behalf of the four CCGs working with financial, clinical, and analytical support. The Financial Recovery Plan for 2017/18 was approved by the four CCG Governing Bodies in June 2017 to deliver financial balance in 17/18. The focus was on four key themes:

- Transactional schemes aimed at getting the best value from its contracts
- Improvement schemes liked to improving the efficiency of local health services
- Better management and control of invoices
- Expenditure controls and managing the balance sheet

An important part of this work ensured that local plans and services deliver high quality patient outcomes, patient experience and value for money.

This year there has been a significant level of scheme savings achievement which enabled the CCGs to meet their control totals for 2017/18:

- Reducing unwarranted variation across Primary Care through management of referrals, triage, peer review of referrals, introduction of improved systems and processes for example F12, and the use of advice and guidance prior to optimise patient outcomes
- Redesigning Continuing Health Care in Nottinghamshire ensured assessments and ongoing care were targeted at those most in need.
- Implementation of new ways of working across prescribing including the management of repeat prescribing
- Roll out of the care coordination model improving the case management of patients with long-term conditions
- Improved processes to discharge people from hospital including better care planning on admission
- Reduction in the prescribing of Gluten Free foods
- Introduction of new community pathways for example the Community pain pathway

The savings requirement in 2018/19 is significantly greater and achieving financial sustainability remains the top corporate priority. The CCGs will continue to undertake meaningful engagement with patients, carers and communities to ensure that the NHS continues to allocate resources to maximum benefit

Delegation of functions

The Governing Bodies of the four Greater Nottingham CCGs have all agreed to establish a Joint Committee with delegated responsibilities for commissioning functions.

This commitment for joint working is driven by a range of factors but the focused work to develop an Integrated Care System is a key reason for change. The joint committee will be fully operational from April 2018, subject to NHS England approval.

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.

The CCG has a contract in place for an accredited Counter Fraud Specialist (CFS) to undertake counter fraud work in line with identified risks.

During 2017/18 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 all staff distribution of the publication "Fraudulent Times".

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

The CFS attends meetings of the Audit Committee and provides comprehensive progress reports on completion and compliance of the Annual Workplan and Standards for Commissioners.

The CCG was not subject to an NHSCFA Quality Assessment during 2017/18 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.

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.

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.

I am providing an opinion of **Significant Assurance**, that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.
This Opinion is based on my review of your systems of internal control, primarily through the operation of your Governing Body Assurance Framework in the year, the outcome of individual assignments completed and your response to recommendations made. It should be noted, however, that the breadth of the actual work to date undertaken is not as extensive as that originally anticipated on agreement of the 2017/18 internal audit plan and the update to it during the year. Changes in the plan have been brought to the attention of the Audit & Governance Committee during the year, and have related to changing CCG priorities and risks, particularly as a consequence of the integrated commissioning arrangements being established across Greater Nottingham. My opinion is, therefore, limited to those reviews where final reports have been issued or where we have had an opportunity to discuss findings with CCG lead officers.
I have reflected on the context in which the CCG operates, as well as the significant challenges currently facing many organisations operating in the NHS, and my Opinion recognises that the system of internal control is designed to manage risk to a reasonable level, rather than eliminate all risk of failure to the achievement of strategic objectives.

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
2016/17 Internal Audit Plan			
Continuing Healthcare and NHS-funded Nursing Care – Financial Arrangements	1617/NNECCG/07/R	Issued	Significant

Audit Assignment	Report Ref.	Status	Assurance Level/Comment
Managing Transformation: STP Governance	1718/NNECCG/02	Issued	Limited*
Personal Health Budgets	1718/NNECCG/05	Issued	Limited*
Commissioning Parity of Esteem in mental health services	1718/NNECCG/06	Issued	Significant
2017/18 Internal Audit Plan			
Primary Care Quality Monitoring	1718/NNECCG/03	Issued	Significant
Key Financial Systems	1718/NNECCG/07	Issued	Significant
QIPP Programme Management Office		Draft Report	
Information Governance Toolkit		Issued	Full Assurance
Governance and Risk Management	n/a	n/a**	Ongoing Project Support
Conflicts of Interest	1718/NNECCG/11	Issued	Significant
Commissioning Strategy Development		Deferred	Deferred to 2019/20
Data Quality and Performance Management Framework – Local Partnerships	1718/NNECCG14	Draft Repot	
Head of Internal Audit Opinion - Stage 1	1718/NNECCG/04	Issued	n/a **
Head of Internal Audit Opinion - Stage 2	1718/NNECCG/09	Issued	n/a **
Partnership Working (Joint Review)		Work in Progress	

* These reviews examined shared arrangements in place across Nottinghamshire and are not specific to the CCG.

** PSIAS require that all work undertaken for an organisation will be considered for the Head of Internal Audit Opinion, even where we have not specifically provided an opinion level.

The opinion of limited assurance issued for the Managing Transformation: STP Governance review was attributed to a lack of evidence to demonstrate effective oversight and management of risks, a lack of evidence to show how groups within the governance structure were being administered and the Governing Body being provided with insufficient information to provide adequate assurance that the

governance arrangements were working effectively. The final report recognised the context in which the review was undertaken, stating:

"The review focussed on the governance structures in place during the planning (and early delivery) stages of the STP. This audit opinion does not detract from the volume of work which was undertaken, during this period, to produce and submit the STP in line with national timescales. Progress of the STP has also been recognised, nationally, as 'advanced' by NHS England (in July 2017)".

Work has since been performed to ensure consistent information is provided to the Governing Body and the follow-up review on the recommendations is scheduled to take place early in 2018/19. The organisation has reflected the findings of the report on to its Organisational Risk Register; which has ensured an ongoing focus on the risk management actions by the Risk and Performance Committee.

In addition, the organisation has utilised the internal audit function to provide independent support for the development of integrated governance and risk management arrangements for the Greater Nottingham Clinical Commissioning Partnership.

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.

Samantha Walters
Accountable Officer
24 May 2018

Remuneration and staff report

Remuneration report

Remuneration committee

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, In 2017/18 the committee met on three occasions as a Committee in Common with NHS Nottingham West and Rushcliffe CCG and twice as an individual committee.

Members of the Remuneration Committee are:

Name	Title
Terry Allen	Lay Member Financial Management and Audit
Janet Champion	Lay Member Patient and Public Involvement
Mike Wilkins	Lay Member Primary Care

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

Policy on the remuneration of senior managers

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 2017/18 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)

17/18						
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	80-85	-	-	-	65-67.5	145-150
Sharon Pickett, Deputy Chief Officer	80-85	-	-	-	57.5-60	135-140
Hazel Buchanan, Director of Operations	70-75	-	-	-	42.5-45	110-115
Janet Champion, Lay Member Patient and Public Involvement	5-10	-	-	-	-	5-10
Mike Wilkins, Lay Member Primary Care	5-10	-	-	-	-	5-10
Ben Teasdale, Secondary Care Consultant	5-10	-	-	-	-	5-10
Terry Allen, Lay Member Financial Management and Audit	10-15	-	-	-	-	10-15
Dr Ian Campbell, GP Representative	20-25	-	-	-	-	20-25

Dr James Hopkinson, Clinical Chair	130-135	-	-	-	20-22.5	150-155
Dr Catriona Kennedy, GP Representative	20-25	-	-	-	-	20-25
Dr Elaine Maddock, GP Representative	20-25	-	-	-	-	20-25
Dr Paramjit Panesar, Assistant Clinical Chair	90-95	-	-	-	-	90-95
Jonathan Bemrose, Chief Finance Officer	35-40	-	-	-	30-32.5	70-75
Andrew Hall, Director of Outcomes and Information	40-45	-	-	-	5-7.5	45-50
Nichola Bramhall, Director of Nursing and Quality	35-40	-	-	-	50-52.5	85-90
Maxine Bunn, Director of Contracting	15-20	-	-	-	7.5-10	25-30
Rebecca Larder, Director of Transformation	95-100	-	-	-	50-52.5	145-150
Gary Thompson, Chief Operating Officer	5-10	-	-	-		

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

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**
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
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

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
Maxine Bunn, Director of Contracting	20-25				22.5-25	40-45

* For 2016/17 the CCG believes that the employment dates for the information it has received from the Pensions Agency are incorrect.

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:

2017/18						
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
Samantha Walters, Accountable Officer	120-125	-	-	-	97.5-100	220-225
Jonathan Bemrose, Chief Finance Officer	115-120	-	-	-	95-97.5	210-215
Andrew Hall, Director of Outcomes and Information	100-105	-	-	-	15-17.5	115-120
Nichola Bramhall, Director of Nursing and Quality	105-110	-	-	-	142.5-145	245-250
Gary Thompson, Chief Operating Officer	25-30	-	-	-		
Maxine Bunn, Director of Contracting	85-90	-	-	-	45-47.50	130-135

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 Nursing and Quality	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

Pension benefits as at 31 March 2018 (subject to audit)

Name and Title	(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 2018 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000	(e) Cash Equivalent Transfer Value at 1 April 2017	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2018	(h) Employers Contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
Samantha Walters, Chief Officer	5-7.5	7.5-10	35-40	90-95	541	113	659	0
Jonathan Bemrose, Chief Finance Officer	5-7.5	7.5-10	45-50	125-130	719	124	850	0

Rebecca Larder, Director of Transformation	2.5-5		30-35	80-85	465	63	533	0
Hazel Buchanan, Director of Operations	2.5-5	-	10-15	0	100	37	137	0
Nichola Bramhall, Director of Nursing and Quality	5-7.5	12.5-15	35-40	95-100	499	142	646	0
Sharon Pickett, Deputy Chief Officer	2.5-5	7.5-10	35-40	110-115	657	99	762	0
Dr James Hopkinson, Clinical Chair	0-2.5	0-2.5	20-25	45-50	253	26	282	0
Gary Thompson, Chief Operating Officer	0-2.5	0	35-40	95-100	625	9	699	0

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 (subject to audit)

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

Payments to past directors (subject to audit)

In 2017/18 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 Rebecca Larder. The banded remuneration of the highest paid officer in the financial year 2017/18 was £95 - £100k (2016/17: £110-£115k). This is 2.33 times (2016/17: 2.75) the median remuneration of the workforce, which is £41,787 (2016/17: £41.373).

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

- From October 2017 a single Accountable Officer was appointed across the four Greater Nottingham CCGs.
- Adjustments to the number and composition of the workforce through restructuring.

In 2017/18, no employees received remuneration in excess of the highest-paid member. Remuneration ranged from £17,816 to £98,500 (2016/2017: £19,217 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	8*	VSM	8	3	5
Senior managers	6	8B - 1 8C - 5	5.77	1	5
Employees	39		34.93	7	32
Agency	1		1	0	1
Total	54		50.70	11	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 £'000	2,267	48	2,315
Programme £'000	519	108	627
Total £'000	2786	156	2,942

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 2017/18:

	2017/18 number of days	2016/17 number of days
Total days lost	104	101
Total staff years	51	50
Average working days lost	2.0	2.0

*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 2017/18.

Expenditure on consultancy

Department	Actual 2017/18
External Consultancy Fees	£236,250*
Agency Fees	£97,608*
Legal Fees	£24,962*
Patient and public involvement Fees	£14,977
Total 2017/18 spend	**£373,797**

* This figure includes fees which cover three or four CCGs

Consultancy definition

The provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the 'business-as-usual' environment when in-house skills are not available and will be of no essential consequence and time-limited. Consultancy may include the identification of options with recommendations, or assistance with (but not delivery of) the implementation of solutions.

This and the following are taken from the Cabinet Office definition of consultancy, which can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405538/6.1_Cons_definitions.pdf

Finance Consultancy	The provision of objective finance advice including advice relating to corporate financing structures, accountancy, control mechanisms and systems. This includes both strategic and operational finance.
IT/IS Consultancy	The provision of objective IT/IS advice including that relating to IT/ IS systems and concepts, strategic IT/IS studies and development of specific IT/IS projects. Advice related to defining information needs, computer feasibility studies, making computer hardware evaluations and to e-business should also be included.
Strategy Consultancy	The provision of strategic objective advice including advice relating to corporate strategies, appraising business structures, Value for Money reviews, business performance measurement, management services, product or service design, and process and production management.
Legal Consultancy	The provision of external legal advice and opinion including advice in connection with the policy formulation and strategy development particularly on commercial and contractual matters.
Property & Construction Consultancy	Provision of specialist advice relating to property services and estates including portfolio management, design, planning and construction, tenure, holding and disposal strategies.
Human Resource, Training & Education Consultancy	The provision of objective HR advice including advice on the formulation of recruitment, retention, manpower planning and HR strategies, and advice and assistance relating to the development of training and education strategies.

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 2017 and 31 March 2018, the CCG had three new off-payroll engagements for more than £245 per day which lasted more than six months.

Off-payroll engagements longer than six months

For all off-payroll engagements as at 31st March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reach six months in duration, between 1st April 2017 and 31st March 2018	3
Of which, the number that have existed:	
for less than one year at the time of reporting	3
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 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reach six months in duration, between 1st April 2017 and 31st March 2018	0
Of Which	
The number of new engagements that fall under the remit of IR35	0
The number of new engagements that do not fall under the remit of IR35	3
The number of those engaged directly (via PSC contracted to the entity) and are on the departmental payroll	0
The number of engagements reassessed for consistency/ assurance purposes during the year	0
The number of engagements that saw a change0 to IR35 status following the consistency review	0

Off-payroll engagements/senior official engagements

For any off-payroll engagements of Governing Body members and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

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

*All on payroll engagements (not including employees).

Exit Packages (Subject to Audit)

In 2017/18 there were no exit packages

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).

Samantha Walters
Accountable Officer
24 May 2018

References

Department for Communities and Local government (2015) Multiple Indices of Deprivation [URL: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015]

NHS Digital (2016) Patients registered at GP practices

Nottinghamshire Insight (2015) - The People of Nottinghamshire JSNA [URL: http://jsna.nottinghamcity.gov.uk/insight/Strategic-Framework/Nottinghamshire-JSNA/Summaries-and-overviews/The-people-of-Nottinghamshire.aspx]

ONS (2011) Census

ONS (2014) Subnational Population Projections for Local Authorities in England

PHE/ONS (various years) Secondary analysis combining PHE local health MSOA data and ONS LSOA population data – Prepared by Nottinghamshire Public Health Analysts

PHE (2006-08) MSOA data estimates (found in PHE 2015 local health profiles)

PHE (2015) Local Health Profiles [URL: http://www.localhealth.org.uk]

PHE (2015) Fingertips tool [URL: https://fingertips.phe.org.uk/]

Appendix 1
Annual accounts & independent auditors report 2017/18

NHS Nottingham North and East CCG - Annual Accounts 2017-18

CONTENTS **Page Number**

The Primary Statements:

Notes to the Accounts

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

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(830)	(1,658)
Other operating income	2	(1,240)	(1,829)
Total operating income		**(2,070)**	**(3,487)**
Staff costs	4	2,942	2,922
Purchase of goods and services	5	211,338	203,353
Depreciation and impairment charges	5	0	0
Provision expense	5	100	(31)
Other Operating Expenditure	5	39	60
Total operating expenditure		**214,419**	**206,304**
Net Operating Expenditure		**212,349**	**202,817**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**212,349**	**202,817**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**212,349**	**202,817**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**212,349**	**202,817**

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'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	1,924	2,209
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	165	11
Total current assets		**2,089**	**2,220**
Non-current assets held for sale	21	0	0
Total current assets		**2,089**	**2,220**
Total assets		**2,089**	**2,220**
Current liabilities			
Trade and other payables	23	(9,200)	(8,112)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(204)	(104)
Total current liabilities		**(9,404)**	**(8,217)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(7,315)**	**(5,997)**
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		**(7,315)**	**(5,997)**
Financed by Taxpayers' Equity			
General fund		(7,315)	(5,997)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(7,315)**	**(5,997)**

The notes on pages 5 to 28 form part of this statement

The financial statements on pages 1 to 28 were approved by the Audit and Governance Committee on 24 May 2018 and signed on its behalf by:

Chief Accountable Officer 

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(5,997)	0	0	**(5,997)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance 01 April 2017	**(5,997)**	**0**	**0**	**(5,997)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(212,349)	0	0	(212,349)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(212,349)**	**0**	**0**	**(212,349)**
Net funding	211,030	0	0	211,030
Balance at 31 March 2018	**(7,315)**	**0**	**0**	**(7,315)**

	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 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 01 April 2016	**(6,045)**	**0**	**0**	**(6,045)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(202,817)			(202,817)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(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)**

The notes on pages 5 to 28 form part of this statement

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(212,349)	(202,817)
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	285	(719)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	1,088	667
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	100	(31)
Net Cash Inflow (Outflow) from Operating Activities		**(210,876)**	**(202,901)**
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		**(210,876)**	**(202,901)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		211,030	202,865
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		**211,030**	**202,865**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**154**	**(36)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**11**	**47**
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		**165**	**11**

The notes on pages 5 to 28 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 2017-18 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.10 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.

1.20 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.

1.30 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.

1.40 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

Notes to the financial statements

1.50 Charitable Funds

Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.
The CCG holds no charitable funds, and so there is no consolidation of charitable funds within these a

1.60 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.

1.70 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- 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

1.7.2 Key Sources of Estimation Uncertainty

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

- 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.

1.80 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.

1.90 Employee Benefits

1.9.1 Short-term Employee Benefits

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

1.9.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme, the cost to the Clinical Commissioning Group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.10 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.
Expenses and liabilities in respect of grants are recognised when the Clinical Commissioning Group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 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.

1.11.1 The Clinical Commissioning Group as Lessee

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.

Notes to the financial statements

1.12 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.

1.13 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 2.42% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

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

1.14 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.

1.15 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.

1.16 Continuing Healthcare Risk Pooling

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

Notes to the financial statements

1.17 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.

1.18 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.

1.18.1 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.

1.18.2 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.

1.18.3 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.

Notes to the financial statements

1.18.4 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.

1.19 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.

1.19.1 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.

1.19.2 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.

1.19.3 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.

Notes to the financial statements

1.20 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.

1.21 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.

1.22 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.

1.23 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).

1.24 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'.

1.25 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.

Notes to the financial statements

1.26 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.

1.27 Prior Period Adjustment

During 2017/18, NHS England issued revised guidance in the treatment of CHC and FNC around Hosting Arrangements. Section 9.2.1 of the guidance states, that where the Host organisation is exposed to the credit risk, then Gross Accounting principles should be used. In this case, the risk is shared on a weighted capitation basis for CHC, and historical for FNC, therefore, Net Accounting procedures should apply.

1.28 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

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

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH group bodies
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS17: Insurance Contracts (application from 1 January 2021)
- IFRIC22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

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

2 Other Operating Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	237	0	237	40
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	830	7	822	1,658
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Non cash apprenticeship training grants revenue	0	0	0	0
Other revenue	1,003	76	928	1,789
Total other operating revenue	**2,070**	**83**	**1,987**	**3,487**

3 Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
From rendering of services	2,070	83	1,987	3,487
From sale of goods	0	0	0	0
Total	**2,070**	**83**	**1,987**	**3,487**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2017-18	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	2,182	2,026	156	1,719	1,672	48	463	355	108
Social security costs	353	353	0	277	277	0	75	75	0
Employer contributions to the NHS Pension Scheme	407	407	0	318	318	0	88	88	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,942**	**2,786**	**156**	**2,315**	**2,267**	**48**	**627**	**519**	**108**
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	**2,942**	**2,786**	**156**	**2,315**	**2,267**	**48**	**627**	**519**	**108**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,942**	**2,786**	**156**	**2,315**	**2,267**	**48**	**627**	**519**	**108**

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	276	276	0	231	231	0	45	45	0
Social security costs	318	318	0	261	261	0	57	57	0
Employer contributions to the NHS Pension Scheme	0	0	0	0	0	0	0	0	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy					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	**595**	**595**	**0**	**492**	**492**	**0**	**102**	**102**	**0**
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	**595**	**595**	**0**	**492**	**492**	**0**	**102**	**102**	**0**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**595**	**595**	**0**	**492**	**492**	**0**	**102**	**102**	**0**

4.2 Average number of people employed

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**54**	**52**	**2**	**52**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.4 Exit packages agreed in the financial year

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	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**

	2017-18 Departures where special payments have been made		2016-17 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

	2017-18 Other agreed departures		2016-17 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**0**	**0**	**0**	**0**

4.5 Pension costs

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

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

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

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

4.5.1 Accounting valuation

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

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

4.5.2 Full actuarial (funding) valuation

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

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

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

For 2017-18, employers' contributions of £339,130 were payable to the NHS Pensions Scheme (2016-17: £318,400) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012.

5. Operating expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	2,784	2,157	627	2,677
Executive governing body members	158	158	0	245
Total gross employee benefits	**2,942**	**2,315**	**627**	**2,922**
Other costs				
Services from other CCGs and NHS England	1,757	63	1,694	1,892
Services from foundation trusts	33,922	0	33,922	32,357
Services from other NHS trusts	84,564	0	84,564	83,573
Sustainability Transformation Fund	0	0	0	0
Services from other WGA bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	41,963	0	41,963	41,163
Purchase of social care	0	0	0	0
Chair and Non Executive Members	0	0	0	0
Supplies and services – clinical	0	0	0	0
Supplies and services – general	6,211	49	6,162	1,407
Consultancy services	198	15	183	127
Establishment	790	193	597	520
Transport	2	2	0	3
Premises	1,227	61	1,166	1,085
Impairments and reversals of receivables	0	0	0	6
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	34	34	0	45
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	22,468	0	22,468	23,066
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	17,996	0	17,996	17,709
Other professional fees excl. audit	30	30	0	105
Legal fees	147	137	10	0
Grants to Other bodies	0	0	0	0
Clinical negligence	1	1	0	1
Research and development (excluding staff costs)	9	0	9	9
Education and training	28	10	18	14
Change in discount rate	0	0	0	0
Provisions	100	0	100	(31)
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions	0	0	0	287
Non cash apprenticeship training grants	0	0	0	0
Other expenditure	29	0	29	44
Total other costs	**211,477**	**593**	**210,884**	**203,382**
Total operating expenses	**214,419**	**2,908**	**211,511**	**206,304**

6.1 Better Payment Practice Code

Measure of compliance	2017-18 Number	2017-18 £'000	2016-17 Number	2016-17 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	2,662	49,152	2,622	45,035
Total Non-NHS Trade Invoices paid within target	2,656	49,030	2,611	45,028
Percentage of Non-NHS Trade invoices paid within target	**99.77%**	**99.75%**	**99.58%**	**99.98%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,909	140,015	2,012	140,805
Total NHS Trade Invoices Paid within target	1,902	139,939	2,007	140,783
Percentage of NHS Trade Invoices paid within target	**99.63%**	**99.95%**	**99.75%**	**99.98%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	2017-18 £'000	2016-17 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

There were no Income Generation Activities during the year (16/17: £nil)

8. Investment revenue

There was no Investment Income during the year (16/17: £nil)

9. Other gains and losses

There were no Other Gains and Losses during the year (16/17: £nil)

10. Finance costs

There were no Finance Costs during the year (16/17: £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

	2017-18				2016-17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	1,226	0	**1,226**	0	1,077	0	**1,077**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**1,226**	**0**	**1,226**	**0**	**1,077**	**0**	**1,077**

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

12.1.2 Future minimum lease payments

	2017-18				2016-17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	0	1,226	0	**1,226**	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

	2017-18 £'000	2016-17 £'000
Recognised as income		
Rent	0	0
Contingent rents	0	0
Total	**0**	**0**

12.2.2 Future minimum rental value

	2017-18 £'000	2016-17 £'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 (16/17: £nil)

14 Intangible non-current assets

The CCG has no Intangible non-current assets at the year end (16/17: £nil)

15.1 Investment property

The CCG has no Investment Property at the year end (16/17: £nil)

16 Inventories

The CCG has no Inventories at the year end (16/17: £nil)

17 Trade and other receivables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	293	0	517	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	596	0	1,224	0
NHS accrued income	80	0	176	0
Non-NHS and Other WGA receivables: Revenue	645	0	166	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	308	0	88	0
Non-NHS and Other WGA accrued income	1	0	38	0
Provision for the impairment of receivables	(6)	0	(6)	0
VAT	7	0	6	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	0	0	0	0
Total Trade & other receivables	**1,924**	**0**	**2,209**	**0**
Total current and non current	**1,924**		**2,209**	
Included above:				
Prepaid pensions contributions	0		0	

17.1 Receivables past their due date but not impaired	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	1	28	52
By three to six months	0	0	7
By more than six months	0	9	1
Total	**1**	**37**	**60**

£27k of the amount above has subsequently been recovered post the statement of financial position date.

17.2 Provision for impairment of receivables	2017-18 £'000 DH Group Bodies	2017-18 £'000 Group Bodies	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	(6)	0	(1)
Amounts written off during the year	0	0	0
Amounts recovered during the year	0	0	0
(Increase) decrease in receivables impaired	0	0	(5)
Transfer (to) from other public sector body	0	0	0
Balance at 31 March 2018	**(6)**	**0**	**(6)**

18 Other financial assets

The CCG has no Other Financial Assets at the year end (16/17: £nil)

19 Other current assets

The CCG has no Other Current Assets at the year end (16/17: £nil)

20 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	11	47
Net change in year	154	(36)
Balance at 31 March 2018	**165**	**11**
Made up of:		
Cash with the Government Banking Service	165	11
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	**165**	**11**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**165**	**11**
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 (16/17: £nil)

22 Analysis of impairments and reversals

The CCG has no Impairments or Reversals at the year end (16/17: £nil)

23 Trade and other payables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	713	0	1,249	0
NHS payables: capital	0	0	0	0
NHS accruals	768	0	935	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	3,476	0	3,697	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	3,330	0	910	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	42	0	38	0
VAT	0	0	0	0
Tax	39	0	36	0
Payments received on account	0	0	0	0
Other payables and accruals	832	0	1,247	0
Total Trade & Other Payables	**9,200**	**0**	**8,112**	**0**
Total current and non-current	**9,200**		**8,112**	

Other payables include £270,000 outstanding pension contributions at 31 March 2018

24 Other financial liabilities

The CCG has no Other Financial Liabilities at the year end (16/17: £nil)

25 Other liabilities

The CCG has no Other Liabilities at the year end (16/17: £nil)

26 Borrowings

The CCG has no Borrowings at the year end (16/17: £nil)

27 Private finance initiative, LIFT and other service concession arrangements

The CCG has no Private Finance Initiatives, LIFT or other Service Concession Arrangements at the year end (16/17: £nil)

28 Finance lease obligations

The CCG has no Finance Lease Obligations at the year end (16/17: £nil)

29 Finance lease receivables

The CCG has no Finance Lease Receivables at the year end (16/17: £nil)

30 Provisions

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'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	25	0	0	0
Continuing care	108	0	104	0
Other	71	0	0	0
Total	**204**	**0**	**104**	**0**
Total current and non-current	**204**		**104**	

	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 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**104**	**0**	**104**
Arising during the year	0	0	0	0	0	0	25	4	71	100
Utilised during the year	0	0	0	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	0	0	0	0	0	0
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**25**	**108**	**71**	**204**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	25	108	71	204
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**25**	**108**	**71**	**204**

31 Contingencies

	2017-18	2016-17
Mental Health Risk Share	0	164
	0	**164**

32 Commitments

32.1 Capital commitments

	2017-18 £'000	2016-17 £'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:

	2017-18 £'000	2016-17 £'000
In not more than one year	44	0
In more than one year but not more than five years	3,825	0
In more than five years	0	0
Total	**3,869**	**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' 2017-18 £'000	Loans and Receivables 2017-18 £'000	Available for Sale 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	373	0	373
· Non-NHS	0	646	0	646
Cash at bank and in hand	0	165	0	165
Other financial assets	0	0	0	0
Total at 31 March 2018	**0**	**1,184**	**0**	**1,184**

	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 2018	**0**	**908**	**0**	**908**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	Other 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	1,481	1,481
· Non-NHS	0	7,638	7,638
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2018	**0**	**9,119**	**9,119**

	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	2,184	2,184
· Non-NHS	0	5,854	5,854
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2018	**0**	**8,039**	**8,039**

34 Operating segments

The CCG and consolidated group consider they have only one segment: Commissioning of Healthcare Services

35 Pooled budgets

The Clinical Commissioning Group entered into a pooled budget arrangement for Integrated Community Equipment Schemes 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 contributions to the pool. The Memorandum Account for the Pooled Budget is:

	2017/18 £'000	2016/17 £'000
Balance at 1 April 2017	**529**	**110**
Income		
Nottinghamshire County Council ASCH&PP	1,504	1,527
Nottinghamshire County Council CFCS	253	249
Nottinghamshire City Council ASCH & CYP	985	1,111
Bassetlaw CCG	449	477
Nottingham City CCG	1,097	1,154
Nottinghamshire County CCG's	2,630	2,937
Continuing Health care funding	185	210
Other income	19	82
TOTAL INCOME	**7,652**	**7,857**
Expenditure		
Partnership Management & Administration costs	643	615
Contract delivery and collection costs	1,361	1,264
ICES Equipment	5,047	4,985
Continuing Healthcare Specialist Equipment	114	252
Minor Adaptations	298	210
Direct Payments	0	3
TOTAL EXPENDITURE	**7,464**	**7,328**
Balance at 31 March 2018	**188**	**529**

36 NHS Lift investments

The CCG has no LIFT investments at the year end (16/17: £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

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	1,080	0	82	0
Stenhouse Medical Centre	1,390	0	65	0
The Ivy Medical Group	536	0	12	0
Trentside Medical Group	1,210	0	31	0
The Calverton Practice	1,223	0	26	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

NHS England;	2,576	621	243	439
NHS Foundation Trusts;	34,027	2	827	13
NHS Trusts;	84,618	0	402	518
Health Education England	0	0	0	0
NHS Special Health Authorities	4	0	0	0
Other Group Bodies	1,003	0	249	0

38 Events after the end of the reporting period

There are no Events after the reporting period

39 Third party assets

The CCG has no Third Party Assets (16/17: £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:

	2017-18 Target N43A	2017-18 Performance N43B	2016-17 Target N43C	2016-17 Performance N43D
Expenditure not to exceed income	214,600	214,419	210,192	206,304
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	212,530	212,349	206,705	202,817
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	3,418	2,825	3,422	2,957

41 Impact of IFRS

Accounting under IFRS had on impact on NHS Nottingham North & East CCG during the 2017-18

42 Analysis of charitable reserves

The CCG has no Charitable Reserves at the year end (16/17: £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:

	2017-18 Number	2017-18 £'000	2016-17 Number	2016-17 £'000
Administrative write-offs	0	0	1	6
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	**0**	**0**	**1**	**6**

43.2 Special payments

	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
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**

44 Prior Period Adjustments

During 2017/18, NHS England issued revised guidance in the treatment of Continuing Healthcare and Funded Nursing Care around Hosting Arrangements. Section 9.2.1 of the guidance states, that where the Host organisation is exposed to the credit risk, then Gross Accounting principles should be used. In this case, the risk is shared on a weighted capitation basis for CHC, and historical for FNC, therefore, Net Accounting procedures should apply.

The 2016/17 accounts have been restated as follows:-

	2016/17 Original Value £000	2016/17 Amended Value £000	Movement £000
Note 5			
Services from Other CCCGs and NHS England	19,503	1,892	(17,611)
Purchase of Healthcare from non-NHS bodies	23,552	41,163	17,611
Note 23			
NHS accruals	1,131	935	(196)
Non-NHS and other WGA accruals	714	910	196
Note 33			
Payables NHS	2,380	2,184	(196)
Payables Non-NHS	5,658	5,854	196

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS NOTTINGHAM NORTH AND EAST CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Nottingham North and East Clinical Commissioning Group ("the CCG") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

We report to you if, in our opinion, the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

In our opinion the parts of the Remuneration and Staff Report subject to audit relating to 2016/17 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 Report on page 133.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 75, the Accountable Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 75, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. 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.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, 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. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- 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.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Nottingham North and 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
St Nicholas House
31 Park Row
Nottingham
NG1 6FQ

25 May 2018