NHS
Erewash
Clinical Commissioning Group

Annual Report & Accounts 2017 - 2018

NHS Erewash
Clinical Commissioning Group



Contents

FOREWORD

We have seen a year of positive transitional change in Derbyshire during 2017/18. We have established closer collaborative working across our four Clinical Commissioning Groups in Erewash, Hardwick, Southern Derbyshire and North Derbyshire to work more efficiently –and responsively on behalf of our citizens and communities locally and across Derbyshire.

Our collective Governing Bodies instigated and supported this change to help create efficiencies and enhanced decision making processes for Derbyshire. The drive to establish closer working relationships is also a key factor in our move towards place-based commissioning and the delivery of enhanced, high quality services to our patients.

The transition to joint working relationships inevitably resulted in changes to the way we operate. On that basis we appointed Dr Chris Clayton as our Chief Executive Officer for our four Derbyshire CCGs from 1 October 2017. We also appointed Louise Bainbridge as our Chief Finance Officer from 1 November 2017. Our interim, single executive team for the four CCGs was also established at that point. Following a consultation process we are now finalising our substantive executive team.

As part of this process, our four previous Chief Executive Officers and Chief Finance Officers left their respective CCGs during the second half of the year to take up new opportunities. In Erewash we said farewell to Rakesh Marwaha and Charlotte Allen-Neale along with our sincere thanks for helping us to establish Erewash CCG, for their contributions to our award winning achievements and their support for the transition process to joint functional working.

Locally, our absolute priority is to ensure that we respond to the needs of our local population in Erewash. To support that objective we have continued to invest in strategic relationships including Erewash Borough Council and Public Health to share our thinking and planning and to ensure that we achieve maximum impact for our patients based upon the resources at our disposal.

I am delighted to say that NHS Erewash CCG has delivered another strong performance across all areas this year demonstrating some really innovative and forward thinking approaches. This includes our core service transformation activities and also the Multi-Specialty Provider Wellbeing Erewash Vanguard programme.

There are many examples of projects and programmes which have delivered a positive impact. From a service transformation perspective I would particularly like to highlight our achievements on mental health where we have focused on bringing together the service managers of the main mental health service providers and upskilled community leaders to become mental health champions. Other examples include our lead on the county wide diabetes programme, our drive with the Future In Minds programme for young people, our activities with the third sector, our falls reduction programme and priority local challenges such as smoking in pregnancy, childhood obesity and reduction in alcohol consumption.

I continue to be extremely proud of our successful Vanguard programme which has attracted interest and positive responses locally but also across our region, nationally and internationally. Whilst the funding at national level comes to an end on 31 March 2018, we are working hard to ensure that we retain and continue the impact of the projects and programmes that made such a positive difference for the communities of Erewash.

Great examples of Vanguard programmes are the On Day Service and Acute Home Visiting Service which both include a reduction in emergency admissions as part of their success. Our

Time Swap programme has helped people to achieve significantly higher levels of personal resilience and the “Be Brilliant” programme for year seven students has reduced level of specialist interventions for young people with diagnosable mental health conditions. We intend that the legacy for our Vanguard programme will be that we embed as many elements as possible into our core activities county wide during 2018 to 2019 and beyond.

I was again very honoured to be invited to continue as Chair of the CCG Governing Body for another year from April 2018, and again look forward to working with all of our partners to make a real difference to the health and wellbeing of the people of Erewash.

Dr Avi Bhatia, Clinical Chair, NHS Erewash Clinical Commissioning Group

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Erewash CCG

23 May 2018

Performance Overview

This overview provides a summary of the purpose and activities of NHS Erewash Clinical Commissioning Group, and how it has performed during the year. It provides the Chief Officer's perspective on the performance of the CCG.

Chief Officer's Statement

As described by our Chair in his foreword, the 2017 to 2018 operational year has seen vitally important change for North Derbyshire CCG and the four CCGs across Derbyshire, and as this is my first Annual Report, it feels appropriate for me to introduce myself.

My name is Dr Chris Clayton, and until 1 October 2017 when I started my role as Chief Executive for the four Derbyshire CCGs, I was Chief Executive Officer of Blackburn with Darwen CCG which I combined with my role as a practising GP. I have spent the last five years managing the challenges and complexities of health system transition which has been invaluable as we drive a process of positive change in Derbyshire. Being close to patients also enabled me to keep a patient focus and perspective, and this has continued to be my absolute focus as we have started to enact our plans for change in the second half of the year.

One of my key priorities has been to address the significant financial challenges we face across the Derbyshire health and care system. I have been very clear that the level of financial challenge continues to require far greater efficiency savings than we projected earlier in the year. I have been working very closely with our regulators as part of the programme of legal directions and special financial measures which apply to parts of our county. Our aspiration has been, and continues to be, to achieve financial turnaround at the very first opportunity and we have ambitious plans for 2018 to 2019 to help us achieve this.

To support the achievement of our challenges it is vital that we have a system wide ownership of the planned solutions. I am pleased to report that alongside regulator colleagues from NHS England and NHS Improvement, Sustainability and Transformation Plan (STP) colleagues and provider organisations have all played their role in the planning, and this is a particularly positive reflection of the health and care system in Derbyshire

To strengthen the capacity and capability of our CCGs across the county and further to a staff consultation, I have restructured my Executive Team to ensure that we have the right people, with the right skills in the right place at strategic level. Following the completion of this process for the Executive Team, I am also conducting a consultation process for all staff across our CCGs. I intend to move this process forward quickly with a view to completion in summer 2018 so that I can give colleagues more certainty as we move forward at pace.

Reflecting on the performance in key areas across the system during 2017/18 the system has performed well. We have seen various levels of achievement against the key national standards, underperforming against the 4 hour Accident & Emergency, 6 week Diagnostic, Cancer 2 week breast and 62 day standards. During 2018/19 we will continue to work with the wider health and care system, regulators and STP colleagues in driving improvements to patient care and delivery of national performance standards for the population of Derbyshire.

We have seen mixed outputs with A&E under four hour waits at 90.4% (target 95%) which we know is a direct result of higher levels of acuity and we are working to address this. However, our performance on Referral to Treatment for elective surgery within 18 weeks is strong at 94.2% (target 93.3%) which is very positive but we still want to improve further. Our cancer waits within 62 days are also mixed with urgent GP referral to first treatment at 78.1% (target

85%) but NHS screening to first treatment at 91.2% (target 90%). Our teams are working hard to respond to the ever increasing demands across the health and care system and in conjunction with provider colleagues we are constantly seeking out, testing, and where we can demonstrate improvement, enacting new and innovative approaches.

Our Chair has covered some of the highlights in his foreword and I encourage you to read the full examples in the pages that follow. As we look forward to 2018 to 2019 we have some very significant challenges but we are making real strides in many of the key areas. I offer you my personal commitment and assurance that I will do everything within my power to ensure that we respond to, and meet the needs of our local population whilst also addressing the challenges we face with innovative and robust solutions.

Dr Chris Clayton
Accountable Officer
23 May 2018

Purpose and activities of the CCG

NHS Erewash Clinical Commissioning Group (CCG) brings together local general practice and other NHS organisations to plan and help shape local health services for the people of Erewash. The CCG has representation from 12 general practices from the area and has a Governing Body, which is made up of local GPs supported by specialist doctors and nurses, lay members and experienced officer staff.

Our CCG area covers the towns of Ilkeston and Long Eaton, consisting of Sandiacre, Risley, Kirk Hallam, Awsworth, Cossall, Stanton Village, Stanley Common and Dale Abbey and serves a population of over 96,000.

NHS Erewash CCG's mission is deliver 'Better Care, Better Health, Better Value', with our vision in delivering this 'By building strong and sustainable partnerships to develop innovative health and wellbeing services that meet the needs of our population, within our financial resources'.

To achieve this, the CCG is striving to:

- Shift the focus of resources away from acute care and towards community based preventative services and self-care.
- Improve the quality of care and patient experience for patients and their carers.
- Work collaboratively with all our partners (Providers, NHS England, Public Health, Social Services, Voluntary Sector, Local Authorities and others).
- Work to join up services so patients can receive the care they need when they need it, regardless of provider.
- Organise services in such a way as to provide value for money for the taxpayer.
- Deliver the requirements of the NHS Constitution.

Key issues and risks that could affect the CCG deliver its objectives

The key issues and risk to the organisation achieving its objectives are described in the Governance Statement section of this report. In summary the key risk identified during 2017/18 were:

- Potential for External Information Governance breaches including Cyber-attacks
- The CCG will not have the level of resources, capacity and capability (both internal and external) to manage future national expectations / demands / challenges
- Outbreak of Pandemic Flu (This risk is contained within the National and Derbyshire risk registers)
- Transformation team capacity
- Healthcare Providers – Contractual Risk
- Failure to reduce Accident & Emergency (A&E) attendance through increasing GP capacity, MCP On Day, HIU and Other QIPP Schemes
- Reduced A&E attendance reducing Non Elective (NEL) admissions

Adoption of the going concern approach

The CCG has adopted a 'Going Concern' approach in the preparation of its annual financial statements. This follows the interpretation in the Government Accounting Manual of going concern in the public sector.

In summary this interpretation provides that where a body can show anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that function in published documents (such as financial allocation plans), is sufficient evidence of going concern. The only exception to this approach would be for public sector organisations, which are classed as trading bodies. CCGs being funded by direct allocation through NHS England are not trading bodies.

The adoption of a going concern approach by an NHS body can be called in to doubt if that body is subject to a report under s30 of the Local Audit and Accountability Act 2014. These reports, from the auditor of NHS bodies to the Secretary of State, relate to issues of unlawful expenditure made or contemplated by the body. For 2017/18 the CCG has been subject to, a report under section 30 of this Act. The report, produced by the CCG's Auditors, KPMG, outlines this in detail. Notwithstanding the issue of this report the CCG has confirmed with its Auditors that the adoption of the going concern approach is appropriate for 2017/18.

Key Developments during 2017/2018

This section will provide an overview of the key developments during 2017/18 against each of the following areas:

Transformation

Multi-specialty community provider – Erewash Vanguard

The operational year ending March 2018 is the second and final year of the Erewash Vanguard as a fully funded pilot. Led by NHS Erewash CCG the local Vanguard has seen a range of innovations developed, tested and most importantly become successful and impactful in terms of benefit to the local community and this learning is being taken forward to 2018/19.

The NHS Erewash CCG vision has continued to be to facilitate the development of thriving local communities where people feel confident and supported to choose a healthier lifestyle, stay well, and know how to get help and support when they need it.

Maternity Transformation Plan

In February 2016 'Better Births' set out the Five Year Forward View for NHS maternity services in England with a compelling vision of what maternity services should look like in the future. It was recognised that the vision could only be delivered through locally led transformation which was supported both at national and regional levels. Providers and commissioners of maternity services were, therefore, asked to come together to form Local Maternity Systems, which would then plan the design and delivery of local services. Key deliverables for Local Maternity Systems were put in place with the requirement to formulate local plans for delivery of 'Better Births'.

The Derbyshire CCGs took the lead in bringing together all key organisations and stakeholders to establish our 'Local Maternity System' in October 2016. This has now evolved to become the Derbyshire Maternity Transformation Board and the Derbyshire Maternity Transformation Programme is now a standalone transformation programme within the Joined up Care Derbyshire Sustainability and Transformation Plan.

There is now strong system-wide commitment from all key organisations and stakeholders who are working together, and with local women and their families, embracing change to ensure high-quality services for the women, babies and their families of Derbyshire. The result has been the development of the Derbyshire Maternity Transformation Plan which was submitted to NHS England in October 2017. The plan was written collaboratively by members of Local Maternity Services (LMS) partner organisations with key input from Delivery Group leads and members; it was coordinated by one of the Derbyshire CCGs Deputy Chief Nurses and the CCG Commissioning Manager (children and maternity).

CCG Patient Experience, Engagement and Communications teams developed and led a tailored exercise to engage with service users during the drafting stages of the plan to ensure the vision for maternity services in Derbyshire was informed by and collaboratively planned with service users- enabling them to influence and share in local decision-making, which is a golden thread throughout the plan.

The plan outlines an ambitious vision for Maternity Services in Derbyshire. Achieving this vision is as much about creating a lasting ethos of greater collaboration as it is about system design and it will require a cultural shift in many communities, organisations, and also for professionals working within the system. The CCGs are committed to this vision and the Chief Nurse is the Senior Responsible Officer for the Maternity Transformation Programme.

Key to local transformation is honesty about what we are not getting right and the plan identifies Derbyshire's Five Year Priorities and how we will know their implementation has made a difference.

The plan is structured around seven key priorities as follows:

1. Engagement with women and their families.
2. All pregnant women have a personalised care plan.
3. All women are able to make choices about their maternity care during pregnancy, birth and postnatally.
4. Most women receive continuity of the person caring for them during pregnancy, birth and postnatally.
5. Care is safe and effective.
6. Develop a collaborative workforce.
7. Better postnatal and perinatal mental health, including neonatal health.

We are now entering the challenging, but exciting, implementation phase of the plan with dedicated project management support. There is now a real appetite and system-wide commitment to improving the safety, effectiveness and quality of, not only maternity services, but other services both statutory and voluntary who contribute to the delivery of care and support services for mothers, babies and their families.

Integrating Patient Care

Integrated care means the care someone receives should be:

- **Person-centred** - the priority should be meeting the needs of the person not just delivering a service
- **Co-ordinated** - whn there is more than one service providing care, this needs to be organised in an effective and efficient manner for the patient

Delivering integrated care is essential to improving the health outcomes for people who use health and social care services. It should involve better planning, more personal involvement of the person using services and free access to good information.

The Derbyshire CCGs have individually been working towards delivering more integrated care over the last few years and now this 21st Century (21C) work programme is being brought together across the county. The roll-out of clinically proven models of home-based care in Derbyshire is part of a national move to provide more care at the right time and in the right place.

Here are some examples of work that has taken place in North Derbyshire, Hardwick, Erewash and Southern Derbyshire CCGs over the past few years. The programme in the north of Derbyshire is called 'Better Care Closer to Home' and the programme in the south of Derbyshire is 'Joined Up Care'

Community support beds and integrated community services

Since the decision to progress with Better Care Closer to Home and Joined up Care was taken, local organisations have been working hard to develop the implementation plan to enable us to move to a system whereby elderly people who require rehabilitation and reablement support, are cared for in the most appropriate care setting. Prior to this programme of work, all too often elderly people were admitted to a community hospital bed following an illness or injury, particularly following an acute hospital episode. This model of care can often results in a loss of confidence and mobility. In the model that we have now adopted the default care setting for all patients will be the place they call home, aiming to maintain a person's own independence, helping people to regain skills and abilities for day to day living.

The model will see half of those people who previously received reablement and rehabilitation support in a community hospital bed, instead cared for at home by a community based service, known as an Integrated Care Service (ICS). The remainder of people who were previously cared for in a community hospital will instead be cared for in a smaller number of more local community support beds, which are also supported by the ICS, or in higher intensity specialist rehabilitation beds.

Since summer 2017 the number of community support beds has been increased, now including beds at Holmlea in Tibshelf and Thomas Colledge at Bolsover. These are within the Derbyshire County Council (DCC) care homes network and are additional to the pre-existing community support beds across the north of Derbyshire. Further expansion of these beds into Meadow View at Darley Dale is also progressing, and this will result in most of our local areas having access to this type of facility. The final area will be the High Peak in the summer of 2018. The care provided is aimed at increasing a person's independence in a safe and caring environment, and includes aspects such as improved mobility and activities of daily living such as dressing independently and preparing prepare a hot meal or drink, with the ultimate aim of a person returning back to their own home.

Community support beds benefit from enhanced care staffing levels and support from the local community ICS in terms of therapeutic and rehabilitative interventions. In addition to supporting the local beds these teams are also on hand to facilitate a more streamlined and person or long term care. Frequently, at times of illness, people want to remain in their own home whenever possible and members of the team are able to assess a person's needs and access the necessary care and equipment in a timely way. In line with the increasing number of community support beds we are working with local providers to increase the capacity of the local integrated health and care services to make sure that the local teams can respond quickly at times of crisis.

Dementia Rapid Response Team

Derbyshire Healthcare NHS Foundation Trust (DHcFT) has begun its expansion of the Dementia Rapid Response Service (DRRT), already delivered in the south of the county, into northern Derbyshire.

The DRRT is a community-based service that aims to improve the health and well-being of people with dementia when their condition deteriorates, by delivering rapid assessment and intensive support. By providing support in people's homes, the team aims to reduce the need for admission into specialist dementia hospital beds, reducing the disruption and confusion that can be created by hospital admission. The DRRT is provided by a multi-disciplinary team which includes mental health nurses, psychiatrists, occupational therapists and health care assistants.

Mental Health

Achieving parity of esteem for people with mental health needs is one of the NHS's core priorities and is written into the Health and Social Care Act. Currently, one in four people will experience a mental health problem in their lifetime and the cost of mental ill health to the economy, NHS and society is estimated to be £105 billion a year. Nationally, the independent Mental Health Taskforce highlighted the need to improve access to high-quality care for all. The introduction of the access and waiting time standard for early intervention in psychosis (EIP) services and improving access to psychological therapy (IAPT) services heralded the start of a new approach to deliver this improved access and embed standards akin to those for physical health. The EIP standard is not just a new approach for mental health but is a clear national priority for the NHS.

The national **Improving Access to Psychological Therapies (IAPT)** programme began in 2008 and has transformed treatment of adult anxiety disorders and depression in England. Nationally, over 900,000 people now access IAPT services each year, and the Five Year Forward View for Mental Health committed to expanding services further, alongside improving quality. IAPT services provide evidence based treatments for people with anxiety and depression (implementing NICE guidelines).

The target for 2020 is for 25% of adults with a common mental disorder are treated in IAPT services. By February 2018, 26.7% of Erewash patients were treated in IAPT services, this figure exceeded our set target for the year, and furthermore, the CCG has been recognised nationally as a 'high performer'. Derbyshire-wide 24% of patients accessed the service. A further target is for 50% of patients who enter therapy to move into a 'recovery' phase. By March 2018 the CCG had again exceeded the target; 51% of Erewash patients entered the recovery stage, whilst the figure Derbyshire-wide was 54%.

The target for **Early Intervention in Psychosis (EIP)** is for 50% of patients referred to be seen within two weeks; by January 2018 we have exceeded this target in southern Derbyshire and 100% of patients were seen within two weeks, whilst the figure for patients Derbyshire-wide is 91%.

Improving mental health services has been a priority for the Derbyshire CCGs. All four Derbyshire CCGs have met the requirements of the Mental Health Investment Standard (MHIS) with an increased expenditure on mental health care in line with the CCGs uplift and investing in children and young people's mental health services in particular. Jointly commissioned with Derbyshire County Council, we have launched new services including; a Recovery and Peer Support service; and Community Advocacy services.

During 2017, the CCGs, local authorities, and service providers have worked together on a Mental Health Transformational Plan. This focuses on four main programme areas where we wish to make progress on: primary care mental health; responsive community mental health and in–patient services; dementia and delirium; rehabilitation and forensic services. The CCGs have seen continued good performance against national indicators for: early intervention in psychosis; dementia diagnosis; and access to psychological therapies in primary care. Mental Health Liaison Teams in Chesterfield Royal Hospital have been enhanced with both of our major hospitals providing 24-hour mental health cover to the hospital emergency departments.

The Derbyshire CCGs consistently achieved national targets to increase the number of people accessing primary care psychological therapies and achieving positive outcomes. We also launched projects to provide psychological support to people with long-term conditions and are now enhancing the primary care psychological therapy service to include employment support.

The local area coordination project in Belper has replicated the good results demonstrated in Derby providing much improved outcomes for people with mental health problems. We anticipate these local examples being taken forward in our placed-based approach to care.

We continued our commitment to the Crisis Care Concordat updating our joint plan and working closely with the Police. HealthWatch Derbyshire produced a report for the Concordat group and the findings were incorporated into our plans that emphasise the need for improvements to urgent care pathways. Derbyshire has performed exceptionally well in reducing the number of people taken to Police cells for a mental health problem and has also seen in a reduction of the use of the police holding power, Mental Health Act section 136.

The number of people being placed in an acute mental health hospital 'out of area' bed has reduced following a high point earlier in 2017 and is set to cease entirely by September 2018.

Children's Mental Health

In 2015, the Government recognised that nationally there was insufficient access for the 10% of children across Derbyshire who are likely to have a diagnosable mental health condition. The Government challenged CCGs to ensure that 32% of these children (approximately 6,200) would have access to support during 2017/18. Derbyshire CCGs are on target to achieve this. The national ambition is that by 2020 of those children who have a diagnosable mental health condition 35% will receive the support that they need. The focus is increasingly on ensuring that children benefit not only from access to services but from outcomes which will have a positive long-lasting impact on their lives.

The Children's Commissioners are now working as one team across the STP footprint. A Future in Mind Strategic Board across the STP footprint has now been established with all key stakeholders, Chaired by the Director of Children's Services for Derbyshire County Council.

The voices of children and young people have underpinned developments during 2017/18 and will continue to do so, including leading events with a wide range of stakeholders.

The vision is to make sure that children's mental health needs are identified early and they receive effective early support to reduce the likelihood of problem escalation. 'Be A Mate' anti-stigma campaign was launched in 2017 to encourage young people to talk and to support one another, but know where to seek help if necessary. Over 1,000 children have benefitted from mindfulness sessions, over 60 schools are engaged in developing whole school approaches to supporting mental health, and the voluntary sector has been engaged in providing 1:1 and group counselling/support just below the Child and Adolescent Mental Health Services (CAMHS) threshold. 2017/18 has also seen the establishment of urgent care services in the north of the county and the continuation of the service in the south.

Further work during 2018/19 will establish place-based provision to address children and young people's mental health needs within their local communities. There remains a challenge in the transition between children and adults mental health, particularly for children with other vulnerabilities, and this will be a focus for 2018/19.

Children's Commissioning

The CCG Children's Commissioning team has continued to work with partners in the local authority to embed the Special Educational Needs and Disabilities (SEND) Reforms. This has included a significant amount of joint working including several multi-agency training and awareness events and continued improvements to the pathway and process for Education, Health and Care Plans. There has also been work with partners in social care and education as part of the Transforming Care Program to enable young people with autism and learning disabilities and with mental health needs to be better supported in their local communities. Transformation funding from NHS England has been used to facilitate increased understanding of this cohort and particularly of children and young people with autism.

Children's commissioners have also developed a Derbyshire-wide outcomes based service specification for specialist children's community nursing services in co-production with service users and their families**.**

Transforming Care

Transforming Care continues as a national programme which has gathered pace and this year we have had to concentrate on ensuring our community services can simultaneously reduce the incidence of avoidable hospitalisation and ensure we continue to get people safely out of long-stay secure placements in a sustainable way. The programme does not only apply to learning disability, it also applies to people with autism. In April 2017 the Transforming Care Plan (TCP) was put on escalation by NHS England due to not having sufficiently developed the structure or plans in place to manage the change of scale and pace demanded.

The rise in the recognition of Autistic Spectrum Disorder (ASD) with people who also have mental illness has been substantial and the proportion of those getting admitted with mental health and ASD dual diagnosis more than doubled from last year. We now have an agreed Derbyshire Wide Autism Strategy which been supported the Health and Wellbeing Boards. A new Staywell with Autism service has also been procured. Autism diagnosis services are being reviewed; for children the waiting times for an ASD assessment have fallen from three years to 18 weeks on average. Community services are now just starting to use their combined skills to start and collaborate to help care for people recognised as having Autism and mental illness. The TCP has applied for funding from NHS England to skill up more Occupational Therapists to do sensory and integration assessments on the Mental Health wards to better inform the care planning needs for people with autism and mental ill health.

From Derbyshire residents in the cohort we currently have a total of 19 adults and six children / young people in secure NHS England beds and around 11 adults in “locked rehabilitation units”. This is too many. Sometimes the length of stay in such units can run into years, the outcomes are variable and the complexities of those remaining are high. So this year it has been key that we develop a dedicated forensic team to work with these people. This will help ensure that community alternatives are well planned and care is delivered in a co-ordinated way alongside probation and social care. This year Derbyshire will have its first dedicated community forensic team. This has included designing the new service specifications in collaboration with the providers and attracting some match–funding from NHS England to help set this up. NHS England are finalising the Funding Transfer Agreements, they will help make the forensic team sustainable and contribute towards the care required in the community.

The TCP has also focussed on the crisis team offer to people in the cohort. With match-funding from NHS England and newly developed service specifications and operating policies now in place, by the end of this year there will be jointly based LD and MH crisis team capability working over seven days a week. This will ensure that there are developing skills within the system to manage the increasingly recognised dual diagnosis issues of acute mental ill health alongside learning disabilities and / ASD.

There are many other positive things that have been happening in Transforming Care but it is important that we recognise how far we have come in a year. Derbyshire already had an excellent track record of admitting relatively few people into hospital settings who have a learning disability. This year Derbyshire has also performed consistently well in not having any delays in moving people out of locked or secure environments including for housing needs. To achieve this we have developed Joint Solution Groups with both local authorities to manage the processes. Derbyshire has been congratulated by NHS England as top performing TCP in the region on achieving Care and Treatment Reviews (CTR) within time, admission without a CTR is very rare. In October and November the target was reached for the first time. First prompting letter of support from NHS England expressing confidence in the structure of the TCP, then in December we were de-escalated from Red.

Safeguarding

Ensuring the delivery of high quality Safeguarding services for both adults and children remains a high priority for the CCG. The Safeguarding team’s primary function is to ensure that robust and consistent statutory arrangements are in place. This is achieved through joined up working with our partners in health, social services, the Police and NHS England.

In May 2017, the Derbyshire CCGs took the positive decision to directly employ the Designated Nurse for Looked after Children (LAC). This has supported the CCG to continue to work alongside the Trust and review service provision from a more objective perspective. In addition, the CCG have worked closely with Derbyshire Healthcare NHS Foundation Trust to review current provision, specifically assessments for LAC children who are placed and live outside Derbyshire. Significant work in this area has resulted in an agreement for our children to be reviewed within an agreed distance. This will ensure they receive the appropriate care in a timely and consistent way. In addition, there has been a significant amount of work between partners, to improve the delivery of care for Looked After Children. Examples include ensuring appropriate health involvement when children are missing from their placement, the compilation of health histories for care leavers, strengths and difficulties questionnaires and process flow charts for use in health assessments. These have contributed to ensuring that this group of children are supported to reach the natural potential enjoyed by their peers.

Primary Care

The Derbyshire CCGs received delegated authority from NHS England in April 2015 to Commission Primary Medical Services. Since receiving this authority the CCG has continued to develop, strengthen, and implement robust governance processes to support the quality and performance of primary medical services and CCG directly commissioned services delivered by our member practices.

During 2017/18 the Derbyshire primary care teams are working collaboratively to develop a more consistent approach to both the commissioning and quality of primary care commissioned services for the population of Derbyshire.

General Practice Forward View (GPFV)

During 2017/18 the four Derbyshire CCGs (Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCG) have continued to work with member practices and to plan how the requirements of GPFV will be delivered for the population of Derbyshire.

A delivery plan has been submitted and approved by NHS England that outlines the Derbyshire Vision for General Practice 2017-2021. The key objectives of the plan are:

- Delivery of the GPFV Targets
- Investment of Local and National Funding in General Practice
- Support of General Practice Transformation

The objectives as above will enable Primary Care to deliver the following outcomes

- Improving population health, particularly amongst those at risk of illness or injury
- Managing short term, non-urgent episodes of minor illness or injury
- Managing and co-ordinating the health and care of those with long term conditions
- Managing urgent episodes of illness or injury
- Managing and co-ordinating care of those who are at the end of their lives

From April 2018 Primary Care Services will be available on a planned and a request on the day basis from 8.00am till 8.00pm (Monday to Friday). This will support increased access to urgent on the day appointments and planned appointments. We are working with member practices to co-ordinate the delivery of this within local communities or ‘Places’. The availability and offer of increased access to Primary Care Services will be further extended, with pre booked and on the day appointments being available 7 days per week by April 2020.

In order to achieve extended access a new model of care supporting practices to work together, at scale and across a ‘Place’ footprint, is being developed with the focus being on specified populations, offering integrated and co-ordinated care across providers.

Care Quality Commission (CQC) Inspections of Primary Care

Every practice has been visited and all new inspections will be in the new format (which was introduced in November 2017):

- For practices that have a ‘Good’ or Outstanding’ report, a fully focused visit will take place up to every five years.
- Practices who are rated ‘Requires Improvement’ will now have a return visit within 12 months, with the six month time frame being abolished.
- ‘Inadequate’ practices will still have a revisit within six months

- More emphasis on well-led in future inspections as this filters into all areas.

The GP insight report is publically available and is published on the CQC website.

Full reports for each practice can be reviewed by following this link: http://www.cqc.org.uk/content/publications#cqc-solr-search-theme-form

The following ratings in response to CQC inspections for the reporting period up to 1 April 2018:

North Derbyshire CCG	
Outstanding	9 practices
Good	25 practices
Requires Improvement	1 practice

Southern Derbyshire CCG	
Outstanding	12 practices
Good	40 practices
Requires Improvement	3 practices

NHS Erewash CCG	
Outstanding	2 practices
Good	10 practices
Requires Improvement	0 practices

Hardwick CCG	
Outstanding	1 practice
Good	13 practices
Requires Improvement	1 practice

Support for Quality Improvement Visits

Supporting Quality Improvement (SQI) visits were rolled out across Derbyshire during 2017/18. The SQI visits have previously been undertaken in North Derbyshire and Southern Derbyshire CCGs. The visits support membership practices to review current health care information in relation to individual practice quality and performance, share good practice, learn from visiting peer GPs, understand the information available and make change where needed to improve the quality of care for their registered population. SQI supports the clinical commissioning groups' commitment to continuously improving the quality of healthcare for the population with a focus on the needs of the registered population of our membership practices.

Aim:

To hold up the mirror of data and get the practice to reflect on its performance regarding resource utilisation; sharing best practice, learning from others and seeking to understand the information more completely in order to change where necessary.

Outcomes:

1. Reduce clinical variation
2. Continue to be a mechanism for encouraging practice development and sharing good practice.

Educational support to General Practice

Ongoing support is offered to general practice in the form of Practice Nurse Forum (Erewash & Southern Derbyshire CCGs), GP Education events and protected learning time across Derbyshire.

Primary Care-based Dermatology

During 2017/18 a proof of concept scheme, to deliver primary care-based dermatology services within local communities demonstrated successful results and as such was commissioned for a period of three years.

The service has demonstrated excellent outcomes and experience for patients, who have been able to be seen and treated closer to home and has reduced the need for hospital outpatient appointments. Patients only have to wait on average four weeks from referral to appointment. The service is operated by GPs with a Special Interest (GPwSI) who have been accredited to provide the service.

Ophthalmology

A Direct Cataract Referral Service has been commissioned across Derbyshire for some years and continues to support timely access to secondary care, which saves inappropriate referrals and unnecessary visits to hospitals resulting in a better experience for patients.

The Glaucoma Referral Refinement service commissioned during 2016/2017 is still in place for three of the Derbyshire CCGs and continues to allow patients to attend their Community Optometrists (high street opticians) and be assessed for symptoms of glaucoma; previously patients would have been referred into hospital for this assessment. If hospital treatment is required the Optometrist can refer the patient directly into secondary care.

Improving communications for clinicians and patients

NHS e-Referral Service

GP Practices across Derbyshire CCGs continue to maximise utilisation of the NHS e-Referral Service (electronic booking and referral system for GP referrals to first outpatient consultant led services). This electronic system enables GPs to safely and securely send referral information and allows patients to book their own appointment, on a time and date to suit them.

In 2017, in support of the referral process, NHS England introduced a 'Paper Switch Off' (PSO) Programme and this is being successfully implemented across Derbyshire. The PSO Programme's aim is to support and enable Trusts to receive 100% of GP referrals to Consultant Led First Outpatient services via NHS e-RS, ahead of the Contract Service Condition that, by 1 October 2018, all such referrals must be received via this method.

Across Derbyshire, the CCGs continue to work with Chesterfield Royal Hospital NHS Foundation Trust and Derby Teaching Hospitals NHS Foundation Trust, evaluating NHS e-RS utilisation; understanding what services should be available; and supporting practices in order to achieve the programme's aim.

NHS Net

The Derbyshire CCGs have been working with Optometrists during 2017/18 to encourage the use of NHS.net which allows secure transmission of referrals or images to Secondary Care Services to expedite timely access for patients.

Enhanced Care Home Service

The CCGs have continued to commission Enhanced Care Home Schemes; delivered by general practice or community providers who are aligned to individual care homes. Whilst still maintaining patient choice of GP surgery, this service provides better management of patient care that is carried out jointly by care home staff, local practices and local providers. During 2017/18 this service has continued to demonstrate improved outcomes from both qualitative and quantitative perspective, including a reduction in unplanned hospital admissions for care home residents who are part of the scheme. During 2018/19 we will be evaluating the full

effectiveness of the service and exploring if it can be delivered in a more efficient way, whilst providing consistent outcomes for patients

Winter Pressures

NHS Erewash CCG General Practices have again worked hard to provide services to patients over a very busy winter. The CCG utilised the additional winter pressures funding to provide extra GP appointments over the winter period. This year the focus has been on capacity in general practice and an evaluation will be undertaken of the effectiveness will be undertaken in 2018/19.

Planned Care

Preventing the onset of Diabetes
'Diabetes is the fastest growing health crisis of our time; and the fact that diagnoses have doubled in just twenty years should give us pause for thought. Both Type 1 and Type 2 diabetes are serious conditions that can lead to devastating complications such as amputation, blindness, kidney disease, stroke and heart disease if people don't receive a timely diagnosis and the right care."

Chris Askew, Chief Executive, Diabetes UK

In Derbyshire, we're in the second year of rolling out the NHS Diabetes Prevention Programme; a national programme led by NHS England, Public Health England and Diabetes UK. The Derbyshire STP was identified as one of the pilot sites and has been running the "Heathier You" diabetes prevention programme over the last year. The programme is specifically for individuals identified as being at high risk of developing Type 2 diabetes. It focuses on creating long term sustainable behaviour change and supporting patients to achieve a healthy weight, increase physical activity and improve diet of those at risk.

We have continued to build on the success of the first year of the programme in 2016/17 where we referred in 219% of the patients that we had targeted to (1,286 against a target if 587). By March 2017 we had already hit the 2017/18 target of 1,952 patients. We secured copies of the 'At High Risk of Type 2 Diabetes – Information Booklet' produced by Leicester Diabetes Centre and distributed to all the GP practices to issue to patients that were unable to commit to the National Programme, providing them with the information to enable them to reduce their risk.

Janet Key, aged 75, from Derbyshire has been on the programme and said:

"I always thought that I had a fairly healthy diet but I did like chocolate and I used to bake lots of homemade cakes. I've cut down on cakes, biscuits, potatoes and bread, but these are the only things that I have had to noticeably change along with getting more exercise.

As a result I have lost two stones. I'm delighted and feel better than I have felt in years. I can't believe it - I need to wear different sized clothes now."

For further information about the service, please visit: http://nhsstaywellderbyshire.co.uk/

Diabetes Treatment Targets

We are working closely with our Derbyshire GP practices to improve the achievement of the NICE recommended treatment targets (HbA1c, cholesterol and blood pressure). We continue to work with our practices to increase their skills and knowledge about this complex condition. In order to obtain a true picture of where our diabetes training needs/gaps lay, a knowledge, skills and confidence audit was undertake across Primary Care, using the EDEN (Effective Diabetes Education Now) tool. The results are this audit will enable the Derbyshire CCGs to develop a more accurate and targeted diabetes training programme for our primary care healthcare professionals.

Silhouette Telehealth for Diabetic Footcare

Regular assessment of patients with diabetic foot ulcers is vital to ensure timely care and treatment and minimise risk of complications. The Silhouette® 3D digital imaging cameras give an accurate assessment of foot ulcers at outpatient clinics, by capturing wound data which can then be shared remotely with other healthcare professionals. This helps Diabetes Foot teams to deliver care based on objective data and rapidly refer patients from community to hospital if required. Following a successful roll out in South Derbyshire the use of 3D cameras to more accurately assess foot ulcers was expanded across clinics in North Derbyshire during the year, improving wound care and waiting times for diabetes patients. Providing an additional 15 cameras in the community means more Derbyshire patients are regularly monitored without the need for a hospital outpatient appointment. Since its launch a year ago, Silhouette® has helped to significantly reduce outpatient waiting times, with 72% of patients at the Royal Derby Hospitals now seen within 30 minutes of their appointment time compared with only 3% previously. In the community, 71% of patients are now seen within five minutes of their appointment time. The project was shortlisted for a Health Service Journal (HSJ) Healthcare Partnership Award for Best Innovation in Medical Technology during the year.

Musculoskeletal (MSK)

The Derbyshire CCGs have worked together to adopt the Musculoskeletal (MSK) pathway for patients with these conditions. This will ensure equity and equality for Derbyshire patients. The operational development of the pathway has been developed with the stakeholders to enable it to be fully deployed across the county during 2018/19.

Integration Agenda

Personal Health Budgets

In 2017/18 we agreed policies and procedures across all four CCGs to ensure a consistent offer around personal health budgets across the patch. We have continued to speak to health and social care teams about personal health budgets to improve understanding and begin to embed personalised approaches. We worked with Treetops Hospice Care and are one of five pilot sites to develop personal health budgets at end of life.

End of Life (EOL)

We jointly developed a programme with Treetops Hospice and Derbyshire Community Health Services NHS Foundation Trust for improved end of life care supported by Personal Health Budgets.

We have listened to patients' needs and desires to help shape our main focuses for this year, and in the long-term, which are:

- Redesigning community services to support more people outside the hospital.
- Helping GPs manage growing demand.
- Improving care and support for people, and their families and carers, at the end of their life. Making services work better together so people spend time in hospital only when necessary and can get care more easily without moving between services.

Person-centred, coordinated EOL services within Place are under development - specific services and pilots are currently being developed

Place Development

We are working strategically in Derbyshire to develop another of our key long term plans to put patients' needs at the centre through 'Place-based Care':

- Approaching care on a more local population basis

- Looking at improving the health of the population, together with other organisations, including community services, mental health, public health, social care and the voluntary sector. The aim is to have GP practices at the heart of patient care, with care being delivered in the local community by health or social care professionals that best meets patient need.

This builds on the progress made by two collaborative pilots in 2016/17; one involving five practices and community provision in the Belper area and another with three practices in Derby. Both have developed far greater integrated working and are starting to see the benefits of this for patient care. The learning from these pilots has been valuable in developing the approach to 'Place based care'.

Falls Reduction

Falls involving older people has been identified as one of the main issues for STP Places to focus upon to take a pro-active approach to reducing demand for health and social care services. Three areas across Derbyshire have been identified as an outlier for injurious falls and hip fractures (South Derbyshire, High Peak and Chesterfield) and each Place is participating in a localised pilot to test and measure selected evidence based interventions in a coordinated way, to gather valuable information as we move forward implementing the Derbyshire Falls Pathway. For example in South Derbyshire individuals at higher risk of a fall are being invited to participate in strength and balance classes such as Strictly No Falling. The pilot includes:

- In their falls prevention pack person/s will receive information about the local 'Strictly No Falling' (SNF) offer including details of all local classes. The standardised GP invitation letter will be modified to encourage attendance of a local SNF class

- A baseline questionnaire will be included that will outline their current physical activity level, SNF attendance history, barriers preventing them from attending and willingness to be referred to or contacted by the SNF team/local instructor

- The number referred to and commencing SNF classes will be monitored and individual outcomes will be monitored through the SNF project

Delivering Urgent Care

The demand for urgent care increases year on year, and there has been significant pressures across Derbyshire, which has also been seen across the country.

In 2017/18 Derbyshire-wide Winter Plan has been developed, in which additional resource was committed to and increased support to deliver the plan. There are schemes that have also been put in place to help support within the hospital and the community over the winter period.

An Operational Resilience Group (ORG) was re-established across Derbyshire and is led by the CCGs. All Health and Social Care partners within Derbyshire are active members of this group. The ORG has been developed to proactively respond to increases in demand and maintain a tight operational grip on the system. The ORG group forward plan for the week ahead, bank holidays and when we expect there to be an increase in services required. This helps to improve the patient access and ensure that patients' needs are met safely and in the right place. The group has been successful in enabling joint working across Derbyshire and has allowed all partners to work collaboratively to support each other at times where there has been pressure.

The Derbyshire A&E Delivery Board has continued to develop and has been integral to ensuring providers can review and work together to improve services for patients.

NHS England requested that all CCGs provide a Primary Care Streaming Service from October 2017. The main aim of this service is to support the Emergency Department to concentrate on the sickest patients and to help meet national targets. The service had been in place since November 2016 and provision was increased from 1 October 2017 as per the NHS England mandate. The numbers streamed to the service is increasing, which improves the service provided to patients, as they are then able to see the most appropriate person within a timely manner.

Please see Performance Analysis section for more detailed information.

Medicines Management

The Medicines Management team works with membership practices and local providers to improve the quality, safety and cost effectiveness of prescribing, working to minimise harm from prescribing and maximise health improvement.

In conjunction with colleagues in general practice and other local providers the team have delivered over £1m in prescribing savings. These savings have been delivered from a number of schemes:

- Prescribing reviews, medication switches and stopping medicines.
- Use of OptimiseRx a prescribing support software that improves the quality, safety and cost effectiveness of prescribing by providing prescribing advice at the point of prescribing.
- Implementation of the Derbyshire Gluten Free Prescribing Policy
- Implementation of the Derbyshire Self Care Prescribing Policy
- Switch to biosimilar medicines in secondary care
- Savings from branded medicines going off patent and the generic price reducing
- Savings by implementing to schemes to reduce waste medicines

In addition to this we have delivered over 15000 Medicines Optimisation Interventions, more than 24 education sessions and improved the reporting of, and learning from medication related incidents.

Antimicrobial Stewardship

Our headline target across the year was to meet the national Quality Premium (QP) targets for Antimicrobial Stewardship in primary care across NHS Erewash CCG for 2017-18. These targets included:

1. Target for, total antibiotic items prescribed, of ≤ 1,161 items (per STAR PU)
2. Target of ≤ 10% of cephalosporins, quinolones and co-amoxiclav prescribed (out of total number of antibiotic items prescribed).
3. 10% reduction (or greater) in the Trimethoprim: Nitrofurantoin prePscribing ratio (*based on CCG baseline data, June 2015-May 2016).* This equates to a 'target ratio' of 0.88 for Erewash for 2017/18.
4. 10% reduction (or greater) in number of trimethoprim items prescribed to patients aged ≥70 yrs (*based on CCG baseline data, June 2015-May 2016).*

We circulated regular antibiotic prescribing reports (3 monthly) to all GP practices across NHS Erewash CCG. These reports were colour coded showing results of all practices (in green, amber or red colour) to highlight how practices were performing against these QP targets. Thus, they could compare their results against other practices within the CCG. Our Medicines Management pharmacists discussed these results with their GP practices and advised on resources that could be used to inform patients about the appropriate use of antibiotics and other actions that could be taken to improve any results, as appropriate. We also visited GP practices to discuss key issues and presented at GP education events.

As part of our joined up and collaborative approach, local GPs agreed to write 'advice and tips' on 'Reducing Unnecessary Antibiotic Prescribing' for other GPs, by explaining how they:

- reduced their antibiotic prescribing
- overcame problems
- implemented the advantages for their practices

Through this approach we ensured that we circulated these helpful tips to all other GP practices along with details of other useful resources in the TARGET Antibiotic Toolkit - RCGP with a useful patient leaflet Treating infection leaflet and videos for patient waiting areas.

Interim results (as available at March 2018 – covering prescribing data from January to December 2017) show that the targets have been achieved for Erewash, as per table below:

Targets for Erewash, for 2017-18	Erewash Results
Target 1. Total antibiotic items prescribed **≤ 1,161** items *(per STAR PU)*	851.55 *antibiotic items/Star PU* *(equivalent to **27%** below the national target of 1,161 items / STAR PU).*
Target 2. **≤ 10%** of cephalosporins, quinolones & co-amoxiclav prescribed (*out of total no. of antibiotic items prescribed*).	**7.96%**
Target 3. **10%** reduction (*or greater*) in the Trimethoprim: Nitrofurantoin presc. ratio	*CCG target ratio was 0.88, but achieved CCG average of 0.38* (*equiv .to* **57%** reduction)
Target 4. **10%** reduction (*or greater*) in number of trimethoprim items prescribed to patients aged ≥70 yrs	>10% reduction achieved *(as initial results show that **49%** reduction has been achieved).*

The Lead Antimicrobial Pharmacist was invited and agreed to present at four national conferences, during 2017/18, in order to outline the work that is being done in NHS Erewash CCG, to reduce unnecessary antimicrobial prescribing in primary care. These conferences included: UK Clinical Pharmacy Association Master Class event; Clinical Pharmacy Congress in London; Pharmacy Show in Birmingham and Primary Care Pharmacists Association conference. She is the Lead for Primary Care, Pharmacy Infection Network at the UK Clinical Pharmacy Association and is also a member of the Expert Advisory Group on Antimicrobials, at the Royal Pharmaceutical Society.

Finally, NHS Erewash CCG received a national 'Antibiotic Guardian' award, in May 2017, for 'Innovation'. This was achieved due to using a wide range of multifaceted interventions to promote prudent prescribing of antibiotics. GPs also provided advice and tips for their peers, on how they managed to reduce their antibiotic prescribing in their practice and continued to maintain this, including how to overcome problems and the resultant advantages for their practice.

Reducing Waste in the Repeat Prescribing Process

Medicines waste is a significant drain on NHS resources (£30M each year in the East Midlands). Much of this waste is in the repeat prescribing process. Some waste is inevitable but an amount will be preventable.

Using a successful model from elsewhere in the country we intend to implement changes to systems at a larger scale by introducing an additional route for patients to order repeat medicines and act as a point of intervention for medicines issues, via a central telephone medicines ordering point across NHS Erewash CCG. By improving the quality assurance in this process it is possible to better manage the repeat prescribing process and reduce waste. During the year we partnered southern Derbyshire CCG to deliver this service.

Other developments include:

The Medicines Order Line (MOL) opened in December 2017 and examples of patient feedback include the following comments:

- I was really unsure about ringing you but you have really put me at ease and I feel so much happier thank you.
- this is a great idea its will save me struggling to park at the surgery
- amazing service what a genius idea
- sometimes I can spend up to 20 mins at the GP reception desk waiting to collect my prescription, sending it straight to the pharmacy is just fantastic

Medicine Co-ordinator programme

We continue to run the Medicines Co-ordinator training programme to provide training to prescription clerks and administration staff in General Practice.

The aims of the training are –

- To Improve patient safety through better prescribing administration
- Reduce the cost of waste medicines
- Help practices meet Care Quality Commission (CQC) standards
- Reduce time spent by clinicians on repeat prescriptions
- Optimise prescription items for patients

The Medicines Co-ordinators complete an e-learning programme and are supported in practice, by a Medicines Management Technician, to implement the learning in practice. A Derbyshire wide Repeat Prescribing Code of Practice has been developed with the Local Medical Council (LMC) and Local Pharmaceutical Council (LPC) with community pharmacies and GP practices all being asked to sign up to the code.

Gluten Free Prescribing Consultation

For over 40 years the NHS has prescribed gluten-free foods e.g. bread, flour, cereal and pasta, to patients who have been diagnosed with coeliac disease and therefore need to follow a gluten-free diet. The NHS began prescribing gluten-free foods when products were expensive and difficult to source. Today these foods have become widely available at much more reasonable prices than previously and discussions have been taking place as to whether prescribing these still represents good value for the NHS.

In line with many other CCGs, North Derbyshire, Erewash, Hardwick and Southern Derbyshire Clinical Commissioning Groups opened a public consultation in February to gain opinions on the prescribing of gluten-free foods. The Gluten Free Prescribing Public Consultation ran from 27 February 2017 to Tuesday 15 August 2017 on the future of gluten-free foods prescribing

Detailed reports were presented to the four CCG Governing Bodies in November and December 2017 and all supported the option to no longer routinely commission the prescribing of gluten free foods and to stop the prescribing of medicines and products that are available over-the-counter from pharmacies and shops such as supermarkets to treat short term, minor self-limiting conditions.

Other Local Erewash Initiatives

NHS Erewash CCG is proud of having a long track record of innovation which has resulted in positive impact locally and fed into plans across the wider region and nationally.

The transformation team at NHS Erewash CCG play a key role in developing and implementing local initiatives and this year they have focused on three key objectives:

1. Planning – planning how to improve the health of the population, manage demand on the NHS within available resources and meet the requirements of NHSE

2. Partnership – building and maintaining constructive working relationships with organisations, both within and outside of the NHS, to address the determinants of health and maximise the use of resources to meet the health needs of the population

3. Service Improvement – reviewing current services and pathways, planning and facilitating service change and improvement to ensure the CCG is obtaining best value (quality and cost effective services) from investment of public funds

The following provides an update on the ongoing work of the transformation team supporting the planning and partnership responsibilities to support Quality, Innovation, Productivity and Prevention (QIPP):

Local Strategic Partnership

The CCG is in continual discussion with partners, including Erewash Borough Council and Public Health, about how we can jointly re-energise strategic partnership working. All partners currently hold small grant budgets which are individually administered and managed. We are exploring opportunities to work more collaboratively and to use these resource across Erewash to maximise impact and improve services and the outcomes for the population. This aligns with the Vanguard work to create integrated care around individuals and communities (see Vanguard section below).

Mental Health Pathways/Place

Our local work has initially focused on bringing together the service managers of the main mental health service providers in Erewash. Alongside the county wide initiatives delivered in conjunction with partners, NHS Erewash CCG has piloted a project in the locality focussed on access to community sector provision and upskilling leaders in those groups as mental health champions. The main aims have been to improve the flow of patients between services, reduce waiting times increase access to services and meet mental health needs in the community (out of hospital).

Diabetes Pathways

Derbyshire has been provided with resources (£2.7m) over a 3 year period to improve outcomes for patients with diabetes. The programme is being managed on a Derbyshire-wide basis by NHS Erewash CCG. At the beginning of June 2017 the CCG facilitated a multidisciplinary session of Erewash service providers looking at the diabetes pathway. This session identified a number of patient cohorts that were not accessing the care they need. Work continues to deliver subsequent actions for improvement. Access to care forms part of an independent evaluation of our local integrated service (Erewash Diabetes Service) by the University of Derby. A root cause analysis for patients who have had major amputations, is integral to this. The transformation programme has a focus on improving 3 treatment targets, the delivery of structured education, diabetes specialist nurse services and multi-disciplinary foot-care services across Derbyshire.

Third Sector

A number of schemes that seek to measure and build an evidence base of how indirect interventions in other areas of public services affect the determinants of health are in place or currently in development. Examples include a service commissioned with Derventio Housing that works with people with housing issues to reduce their admissions to hospital. The CCG is also working with Community Concern Erewash (CCE) to strengthen the links between their services and the NHS and to demonstrate how they reduce demand on NHS Services. Examples of the work include building relationships with the discharge team at Ilkeston hospital and the DCHS Care Co-ordinators to improve care for individuals and ensure they have access to resources from the third sector when appropriate.

Erewash Future in Mind (FiM)

Historically Child and Adolescent (CAMHS) waiting times in Derbyshire are long and access thresholds are high. FiM aims to increase access to CAMHS and develop support outside specialist services. The CCG through FiM is supporting and training staff already working with children and young people where a problem is identified to reduce the need for specialist interventions and offer early interventions. One of the National Quality Premium targets is to ensure 32% of Children & Young People (CYP) with a diagnosable mental health condition can access support when needed. To date,

Erewash are over performing on this target at the end of quarter 3. The CCG is supporting the Derbyshire-wide Mindfulness programme in the next academic year to build resilience in schools, teaching staff to build Mindfulness into their day to day teaching and to complement and support “Be Brilliant.” (see Vanguard)

Priority Areas – Reducing Smoking in Pregnancy, Childhood Obesity and Alcohol Consumption

In late 2015 an analysis of the health needs of the Erewash population led to our Governing Body deciding that our three priority areas for partnership working would be reducing smoking in pregnancy, reducing childhood obesity and reducing alcohol consumption. Local interventions have included a Champion Midwife (in the Erewash Community midwifery team) for reducing smoking in pregnancy and to support the team to implement best practice, and Love Bump: a social marketing campaign to reach out to women who are thinking of conceiving and highlight the risks to pregnant smokers and their partners and families. These have attracted interest across the wider region and nationally.

Falls Reduction

The CCG are putting considerable focus on falls reduction within care homes to reduce injurious falls and non-elective and A&E admissions. Evidence shows that personalising walking aids has reduced falls by up to 60% in some care homes. NHS Erewash CCG has commissioned AgeUK to carry out this work on their behalf. 27 out of 28 care homes within Erewash have signed up to this piece of work. AgeUK will also be asked to work with the Care Home Advisory Service to identify unused equipment within care home and return this to Medequip which will also result in some non-recurrent financial savings.

Multi-specialty community provider – Erewash Vanguard

The operational year ending March 2018 is the second and final year of the Erewash Vanguard as a fully funded pilot. Led by NHS Erewash CCG the local Vanguard has seen a range of innovations developed, tested and most importantly become successful and impactful in terms of benefit to the local community. The learning is being taken forward to 2018/19.

The NHS Erewash CCG vision has continued to be to facilitate the development of thriving local communities where people feel confident and supported to choose a healthier lifestyle, stay well, and know how to get help and support when they need it. Examples of initiatives delivered as part of the Erewash Vanguard include:

On Day Service

The ‘on day’ primary care service which improves access to primary care has been introduced across the NHS Erewash CCGs footprint following its success and impact in the previous year. The service has a 98% satisfaction rate and of 2,228 people surveyed as part of an impact survey, 18% said they would have gone to A&E if an on day appointment had not been available.

Acute Home Visiting Service

Developed as a nurse-led home visiting service to support GPs in providing care close to home at the right time during practice hours the service had provided 2,480 (at month eight) appointments with over 50% of appointments for those over the age of 80. Six out of every

seven of the top Acute Home Visiting Service users have seen reduced emergency admissions for the 80 plus age group.

Time Swap

Erewash Time Swap is one of the projects that make up the Wellbeing Erewash vanguard. In April 2015 the first member signed up for Erewash Time Swap by the end of this year the continually growing membership has carried out 72 swaps of time and skills. Time banks such as the Erewash Time Swap project allow people to offer their time and skills - such as home DIY and garden maintenance - and receive time back from other people with different skills in return. Time banking is an easy way for people to become a valued part of their community as well as giving practical help to those who need it and is proving to be an effective and popular service in Erewash.

Brilliant Erewash

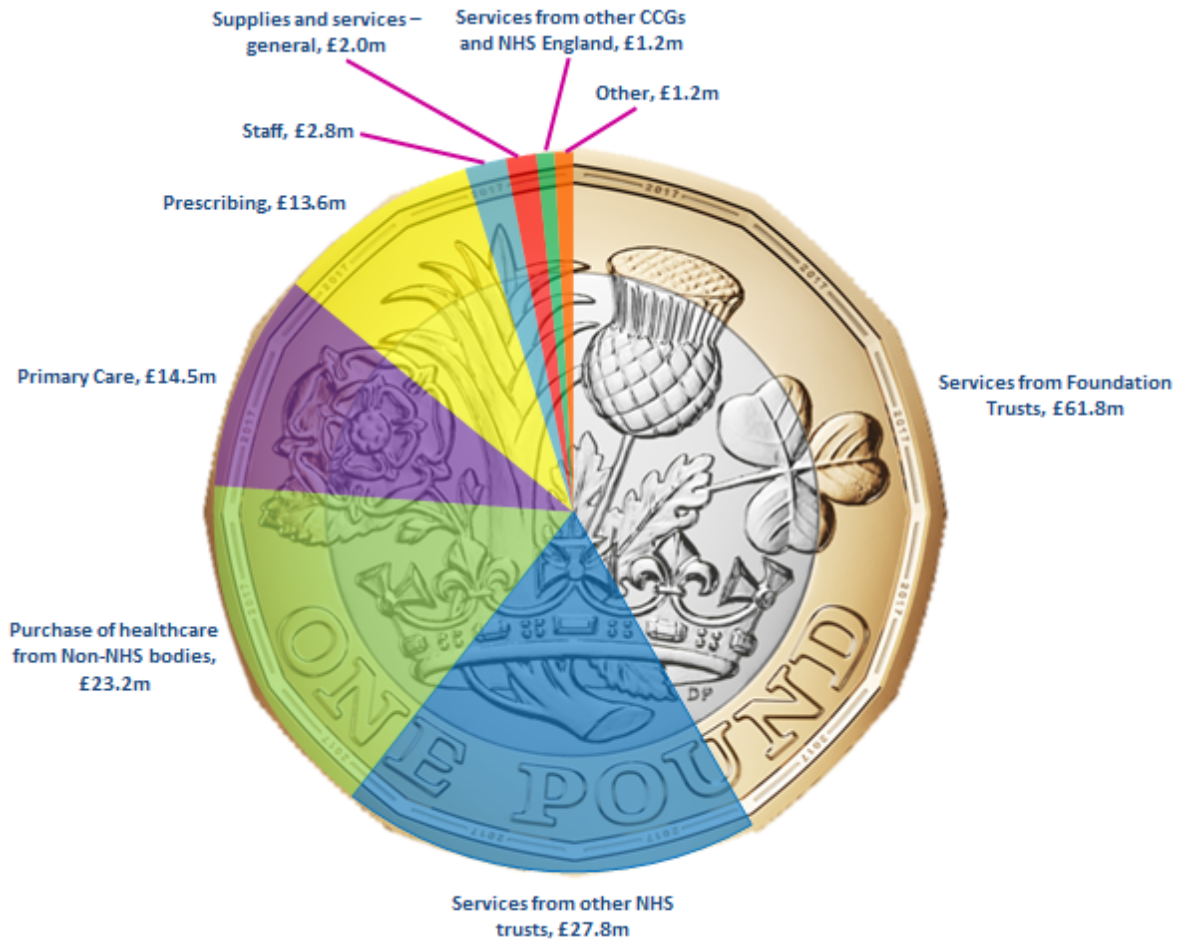
Brilliant Erewash works with all year seven pupils at Erewash secondary schools. Specialist trainers deliver workshops that support and encourage young people to develop resilience, improve 'mental wealth' and build confidence. Of the 695 students taking part in the training there has been a118% increase in those who report feeling optimistic about the future, a 51% increase in those reporting they deal well with problems and an 88% increase in those aiming to have a positive effect on others. Evidence from similar programmes suggests this may lead to improved academic attainment, improved social, emotional, physical and mental health and a subsequent reduction in demand on other services.

Addressing our financial challenge during 2017/18

CCG funding

The NHS England five year Strategic Plan 'Five Year Forward View' included the introduction of a revised formula used to determine the share of funding given to each CCG in England. Under this revised funding formula, NHS Erewash CCG is deemed to have previously received 2.1% more than its 'fair share' of the national funding available. The impact of this has been that for the past two years NHS Erewash CCG has received lower levels of funding growth, when compared to the national average.

A breakdown of the CCGs spend in 2017/18 is shown pictorially as follows:



2017/18 Financial Performance

NHS Erewash CCG was set a financial target (control total) of delivering an in-year balanced position in 2017/18 (a cumulative underspend of £2.681m – the same as in 2016/17). The CCG's financial plan was based on a level of activity growth in each of the main service areas and budgets were set to meet this expenditure and deliver this position. In order to achieve this financial position, planned savings totalling £5.63m had to be identified and these were set out in the QIPP programme for 2017/18.

Despite deviation from the financial plan in a number of areas (acute, mental health and continuing care), due primarily to increased cost pressures, the CCG has delivered QIPP savings of £5.78m and achieved an in-year underspend of £13k and a cumulative underspend of £2.694m.

Impact on 2018/2019 financial planning

Moving forward, it is recognised that there is still more work to do to improve financial resilience. We are currently developing our capability and capacity improvement plan and working in conjunction with NHS England to develop our financial recovery plan; both will enable us to improve our financial position.

The CCG will receive additional resources in 2018/19 but estimated increases in patient care demands from population growth and developments in treatment will add more to CCG

spending. In order to meet the agreed 2018/19 control total, the CCG therefore faces savings initiatives required of approximately £8m. This is a very significant challenge and substantial planning and effort is underway to identify and deliver this major task over the next 12 months.

Performance Analysis

One of the key areas of focus outlines in the CCGs Operational Plan for 2017/18 was to maintain system resilience, performance and meeting all constitutional exceptions.

The constitutional expectations are those performance standards outlined in the NHS Constitution. These include measures such as Referral to Treatment times, Accident & Emergency (A&E) waiting times and Cancer waiting time standards.

The CCGs Governing Body receives a performance report against these measures on a monthly basis. The Finance Committee of the CCG monitors and gains more detailed assurance against the CCGs performance metrics. As part of the development of the Sustainable Transformation Plan (STP), the Derbyshire CCGs have developed an integrated performance report, which gives a system-wide view across Derbyshire for all CCGs and providers, in addition to CCG level information.

How performance is measured

Performance against the NHS Constitution targets is monitored regularly in the Derbyshire CCGs. We look at a range of data, validated and un-validated, at provider level, CCG level and by specialty where applicable. A large proportion of performance information is supplied via our Commissioning Support Unit, and the Derbyshire CCGs produce regular internal reports which are discussed with Executive Directors and lead senior managers, making best use of 'formal' and 'informal' intelligence and ensuring performance management is continuous, not periodical.

The national policy direction to reduce dependency on acute care continues and has been reinforced through the focus on the Derbyshire STP during the year. Ensuring good access to effective local primary care and community services remains a priority. The Derbyshire CCGs have continued to support a successful transformation programme that began in 2015/16. These individual projects that make up this transformation programme all have identified target measurements that show:

- **Improved quality** – more care available local to home
- **Innovation** – working to a new model of care provision through Advanced Nurse Practitioners to complement GP services and ensuring access 7-days a week
- **Preventio**n – services more accessible locally and to patients at risk of their condition worsening without that local support
- **Improved productivity** – the local services developed need to show how they achieve more coverage for less money than the alternative available within the hospitals.

The effectiveness of these schemes is linked to the measurement of the number and type of A&E attendances, the number of non-elective (emergency) admissions to hospital and the number of referrals for out-patient appointments and follow-up out-patient appointments at hospital. Whilst the drivers affecting this demand are complex (for example a 'flu outbreak can increase demand on the health system overall and there is no agreed validated measure for tracking the number of urgent available GP appointments), analysis of the introduction and capacity within these transformation schemes is undertaken at GP practice, population level and time/day of attendance which is linked back to acute hospital demand.

Performance Summary

The overall performance of the CCG in 2017/2018 has been strong. We have delivered 17 of the 22 constitutional or mandated standards for our patients. The standards not delivered are detailed by exception in the Performance analysis section of this report.

Performance Analysis

The table below shows how we have performed against our targets for the year 2017/2018.

Indicator		Standard	CCG	County Wide
Referral to Treatment	18 weeks Referral to Treatment – Elective Surgery	92%	**93.8%**	**92.8%**
	18 weeks Referral to Treatment - 52+ week wait	0	**4**	**83**
Diagnostic waits	Diagnostic test waiting more than 6 weeks from referral	1%	**0.36%**	**1.11%**
A&E waits	A&E <4 hours	95%	**88.9%**	**89.7%**
Cancer waits - <14 days	Urgent GP referral to 1st outpatient appointment	93%	**96.2%**	**94.4%**
	Urgent GP referral to 1st outpatient appointment. (Breast symptoms)	93%	**95.0%**	**91.1%**
Cancer waits - <31 days	Diagnosis to first definitive treatment for all cancers	96%	**97.8%**	**96.6%**
	Subsequent Surgery within 31 days of Decision to treat.	94%	**95.4%**	**96.8%**
	Subsequent Drugs treatment within 31 days of decision to treat.	98%	**98.5%**	**98.7%**
	Subsequent radiotherapy treatment within 31 days of decision to treat.	94%	**93.7%**	**95.0%**
Cancer waits - <62 days	Urgent GP referral to first definitive treatment for cancer	85%	**80.1%**	**79.5%**
	NHS screening service to first definitive treatment for all cancers	90%	**97.9%**	**91.8%**
	First definitive treatment following a consultant's decision to upgrade (all cancers)	N/A	**82.4%**	**84.9%**
Mental Health	CPA 7 days follow up	95%	**98.5%**	**98.1%**
	IAPT Access	15%	**27.1%**	**24.3%**
	IAPT Recovery	50%	**50.9%**	**54.4%**
	IAPT Waiting times (6 weeks)	75%	**90.7%**	**81.4%**
	IAPT Waiting times (18 weeks)	95%	**99.9%**	**99.8%**
	Early Intervention in Psychosis – Completed	50%	**63.6%**	**89.0%**
	Dementia Diagnosis	67%	**85.5%**	**73.2%**
Infection control	C. Diff	**19**	**26**	**270**
	MRSA	0	**0**	**3**
Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	**3**	**145**

2017/2018 Performance Exceptions

Patients waiting more than 52 Weeks for treatment

During the year four Erewash CCG patients had to wait more than 52 weeks for their treatment. Three of these patients were treated at NUH and one at Derby Hospital.
Patients over 52 weeks are reported to NHSE and RCA's are requested for each patient and reviewed by the Quality Team.

A&E waiting time – proportion with total time in A&E under 4 hours

The CCG patients attend both Derby Teaching Hospital Foundation Trust and Nottingham University Hospital Emergency Departments. Both trusts have been unable to meet the 95% standard which is due to the higher acuity of patients being treated The Primary Care Streaming service commenced 15 hours each day at both trusts at the beginning of October 2017 to enable some of the pressure to be taken off the Emergency Department.

Contract Performance notices are currently open for both trusts with an expected delivery of 90% by September 2018 and 95% by March 2019.

Cancer

Erewash CCG failed to achieve the cancer 31 day waits for subsequent radiotherapy this standard by 0.3%. This relates to patients from Derby Hospital Foundation Trust. Work is being undertaken to review this pathway to ensure it is compliant. Failure of this standard was in the first part of the year and unfortunately improvement was too late to affect the year end figure.

Erewash CCG failed to achieve against the two Cancer 62 day standards (urgent GP referral or from a screening service). The performance was mainly affected by patients attending Derby Teaching Hospitals (DTHFT) and Nottingham University Hospital (NUH).

At DTHFT a contract Performance notice was issued in April 2017 due to poor performance. A quality visit was undertaken during May 2017 and Cancer Escalation meetings have been taking place weekly since May 2017 to go through the actions from the weekly Patient Tracking List (PTL) meetings. Recovery is expected in April 2018.

NUH met the 62 day first standard during October 2017 for the first time since August 2016. Remedial Action Plan (RAP) is in place for 62 day with the view that performance improves against national standard.

IAPT Recovery Times

Derbyshire system is on track to deliver against the 5 year forward view target of 25% of the population accessing IAPT, with 50% recovery rates across services by April. First treatment times are good across Derbyshire, however further work is required to meet the second treatment local standard. Derbyshire has introduced a tariff based AQP system to incentivise achievement of targets. Derbyshire wide employment advisors procurement has started in IAPT. Long term conditions pilot underway to embed IAPT and ensure accessibility for patients with Long Term Conditions.

Healthcare Acquired Infections

Clostridium difficile (C. Difficile)

Each CCG has an individual Objective for Clostridium difficile infection. Across the 4 CCG's as a whole Derbyshire is under objective. ECCG have an annual objective of 19 and at the 2017/18 year end there have been 26 cases.

Cases of Clostridium difficile are apportioned to either the acute trust or community. Those patients that develop the infection post 72 hours of admission are classed as attributed to the acute trust. The percentage of acute trust cases differs between the north and south of the county. For Erewash and Southern Derbyshire CCG 55% of cases are attributed to the trust but only 12% of Hardwick and North Derbyshire CCG cases. This is reflective of the acute trust positions as Derby Teaching Hospitals (DTHFT) and Nottingham University Hospital (NUH) are both above their objective and Chesterfield Royal Hospital (CRHFT) and Sherwood Forest are below their objectives.

MRSA

There continues to be a zero tolerance approach set by NHSE for MRSA Bacteraemia. During 2017/18, across Derbyshire there have been 10 reported cases. 1 were relating to E CCG patients. A post infection review (PIR) has been carried out on all cases. Following the investigations 7/10 cases were attributed to third party by Public Health England (PHE). This signifies that no lapses in care or significant learning were identified by the investigation. One NDCCG case was attributed to Macclesfield General Acute Trust and two cases were attributed to NHS Hardwick CCG.

Mixed Sex Accommodation

The NHS has a zero target for mixed sex accommodation breaches. The CCG reported 3 mixed sex accommodation breaches – these breaches took place at Derby Teaching Hospital Foundation Trust.

All reported breaches at DTHFT and BHFT have occurred in Critical Care beds (either Intensive Care or specialist High Dependency) where mixed sex accommodation is allowed as an exception due to the specialist care required. Once a patient is fit for transfer to a ward the Trust work to a 4 hour transfer target and performance is measured against that. There is currently no nationally agreed transfer target time for these patients and there is therefore variation between providers in what they are measuring this target against. Breaches occur when there is no availability of appropriate beds for the patient which is mainly due to pressure within the hospital affecting patient flow. A visit was undertaken by NHSE and the CCG Chief Nurse to establish the reason for these breaches and to understand the actions undertaken by the Trust to prevent them. There is no harm to the patient from these breaches.

Ambulance Response Times

In July 2017, East Midlands Ambulance Service (EMAS) moved to new national operational performance standards following the announcement by the Secretary of State regarding the Ambulance Response Programme (ARP). Comparison between the old and new performance standards is not possible due to the significant differences. Commissioners continued to monitor performance against the new standards but were not contractually binding during 2017/18.

Indicator		Standard	County Wide	EMAS Wide
Ambulance Response times (August '17 – March '18)	Category 1 - Average Response Time	00:07:00	**00:08:47**	**00:08:57**
	Category 1 - 90th Percentile Response Time	00:15:00	**00:15:17**	**00:15:56**
	Category 2 - Average Response Time	00:18:00	**00:30:58**	**00:31:44**
	Category 2 - 90th Percentile Response Time	00:40:00	**01:06:45**	**01:15:29**
	Category 3 - 90th Percentile Response Time	02:00:00	**02:49:30**	**03:29:42**
	Category 4 - 90th Percentile Response Time	03:00:00	**03:36:04**	**03:37:56**

Over the winter period EMAS experienced demand pressures resulting in frequent application of their Capacity Management Plan (CMP) level 4, which is the highest level. Handover delays at Acute Trusts continue to cause further operational pressures, with work ongoing between Acute Hospitals, Commissioners and Regulators to improve.

A demand and capacity review was undertaken during 2017/18 which identified that EMAS required additional front line resources to deliver national performance standards at a County level. Given the timeline to recruit, locally agreed trajectories have been agreed from Quarter Two 2018/19 onwards which work towards delivery of national standards at a county level from Quarter One 2019/20.

NHS 111

Indicator		Standard	Performance against the standard
NHS 111	Calls Abandoned	< 1.0%	**4.2%**
	Calls Answered	< 60 secs	**80.7%**
	Call Transfer	> 50%	**33.7%**
	Closed with self-care	> 20%	**15.2%**
	Calls reaching ambulance disposition	< 9%	**12.5%**
	Calls recommended to attend ED	< 8%	**6.7%**

The NHS111 service across Derbyshire is provided by DHU111 (East Midlands) CIC, (DHU111), the contract is regional and covers four other counties also. This contract has been in place now for the last 19 months. The past 12 months have seen significant change in the NHS111 service. Part of this change has been directed nationally with the publication of the Integrated Urgent Care Service Specification. This document mandates the implementation of ambulance disposition validation, which DHU111 have been doing for the past year. This has saved thousands of ambulance referrals to EMAS. Another element that DHU111 have delivered is to increase the number of calls that have clinical input.

DHU111 have worked with a number of national bodies over the year and are often asked to trial and develop new initiatives. DHU111 have been fundamental to the development of the workforce blue print which suggests a different staffing model to that normally seen within NHS111 providers.

There has been a significant increase in awareness and utilisation of the service, which has put pressure on the provider to deliver. Performance was strong in the first six months of the year however was not maintained throughout the last six months. A number of factors have contributed to this not least the increase in the number of calls the service has seen, which

has been exacerbated by an NHSE media campaign across the region. Performance in a NHS111 service is inextricably linked to staffing levels and much effort has been placed here over the past year. DHU111 have a rolling recruitment programme and have invested considerable time and money on improving staff retention and reducing sickness and absence levels to deliver a more robust workforce model.

As part of achieving a local CQUIN indicator, DHU111 have been developing their IVR (Interactive Voice Response) menu when you first dial 111, which gives various options for callers and ensures that patients and professionals alike are routed to the correct member of staff without delay.

In addition to developing and delivering NHS111 provision DHU111 have moved their headquarters to a new building in Derby. The new call centre is far more desirable for employees and it is hoped that the improved facilities will help boost morale and further aid staff retention within the service.

CCG Improvement and Assessment Framework (CCG IAF)

During 2017/2018 the CCG continued to be monitored through the CCG IAF which was introduced in 2016/2017 with the aim of driving improvement in the health and wellbeing of the population, quality improvements for all patients and better value for money.

My NHS is a publicly accessible website which reports on all of the elements of the CCG IAF and allows a user to compare the CCG position against other CCGs. The link is: https://www.nhs.uk/Service-Search/performance/search

During 2017/2018 the Assessment framework consisted of 51 indicators which are split into four domains.

These are: Well Led, Sustainability, Better Care and Better Health. Each CCG is assessed as Inadequate, Requirement Improvement, Good and Exceptional.

The IAF also contains six clinical priority areas – the standards for these are included in the 51 indicators mentioned above but are assessed separately by a panel.

The final assessments will be published in July 2018.

Children's Wheel Chairs

During 2017/18, the 4 Derbyshire CCGs completed a review of Derbyshire Wheelchair Service. We were concerned that waiting times were long, there was a big backlog of patients that had built up, and there wasn't enough clarify about what type of wheelchairs and associated equipment the service could provide. We established the Derbyshire Wheelchair Service Review Group, which included officers from the 4 CCGs, managers from Derbyshire Community Health Services, who provide the Wheelchair Service, and lay representatives. Over the year, the Group worked together to:

- Review the Eligibility Criteria for the Service, and compare this to what is available in other parts of the country
- Set up a panel, with independent clinical representation, to make decisions on unusual cases which don't fall within the Eligibility Criteria. This ensures that decisions are taken swiftly, within agreed timescales

- Agree what information commissioners need to understand how well the service is performing, and ensure that this is received every month
- Worked with NHS England on the development of personal wheelchair budgets
- Researched what works well in other areas, particularly those services who have a 'child in a chair in a day' system

This joint working has led to some improvements in the service; with the number of children who have an open episode of care of 18 weeks or longer falling from 101 in July 2017 to 53 in March 2018. However, to ensure that Derbyshire patients can benefit from the most evidence based, innovative service, commissioners agreed to re-tender the service and give any potential provider the opportunity to bid to deliver the service. This process will take some time to complete, with a new Derbyshire Wheelchair Service commencing in January 2019

Healthcare Acquired Infections

Methicillin-resistant straphylococcus aureus (MRSA)

There continues to be a zero tolerance to MRSA bacteraemia. Ten Derbyshire CCG patients have developed an MRSA bacteraemia since April 2017.

Number of cases by CCG	April 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	March 18	**Total**
Erewash	0	0	0	1	0	0	0	0	0	0	0	0	**1**
Hardwick	0	0	0	0	0	0	1	1	0	0	0	0	**2**
NDCCG	0	1	0	0	0	1	0	1	0	0	1	0	**4**
SDCCG	1	1	0	0	0	0	0	0	0	1	0	0	**3**
Total	**1**	**2**	**0**	**1**	**0**	**1**	**1**	**2**	**0**	**1**	**1**	**0**	**10**

A post infection review (PIR) has been carried out on all cases. Following the investigations 7/10 cases were attributed to third party by Public Health England (PHE). This signifies that no lapses in care or significant learning was identified by the investigation. One NDCCG case was attributed to Macclesfield General Acute Trust and two cases were attributed to NHS Hardwick CCG.

Clostridium difficile

For Clostridium difficile (CDI), the total annual threshold set by NHS England for the four Derbyshire CCGs for 2017/18, was 283 cases. The table below demonstrates each CCGs performance and individual threshold to January 2018. The total of 229 to date across the four CCGs puts Derbyshire under its threshold for end of January 2018 by 13 cases.

Number of cases by CCG	Annual Threshold Cases(rate per Population)	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	**Total cases (Rate per Population)**
Erewash	19(20.0)	1	1	2	5	1	2	3	3	2	4	0	2	**26(26.6)**
Hardwick	43(39.7)	0	2	5	2	2	2	3	2	2	3	1	4	**28(27.01)**
NDCCG	107(37.5)	9	5	8	6	12	6	5	7	11	8	11	6	**94(32.1)**
SDCCG	114(22.0)	10	10	8	5	9	16	14	11	12	10	11	6	**122(22.2)**
Derbyshire Wide Total	**283**	**20**	**18**	**23**	**18**	**24**	**26**	**25**	**23**	**27**	**25**	**23**	**18**	**270**

The CCG objectives were set in 2015/16 and have remained unchanged. The objective was calculated on a 5.6% reduction on the 2013 rate per population for each CCG this explains why the objectives across the four CCGs are very different. Currently Erewash and Southern Derbyshire CCG are over their objectives although Southern Derbyshire currently has the lowest rate per population across the four Derbyshire CCGs.

Cases of Clostridium difficile are apportioned to either the acute trust or community. Those patients that develop the infection post 72 hours of admission are classed as attributed to the acute trust. The percentage of acute trust cases differs between the north and south of the county. For Erewash & Southern Derbyshire CCG 55% of cases are attributed to the trust but only 12% of Hardwick and North Derbyshire CCG cases. This is reflective of the acute trust positions as Derby Teaching Hospital (DTHFT) and Nottingham University Hospital (NUH) are both above their objective and Chesterfield Royal Hospital (CRHFT) and Sherwood Forest Hospitals NHS Foundation Trust are below their objectives.

Escherichia coli (E.coli) bacteremia

Government expectation and guidance has been issued to address the high national incidence of gram negative blood stream infections. The majority of these infections are acquired outside of acute care. NHS England has implemented the Quality Premium Guidance 2017-19: Reducing Gram Negative Blood Stream Infections (GNBSIs) and inappropriate antibiotic prescribing in at risk groups. The 10% reduction for 2017/18 across the 4 Derbyshire CCG's gives a target of 801 cases for Derbyshire. At the end of March 2018 there have been 891 cases across Derbyshire therefore as a whole county Derbyshire is over objective. Although we have not achieved the 10% reduction in 2017/18 there has been a decline in the year on year increase in number of cases.

The following table demonstrates each CCGs performance and individual objective to March 2018. Currently Hardwick CCG is the only Derbyshire CCG on track to achieve the target.

Number of cases by CCG	Annual Target Cases(rate per 100,000 Population)	Apr17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	**Total cases (Rate per 100,000 Population)**
Erewash	74(77.0)	8	10	9	12	7	3	5	6	8	1	2	8	**79(81.08)**
Hardwick	112(109.8)	8	7	8	15	6	11	12	4	8	10	4	6	**99(95.53)**
NDCCG	212(73.0)	25	21	21	23	16	26	24	23	18	23	17	22	**259(88.71)**
SDCCG	403(76.7)	35	36	42	36	35	33	30	40	61	34	36	36	**454(82.65)**
Total	**801**	**76**	**74**	**80**	**86**	**64**	**73**	**71**	**73**	**95**	**68**	**59**	**72**	**891**

In response to the reduction target providers and commissioners across Derbyshire have set up an E.coli task and finish group which is a sub group of the Derbyshire Infection Prevention & Control (IP&C) Health Economy Group. The group have developed a health economy action plan and are in the process of conducting a deep dive surveillance on a number of cases to establish what proportion of cases are healthcare associated and identify themes and trends in relation to risk factors and focus for infection. A number of education events for both professionals and carers have been held across the county and the group are looking to secure funding to plan, develop and launch a Derbyshire wide public campaign. The national HCAI (Healthcare Associated Infection) lead for NHS Improvement attended the December 2017 Derbyshire wide E.coli group meeting, updating the group with the current national picture and shared some of the actions put in place across the country and were pleased to note the action plan and progress that the Derbyshire group had implemented to date.

Serious Incident reporting

The quality of the Serious Incident (SI) reports submitted to the CCGs, have been of a high standard throughout the year. The main focus for the CCG is to ensure that actions have been completed to gain assurance. SI reports have been submitted in the required timeframe. The four Derbyshire CCGs have worked together to collate the SI processes and to ensure consistency in how reports are reviewed by the Clinical Quality Team, an agreed process is now agreed and in place.

Never Events

Never Events are incidents that require investigation under the Serious Incident Framework. Never events are defined as serious incidents that are preventable because guidance or safety recommendations are available nationally that should have been implemented by all healthcare providers. Across Derbyshire there have been four never events reported within 2017/18, all of which have been thoroughly investigated by the Provider, and signed off by the relevant CCG Chair and Chief Nurse.

Organisation	Type	Total
Derby Teaching Hospitals NHS FT	Wrong route administration of medication Unintentional connection of a patient requiring oxygen to an air flowmeter	2 1
Derbyshire Community Health Services FT	Retained foreign object post-procedure	1
Chesterfield Royal Hospital NHS FT	None reported	0

Better Care Fund metrics

In 2017/18, the CCG has pooled £3.6m of its resources directly with Derbyshire County Council (£7.2m in total and £21.3m in total including other CCG spend on BCF) as part of the nationally mandated Better Care Fund. The intention is that the money be used to reduce non-elective admissions to acute hospitals, reduce delayed transfers of care, reduce admissions to residential and nursing care homes, increase access to reablement/rehabilitation services, increase dementia diagnosis and improve patient experience.

The dashboard shows performance against the mandated standards and can be found in Appendix 1.

Friends and Family Test

The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed. It is a quick and anonymous way for patients to give their views after receiving care or treatment across the NHS. From April 2014, the Staff FFT was introduced to allow staff feedback on NHS Services based on recent experience. Staff are asked to respond to two questions. The 'Care' question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or

care. The ‘Work’ question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work. Staff FFT is conducted on a quarterly basis.

Indicator taken from latest 2017 survey	Chesterfield Royal Hospital NHS Foundation Trust	Derby Teaching Hospitals NHS Foundation Trust	Derbyshire Community Health Services NHS Foundation Trust	Derbyshire Healthcare NHS Foundation Trust	Data Source
Staff 'Response' rates Staff '	63%	42%	55%	45%	https://www.england.nhs.uk/statistics/statistical-work-areas/patient-surveys/
Staff results - staff who would recommend the organisation to friends and family as a place to work (KF1) as scale 1 - 5	3.71	4.02	3.92	3.57	https://www.england.nhs.uk/statistics/statistical-work-areas/patient-surveys/
Inpatient results - % of patients who would recommend the organisation to friends and family as a place to receive care	98%	96%	98%	100%	https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/
A&E results - % of patients who would recommend the organisation to friends and family as a place to receive care	64%	81%	n/a	n/a	https://www.england.nhs.uk/ourwork/pe/fft/friends-and-family-test-data/

Sustainable Development

NHS Erewash CCG has the following sustainability mission statement located in our sustainable development management plan:

> *“The aim of NHS Erewash Clinical Commissioning Group is to provide high quality sustainable health care in this region and it is committed to embedding sustainability into its operations and to encourage key partners and stakeholders to do the same”.*

Sustainability has become increasingly important as the impact of people’s lifestyles and business choices change the world in which we live. As an organisation that acknowledges its

responsibility towards creating a sustainable future, we help to achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff and partners.

The CCG works in accordance with the Sustainable Development Unit's guidance for CCGs and has embedded the sustainable development strategy for the NHS, Public Health and Social Care system into its programme development. The CCG is compliant with those elements of the Climate Change Act and adaptation reporting requirements, which are relevant to them as a commissioning organisation with no responsibility for estate/property assets.

The CCG is also aware of its responsibilities as a socially responsible commissioner and includes this within procurement programmes. The organisation has sought to secure emission reductions and improved sustainability in the following areas:

- **Energy:** by reducing total consumption.
- **Consumables:** by sending key meeting papers electronically instead of print copies and encouraging recycling.
- **Travel:** by reducing the carbon footprint through sensible and pragmatic approaches such as the use of teleconferences, working from home and the use of public transport where appropriate.
- **Procurement:** by taking account of the Procurement for Carbon Reduction (P4CR) Sustainable Procurement tool.

Improving Quality

The CCG has a duty to improve the quality of services, particularly in the following areas:

- **Patient safety:** ensuring healthcare services are provided safely with effective systems in place to protect patients from harm.
- **Clinical effectiveness:** ensuring services are provided in accordance with quality standards, NICE guidance and best evidence practice.
- **Patient experience:** ensuring patients have a positive experience of care.

The CCG pay great regard to the outcomes of safeguarding adults and children and have a focus on ensuring that healthcare providers have the right workforce in place at the right time and with the right skills to meet patients' needs.

The CCG have systems and processes in place to measure the quality of services and use this information to work with healthcare providers to both improve the quality of services and develop new ways of delivering healthcare services. Issues are discussed at Quality Assurance Groups or Quality Scrutiny Panels and the CCG Quality Assurance Committees. Work has commenced to roll out one model of quality assurance across Derbyshire and seats have now been obtained on Chesterfield Royal Hospital NHS Foundation Trust , Derby Teaching Health NHS Foundation Trust and Derbyshire Community Health Services NHS Foundation Trust internal quality assurance meetings to provide commissioners with additional assurance through involvement in the provider internal assurance processes.

The CCG has seen numerous good examples of continuous improvement across providers including:

- CRHFT have worked to reduce avoidable harm to patients focusing on recognising and responding to deteriorating patients and the development of a new trust wide observation policy and chart.

- The CCG has seen significant work across the system in the implementation of D2AM pathways, including at CRHFT where there has been significant work around communication and discharges with the introduction of a multi-agency discharge hub and integrated working across the system to introduce discharge to assess and manage pathways which has directly improved patient care through the reductions in delayed discharges and ensuring that patients are assessed closer to home.

- The CCG has seen evidence of significant work being undertaken at DTHFT in relation to pressure ulcers with a thematic review identifying medical device related injuries as a contributory factor to pressure ulcer incidents. Communication between departments, training and awareness has been rolled out and a significant fall in medical device related harms associated with casts and splints has been seen.

- The CCG have worked with providers to share learning between them in relation to Clostridium Difficile, NHSI was also involved in reviewing every case at DTHFT and were invited by the Trust to review Trust policies which led to a green rating from the reviewers on the NHSI risk assessment tool. The CCG will continue to monitor progress closely and expect to see sustained improvements in 2018/19.

In addition, the CCG is involved in quality visits to our providers, which also include lay representatives. The quality visits may be a proactive general review of the quality of services, or may be reactively focussed to investigate concerns. Visits have taken place in 2017/18 to Provider Emergency departments to gain assurance regarding the patient experience when departments are under pressure and not achieving the national waiting times targets.

In accordance with the recommendations of the Francis Report some of the measures and information sources used by the Derbyshire CCGs to inform quality monitoring are:

- Complaints, service concerns and compliments.
- Serious patient safety incidents.
- Patient experience data such as surveys and the Friends and Family Test.
- Safeguarding Markers of Good Practice.
- Staff surveys.
- Care Quality Commission inspections.
- Workforce metrics such as mandatory training compliance, staff appraisal rates and bank usage.
- Ward assurance metrics, such as falls and number and grades of pressure ulcers.
- Health care acquired infection rates.
- Mortality rates.

Commissioning for Quality and Innovation

The Derbyshire CCGs have systems in place that focus on quality improvement through the quality schedules of each of the provider contracts and also through a system known as Commissioning for Quality and Innovation (CQUIN). CQUIN indicators are both national and locally determined areas of quality improvement and include a financial incentive.

National indicators for 2017/18 included:

- Increasing the uptake of flu vaccinations amongst staff
- Identification and early treatment of sepsis
- Reducing antimicrobial resistance

Specific, local provider CQUIN indicators for 2017/18 were set and providers have worked to achieve good results during 2017/18 with only minor exceptions. The Acute Trusts have worked to improve the diagnosis and early detection of sepsis, the CCGs have worked to monitor progress via the quality assurance process, DTHFT have seen good improvements in relation to sepsis screening and antibiotic administration, which has started to affect the Trust mortality rate for sepsis which has improved at CRHFT.

The Quality and Outcomes Framework (QOF) is an annual reward and incentive programme for GP practices. It rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services. It is a voluntary process for all surgeries in England. The indicators for the QOF change annually, with new measures introduced and other indicators being retired. The indicators during 2017/18 remain the same as 2015/16 and are related to three main areas:

- Managing some of the most common chronic diseases, e.g. asthma, diabetes and heart disease.
- Managing major public health concerns, e.g. smoking and obesity.
- Implementing preventative measures, e.g. regular blood pressure checks and screening

Care Homes

Hardwick Clinical Commissioning Group (HCCG) holds the NHS standard contract (AQP) on behalf of all of the four Derbyshire Clinical Commissioning Groups and host the Care Home Clinical Quality team.

The Clinical Quality Team is responsible for quality monitoring the standards of care homes across Derbyshire to improve the outcomes and experiences for people who live in care homes. The team work closely with Local Authorities in Derbyshire to support people to remain in care homes rather than be admitted to hospital; and to improve standards of clinical care.

For the past few months work has begun across Derbyshire in partnership with the national New Models of Care Vanguard Team at NHS England. Care Homes are now a key focus within ‘A Place based care system’ and the aim is to bring together all of the excellent work that CCGs have done with care homes into one framework. The plan is to engage key stakeholders across the system and use this expertise to develop a new, consistent model of care and secondary care support to care homes, across Derbyshire.

The exemplary work within the Derbyshire CCGs continued in 2017 through close working with partners in health and social care across Derbyshire. The CCG produces a newsletter quarterly which highlights good practice and new initiatives that care homes may wish to replicate and improve the care they provide to their residents.

Engaging People and Communities

Public Engagement and Consultation

The four Derbyshire CCGs have discharged their public involvement duty by having arrangements in place to provide for the public to be involved in:

(a) the planning of services,
(b) the development and consideration of proposals for changes which, if implemented, would have an impact on services and
(c) decisions which, when implemented, would have an impact on services.

In addition to the local engagement and involvement programmes we have worked on a number of external national consultations which have ensured the population of Derbyshire have influenced national decision making at a local level. These include:

- Low value medicines and over the counter provision of medicines
- Self-care
- Gluten free prescribing

The results of these consultations have seen us implementing changes in keeping with national feedback but also relative to local need for example the gluten free prescribing decision reflected the views of the local population. The next 12 months will see increased external consultation as more quality and financial schemes are discussed with the local population to ensure Place Based relevance.

Prescribing Public Consultations

Two countywide prescribing consultations were led by North Derbyshire CCG during 2017:

The Better Health Starts at Home 'Self Care' Public Consultation outlined proposed changes to the prescribing of medicines and products for short-term minor conditions that can be purchased over the counter in pharmacies and shops. The public consultation ran from 26 June - 1 September 2017.

The Gluten Free Prescribing Public Consultation ran from 27 February 2017 to Tuesday 15 August 2017 on the future of gluten-free foods prescribing. Feedback Reports for both are available to view http://www.northderbyshireccg.nhs.uk/consultations

Detailed reports were presented to Governing Bodies in November and December 2017 and all supported the option to no longer routinely commission the prescribing of gluten free foods and to stop the prescribing of medicines and products that are available over-the-counter from pharmacies and shops such as supermarkets to treat short term, minor self-limiting conditions.

Better Births Derbyshire

A targeted countywide engagement exercise took place for two weeks in September 2017 to gather the views of service users and staff to inform the writing of the Better Births Derbyshire five-year plan. Engagement took the form of an online survey and a series of outreach events. Details of the engagement are provided in the Plan. https://joinedupcarederbyshire.co.uk/what-is-joined-up-care-derbyshire/work-areas/maternity-2/maternity-2/

The first meeting of the newly established Derbyshire Maternity Voices Partnership was held in Matlock in March 2018. This is a group where parents and parents-to-be come together to share their views and make recommendations on how maternity care can be improved. Anyone interested in participating in the Maternity Voices Partnership should contact nderccg.enquiries@nhs.net

Patient and Public Involvement in Derbyshire

Further information is available on the link below of how the CCG involves on an ongoing basis patients and the public in its commissioning arrangements (planning, decision-making and proposals for change) http://www.erewashccg.nhs.uk/getting-involved/

Engaging Patients in STP

Health and social care organisations across England are working together more closely than ever before to produce joint plans called 'Sustainability and Transformation Plans' (STPs). The plans set out a vision for a more joined up approach to health and social care, the steps that should be taken to get there and how everyone involved needs to work together to improve what we deliver. Derbyshire's STP is called **'Joined Up Care Derbyshire'**. It brings together twelve partner organisations and sets out ambitions and priorities for the future of the county's health and care, focussing on:

- help keep people healthy
- give people the best quality care
- run services well and make the most of available budgets

Together, with Derby and Derbyshire Healthwatch and voluntary organisations, more than 20 events across Derbyshire were attended during the summer to start the conversation about the future of health and social care. People across the county and city have given us their views and have answered a questionnaire which aims to raise awareness of the changes needed to be made to health and social care and get their views on the initial priorities. During the events more than 1,000 people were reached as well as carers from across the city and county. 120 people have filled out a short and simple questionnaire, whilst 44 people chose to complete it online.

The engagement focused on:

- Promoting the questionnaire and working with organisations to involve staff
- Approximately 8 – 10 sessions specifically for carers
- Healthwatch Derby focused on reaching specific communities in the city
- Working with Healthwatch Derbyshire to attend markets and outdoor events

Find out more, visit joinedupcarederbyshire.co.uk/

Reducing Health Inequality

The CCG has discharged its duties under section 14T of the NHS Act 2006 as detailed in the CCG Constitution by agreeing strategic priorities which aim to contribute to increasing life expectancy. These are:

a. Reducing mortality rates from preventable diseases (see table below for Mortality Rates).
b. Working with practices to tackle practice and clinical variation.
c. Focussing on evidence-based and effective delivery
d. Improving the integration of health and social care
e. Improving integration of primary and secondary care to improve care for the frail, elderly and those with one or more long term conditions
f. Working with partners to improve lifestyle choices of the Derbyshire population in relation to smoking, alcohol, diet and exercise

Moving forward, one of our main improvement objectives for 2017/2018, is to encourage and develop further innovative ways of including people who would not ordinarily get involved and sharing and linking better with our wider NHS, local authority and voluntary sector providers. This includes exploring how we can better speak and listen to people of all ages in particular young people, carers and people who find it difficult to leave their homes. We will also be looking to find ways of encouraging people from diverse communities to tell us their views.

Place-based care strives to reduce healthy inequalities for patients living in specific geographical areas by bringing health and social care organisations together to work collaboratively. We aim for health and social care provision to be thought of in a wider context. We know that only 15% of patient outcomes can be improved by health care alone. Patients should have seamless care not restricted by organisational boundaries. It makes sense to work together with organisations that impact on health and wellbeing to ‘co-produce’ and manage patient care in a coherent and efficient way. Those organisations include, but are not be limited to, community services, social care, mental health, public health and voluntary sector and community groups.

Working together with a wider team means we will be able to provide a more coordinated approach to patient care. It will ensure patients have access to the organisations that are the most appropriate to help and support them. The clinicians involved will be able to provide the skills and mentorship for each other, to work together, freeing up more time for them to focus on their areas of expertise. In addition, the closer working relationships will mean improved access to support and advice when needed. Collaborative working across ‘places’ means that there will be a pooled workforce which should create flexibility in clinicians’ roles.

One of the Patient Experience Team’s main improvement objectives for 2017/18, was to encourage and develop further innovative ways of including people who would not ordinarily get involved and sharing and linking better with our wider NHS, Local Authority and voluntary sector providers. This includes exploring how we can better speak and listen to people of all ages in particular young people, carers and people who find it difficult to leave their homes.

The Patient Experience Team are regular participants in the Chesterfield Equality & Diversity Forum which provides a forum to consider Equalities issues. The team has been able to participate in specialist training such as Lesbian, Gay, Bisexual and Transgender (LGBT) awareness and LGBT Deaf Awareness. Contacts made led us to link the Derbyshire LGBT forum with Quality Managers in the CCG in order to pursue LGBT

awareness training for care home staff. Through the forum we were also able to participate in the Links CVS Celebrating Diversity lunch and mingle events which have proven a valuable forum for us to make links with diverse groups in our community.

In order to access a wider range of participants we have expanded our use of social media through the use of Face Book and Twitter. This was particularly useful when targeting engagement to specific demographics such as our maternity services engagement, and increasing our engagement reach during the Gluten Free and Self-Care prescribing consultations.

Health and Wellbeing in Derbyshire

The health of people in Derbyshire is varied compared with the England average, in terms of life expectancy it is lower for both men and women. We know there are marked inequalities in life expectancy between those in the least and most deprived areas in Derbyshire, for men it is 8.2 years lower and for women 6.4 years.

An estimated 50-80% of cardiovascular disease cases are caused by modifiable and preventable risk factors including smoking, obesity, hypertension and harmful drinking. These modifiable risk factors are most prevalent in deprived communities or certain groups such as those with severe and enduring mental health. In Derbyshire estimated levels of adult excess weight, the rate of adult alcohol-related harm hospital stays and smoking at time of delivery are worse than the England average. The rate of smoking related deaths is 291*, this represents 1,391 deaths per year.

The wider determinants of health underpin lifestyle risk factors; in Derbyshire around 17% (22,200) of children live in low income families and GCSE attainment is worse than the England average. Whilst rates of statutory homelessness, violent crime and long term unemployment are high, they are all better than average.

Early intervention and prevention in childhood can avoid expensive and longer term treatments. In Year 6, 17.9% (1,333) of children are classified as obese, better than the average for England, as is the levels of teenage pregnancy. The rate of alcohol-specific hospital stays among those under 18 is 48* which is worse than the England average and represents 75 stays per year. Priorities for Derbyshire include reducing inequalities in healthy life expectancy, emotional health and wellbeing of children and young people, and smoking in pregnancy.
* rate per 100,000 population

Health and Wellbeing Board and Health Improvement Scrutiny Committee

The four Derbyshire CCGs have contributed greatly to the delivery of the Joint Health and Wellbeing Strategy. The CCGs have been fully engaged with the Health and Wellbeing Board (H&WB) since early in 2011. The Accountable Officer sits on the Core Group on behalf of the Derbyshire CCGs.

A sub group of the H&WB ensures that coordinated progress on integrated care is made, as well as to jointly progress the development of the Better Care Fund.

In addition representatives from the CCG's governing bodies regularly attend the Health Improvement and Scrutiny Committee to update, present reports and to develop a dialogue and partnership with Derbyshire County Council councilors.

Health and Wellbeing Strategy

The Derbyshire Health and Wellbeing Strategy is agreed by a partnership of health and social care and other public and voluntary sector organisations led by Derbyshire County Council. The CCG's strategic objectives are closely linked to those of the Health and Wellbeing Board, ensuring that the CCG is contributing to the delivery of the Health and Wellbeing Strategy.

A sub group of the Health and Wellbeing Board ensures that coordinated progress on integrated care is made, as well as to jointly progress the development of the Better Care Fund.

Derbyshire's Health and Wellbeing Strategy focuses on four priority areas, these are:

- keep people healthy and independent in their own home
- build social capital
- create healthy communities
- support the emotional health and wellbeing of children and young people

Addressing these priorities will help us work to achieve our overarching outcomes for Derbyshire:

- increased healthy life expectancy
- reduced differences in life expectancy and healthy life expectancy between communities

Equality Delivery System (EDS2)

The Derbyshire CCGs have demonstrated a proactive approach to meeting the requirements of the Public Sector Equality Duty through the use of the NHS Equality Delivery System 2. The CCG's equality objectives can be found via the following link: http://www.erewashccg.nhs.uk/equality-inclusion-and-human-rights/

Equality Statement

The following Equality commitment statement is embedded in all CCG policy developments and implementations, while also providing the framework to support CCG decisions through equality analysis and due regard:

NHS Erewash CCG aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. This document has been designed to ensure that no-one receives less favourable treatment due to their protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to socio-economic status, immigration status and the principles of the Human Rights Act.

In carrying out its function, NHS Erewash CCG must have due regard to the Public Sector Equality Duty (PSED). This applies to all activities for which the CCG is responsible, including policy development, review and implementation.

Workforce

With the publication of the NHS Workforce Race Equality Standard (WRES), the CCG has reviewed the submissions by the main NHS Providers in Derbyshire and identified both their compliance with the standard, their current position in terms of BME staff experience and the actions they intend to take. The CCG has noted the requirements of the WRES and applies 'due regard' to all its activities.

As a Two Ticks symbol (now Disability Confident, Level 2) holder, the CCG is passionate about supporting disabled members of staff, to apply for jobs, to be successful at interview and to be supported through reasonable adjustments in post. The CCG has successfully supported various staff to remain in employment with support from the Occupational Health team.

Equality Analysis and 'Due Regard'

The CCG has adopted a robust model of Equality Analysis and 'due regard' which it has embedded within the decision making process. This is evidenced in the design of policies, service specifications and contracts. Such evidence is reviewed as part of the decision process and summarised in all Committee and Governing Body cover sheets.

Due regard

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

ACCOUNTABILITY REPORT

Dr Chris Clayton

Accountable Officer

NHS Erewash CCG

23 May 2018

Corporate Governance Report

Members Report

Member Practices

NHS Erewash CCG Member Practices	
Main Practice	**Branch Surgery**
Adam House Surgery	Hillside
Aitune Practice	
College Street Medical	Long Eaton HV
Dr Purnell and Partners	
Dr Webb and Partners	
Eden Surgery	
Gladstone House Surgery	
Golden Brook Practice	
Littlewick Medical Centre	West Hallam
Moir Medical Centre	Toton & Sawley
Old Station Surgery	Cotmanhay & Kirk Hallam
Park View Medical Centre	

Composition of Governing Body

Governing Body Position	Name
GP Clinical Chair & Leader of NHS Erewash CCG	Dr Avi Bhatia
Chief and Accountable Officer (from 1 October 2017)	Dr Chris Clayton
Chief and Accountable Officer (to 30 September 2017)	Rakesh Marwaha
Chief Finance Officer (from 1 November 2017)	Louise Bainbridge
Chief Finance Officer (to 31 October 2017)	Charlotte Allen-Neale
Interim Director of Governance	Falu Bharmal
Lay Member, Audit and Conflicts of Interest Guardian	Andrew Booth
GP Member & Clinical Vice Chair	Dr Markus Henn
Engagement Officer, Healthwatch Representative	Sharon Mellors
Chief Transformation Officer (to 31 July 2017, non voting)	Samantha Millbank
GP Member / Clinical Lead	Dr Arvind Mistry
Interim Chief Nurse & Quality Director (from 1 June 2017)	Jayne Stringfellow
Chief Nurse and Quality Director (to 31 May 2017)	Heidi Scott Smith
Lay Member, Governance	Professor Ian Shaw
Derbyshire County Council Representative Lay Member, Patient and Public Involvement (and Equality Champion / Freedom to Speak Up Guardian)	Simon Stevens Pam Watson
Secondary Care Doctor (from 1 July 2016 to 31 December 2016)	Dr Asrar Rashid

Audit Committee

The Audit Committee is accountable to the Governing Body and provides 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. The Governing Body has approved and keeps under review the terms of reference for the Audit Committee, which includes membership of the Audit Committee.

The Audit Committee Chair is a qualified accountant and a Fellow with the Chartered Institute of Management Accountants and is suitably qualified to Chair the Audit Committee. He also chairs the Remuneration Committee.

There are two other lay members who serve on the Audit Committee. One is a Professor and health academic with extensive experience in being a non-executive in the health service and Chairs the Governance Committee, Finance & Investment Committee and Primary Care Co-commissioning Committee. The other worked in various commercial roles for a large company in the private sector and again has experience in health related services (enhanced by other non-executive and trustee roles currently held). This member also sits on the CCG's Quality Group and Clinical Innovation Group.

The Directors on the Audit Committee are Falu Bharmal, Interim Director of Corporate Governance and Louise Bainbridge, Chief Finance Officer.

Audit Committee Member Position	Name
Chair	Andrew Booth
Lay Member	Pam Watson
Lay Member	Ian Shaw

In respect of Clinical Audit, the Audit Committee receives reports relating to all areas of risk including clinical risk. It also has "deep dives" covering clinical quality with the lead Director responsible. The Audit Committee also receives Audit Reports relating to quality and clinical matters based on the assessment of risk.

Please see the Remuneration Report for details of the membership of the Remuneration Committee, and the Governance Statement for details of and membership of all other Governing Body and Membership Body Committees.

Register of Interests

The link below is to the interest register section of the NHS Erewash CCG website:

http://www.erewashccg.nhs.uk/key-documents-and-links/

Personal data related incidents

There have been no serious information governance incidents during 2017/18 that have met the criteria for reporting through the IG Toolkit to the Information Commissioners Office.

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.

- 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 Statement

NHS Erewash CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2018 is published on our website at http://www.erewashccg.nhs.uk/equality-inclusion-and-human-rights/
The CCG expects commissioned organisations and other companies we engage with to ensure their goods, materials and labour-related supply chains to fully comply with the Modern Slavery Act 2015; and we are transparent, accountable and auditable; and are free from ethnical ambiguities.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) (the NHS Act 2006) states that each Clinical Commissioning Group (CCG) shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Dr Chris Clayton to be the Accountable Officer of NHS Erewash CCG.

The responsibilities of an Accountable Officer are set out under the NHS Act 2006, Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- 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; and,
- Assess the CCGs 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.[1]

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.

Dr Chris Clayton
Accountable Officer
NHS Erewash CCG
23 May 2018

[1] The standard wording of the last bullet is "use the going concern basis of accounting unless they either intend to liquidate the Group or the parent Company or to cease operations, or have no realistic alternative but to do so". The only circumstance under which the Accountable Officer would prepare the accounts on a non-going concern basis is if 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.

Governance Statement

Introduction and Context

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

The Clinical Commissioning Groups 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 of 1 April 2018, the Clinical Commissioning Group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

NHS Erewash Clinical Commissioning Group (CCG) brings together 12 local GP Practices (General Practitioners) and other NHS organisations to plan and help shape local health services for the people of Erewash. The CCG works closely with other health economy stakeholders including Local Authorities and other CCGs. During 2017/18 the CCG has further developed.

The CCG serves a resident population of around 96,000 and covers the towns of Ilkeston and Long Eaton, consisting of Sandiacre, Risley, Kirk Hallam, Awsworth, Cossall, Stanton Village, Stanley Common and Dale Abbey.

NHS Erewash CCG has a revenue income of £148.265m for 2017/2018 and has a workforce of around 38 employees.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG'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 Services 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 CCG 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 role of the Governing Body is corporate responsibility for the CCG's strategies, actions and finances. As a Governing Body of an NHS organisation, it is the custodian of a national asset, provides stewardship and remains publicly accountable.

Key Features of the CCG's Constitution in relation to Governance

The CCG is a clinically-led organisation and has 12 member practices as detailed in the Constitution. In addition to our accountability to the public and patients we serve, the CCG is accountable to NHS England and to its Membership.

The CCG Governance Framework

The governance framework for the CCG is set out in its Constitution, which ensures that the CCG complies with section A of the UK Corporate Governance Code in all respects. The Constitution is currently under review and is currently under review to bring consistency across the four Derbyshire CCG's constitutions.

Membership Forum

The Membership Forum holds the Governing Body to account and discharges the functions reserved to the Membership. The Membership Forum comprises representation from each of the member practices plus a CCG representative.

The Membership Forum meets monthly throughout the year. Member practices can nominate any member of staff to represent them at the Forum as they see fit. Although the CCG does not have equity shareholders, the Membership Forum fulfils the functions that shareholders would perform in other organisations, and therefore enables the CCG to comply with section E of the Code.

Governing Body

The Governing Body is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically, and in accordance with sections 14L(2) and (3) of the National Health Service Act 2006, as inserted by section 25 of the Health & Social Care Act 2012 and the Constitution of the CCG.

The Governing Body was appointed in accordance with section 14L of the National Health Service Act 2006. The appointment process for Governing Body members varies according to the role they undertake and the appointment process specific to each role is therefore specified in detail within section 2, Appendix C (Standing Orders) to the Constitution. The CCG has therefore necessarily had to depart from sections B2 and B3 of the Code in that it is not in a position to have a Nomination Committee as set out in the Code. The Governing Body is supported by a Head of Governance and its composition is as follows, each with a single non-transferable vote:

NHS Erewash CCG Governing Body Membership
Chair (the designated Clinical Leader), elected by members
Deputy Chair – Lay Member - Audit
Accountable Officer
Chief Finance Officer
Chief Nurse Officer (Registered Nurse)
3 Lay Members, of whom: • one is Deputy Chair, lead for audit and Conflicts of Interest Guardian • one is Lead for patient and public participation matters • one is Lead for Governance

NHS Erewash CCG Governing Body Membership
Secondary Care Specialist Doctor
4 GP Members one of which is Vice Clinical Chair
Chief Nurse
Local Authority representative – Non Voting
Healthwatch Representative – Non Voting
Interim Director Corporate Governance (Board Secretary) – Non Voting
Chief Transformation Officer – Non Voting Member with Speaking Rights

The Governing Body met a total of 11 times in public during 2017/18. The Governing Body also met twice jointly with Hardwick CCG, NHS Erewash CCG and Southern Derbyshire CCG to discuss the future collaborative working arrangements of the Derbyshire CCGs.

Governing Body Performance

From January 2018, the Derbyshire Accountable Officer has been working closely with NHS England on developing a Derbyshire Financial Recovery Plan across the four CCG's and a Derbyshire Improvement Plan. The CCG Governing Body has been involved in the development of these plans.

Following the appointment of the Derbyshire Accountable Officer and Chief Finance Officer, the four Derbyshire CCGs have evolved from working as individual CCG organisations to joint functional working across Derbyshire.

Governing Body approved a single Executive/Director structure in February 2018 and the consultation and appointment process took place during March and April 2018.

NHS Erewash CCG Governing Body, together with North Derbyshire, Hardwick and Southern Derbyshire CCG's met jointly in December 2017 to establish a joint decision making structure across the CCGs. The Governing Bodies agreed to establish a Transition Working Group (TWG) with representation from across the four CCGs to oversee the development of the proposals and the following governance arrangements were agreed to be established by the Governing Bodies:

- Committees in Common in respect of statutory duties (Audit; Remuneration; and Primary Care Commissioning)
- Committees in Common to support the Joint working (Quality and Performance; Finance; Governance; and Clinical and Lay Commissioning);
- Strategic Programme Board to develop and inform the STP and Strategic Commissioner.

Terms of References have been approved by Governing Bodies in March 2018 and the first Audit Committee in Common took place in March 2018. The remaining Committees commenced April 2018.

Governing Body received Cyber Reports of the 'Wannacry' incident on the 12th May 2017, where a widespread ransomware attack affected a significant proportion of NHS organisations and its infrastructure. The incident affected many communities across the NHS and other industries across the world. The incident tested system wide continuity arrangements, internal and external communication plans and organisation response/recovery of IT systems. Lessons learnt and recommendations have been fed into the system wide lessons learnt and NHS England and NHS Digital programmes as a result of the incident.

During 2017/18, NHS Erewash CCG Governing Body approved the re-procurement of its Commissioning Support Unit (CSU) services that the four Derbyshire CCG's commission from Arden and GEM CSU. As a result, from 1st April 2017, Continuing Healthcare services are commissioned from Midlands and Lancashire CSU and 1st October 2017, IT, GP IT and Business Intelligence service are commissioned from North of England Commissioning Services (NECS).

Business cases for services to be brought in-house were developed and submitted to NHSE in February 2017 for consideration, and approval given in September 2017. The following services were 'in-housed' to the Derbyshire CCGs and Transfer of Undertakings Protection of Employment (TUPE) transfers took place on the 1st February 2018: Communications and Engagement, Information Governance, Human Resources – (Business Partner element), Equality, Inclusion and Human Rights, Individual Funding Requests, and Voluntary Sector contracts, Business Continuity, PALS & Complaints, Freedom of Information, Collaborative Contracting. Commissioning Support Unit Finance services will transfer to the Derbyshire CCG's from 1st May 2018.

Sub Committees of the Governing Body

To support the Governing Body in carrying out its duties effectively, committees reporting to the Governing Body have been formally established. The remit and Terms of Reference of these committees are reviewed annually. Each committee receives regular reports, as outlined within their terms of reference and provides exception and highlight reports to the Governing Body.

The governance structure of the CCG comprises:

- Governing Body
- Committees of the Governing Body:
  - Audit Committee
  - Remuneration Committee
  - Primary Care Commissioning Committee
  - Governance Committee
  - Finance Committee
  - Quality Assurance Committee

Committee minutes are formally recorded and submitted to the Governing Body in public sessions, wherever possible, as soon as practicable after meetings have taken place.

Audit Committee

The Audit Committee is constituted in line with the provisions of the NHS Audit Committee Handbook and the *"Towards Excellence"* guidance. It has overseen internal and external audit plans and the risk management and internal control processes (financial and quality), including control processes around counter fraud.

The duties of the Audit Committee are driven by the priorities identified by the CCG, and the associated risks. It operates to a programme of business, agreed by the CCG, which is flexible to new and emerging priorities and risks.

The Audit Committee also monitors the integrity of the financial statements of the CCG and any other formal reporting relating to the CCG's financial performance.

The composition of the Audit Committee is as follows:

NHS Erewash CCG Audit Committee Membership
Chair – Governing Body Lay Member Audit and Conflicts of Interest Guardian
Deputy Chair – Governing Body Lay Member Governance
Lay Representative Public and Patient Involvement and Freedom to Speak Up Guardian
Chief Finance Officer
Interim Director Corporate Governance

The Audit Committee requests and reviews reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. Significant items that were discussed and approved during 2017/18 were:

Significant items approved/discussed by the Audit Committee 2017/18
Governance, Risk Management and Internal Control
Annual Report and Accounts
Board Assurance Framework / Risk Registers 2017/18
Risk Management Strategy and Framework
Service Auditor Reports
Standards of Business Conduct and Compliance
Internal Audit
Internal Audit Progress Reports
Head of Internal Audit Opinion
Internal Audit Plan
External Audit
Annual Audit Letter
External Audit Plan
KPMG International Standard on Auditing 260 Report
Counter Fraud
Counter Fraud, Bribery & Corruption Risk Assessment Work Plan
Local Security Management Work Plan

A benchmark of one meeting per quarter at appropriate times in the reporting and audit cycle is suggested. The Committee met six times in 2017/18 and attendance is detailed in the table below:

Audit Committee Attendance Record 2017/18						
Member	Date 26.04.17	Date 23.05.17	Date 12.07.17	Date 11.10.17	Date 10.01.18	Date 19.03.18
Louise Bainbridge – Chief Finance Officer	N	N	N	N	N	Y
Charlotte Allen-Neale – Chief Finance Officer to February 2018	Y	Y	Y	Y	N	No Longer a Member
Falu Bharmal	Y	Y	Y	Y	Y	Y
Andrew Booth (Chair) – Lay Member	Y	Y	Y	Y	Y	Y
Professor Ian Shaw – Lay Member	N	Y	Y	Y	N	Y
Pam Watson – Lay Member	Y	N	Y	Y	N	N

The quorum necessary for the transaction of business is two of the three Lay Members of the Audit Committee. This requirement was met and exceeded at each meeting.

Remuneration Committee

The Remuneration Committee is accountable to the Governing Body and makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people providing services to the CCG.

The Governing Body has approved and keeps under review the terms of reference for the Committee, which includes information on the membership. The Governing Body ensures that all members appointed remain independent. No decisions are made by Executive Officers.

The Governing Body has delegated specific functions and responsibilities, connected with the Governing Body's main function, Remuneration, as specified in the terms of reference and the Group's Scheme of Reservation and Delegation. The work of the Remuneration Committee enables the CCG to declare compliance with Section D of the Corporate Governance Code of Conduct.

The Committee meets as required but as a minimum annually. The Committee met 3 times during 2017/18. The meetings were quorate and in accordance with its Terms of Reference.

The composition of the Remuneration Committee is as follows:

Remuneration Committee Membership
Lay Member Audit and Conflicts of Interest Guardian (Voting)
Lay Member for Governance (Voting)
Lay Members for Patient and Public Involvement and Freedom to Speak up Guardian (Voting)
Interim Director Corporate Governance (Board Secretary) (Non-voting)
Senior HR Representative Advisor (Non-voting)

Significant items that were discussed and approved during 2017/18 were:

Significant items approved/discussed by the Remuneration Committee 2017/18
Remuneration of a Substantive Accountable Officer and Chief Finance Officer across the four CCG's.
Very Senior Manager (VSM) Salary Review and Cost of Living Increase

Finance Committee

The purpose of the Finance Committee is to review both the financial and service performance of the CCG against financial and financial control targets and the annual commissioning plan. The Committee also identifies where remedial action is needed, ensuring that action plans are put in place and delivery is monitored.

The composition of the Finance Committee is as follows:

Finance Committee Membership
Lay Member Governance & Conflicts of Interest Guardian (Chair)
Chief Finance Officer
Chief Nurse & Director of Quality
Interim Director Corporate Governance
Turnaround Director (no longer a member since March 2018)
Lay Member Patient & Public Involvement and Freedom to Speak up Guardian
Lay Member Audit & Conflicts of Interest Guardian
GP Clinical Lead
Chief Executive Officer

Significant items that were discussed and approved during 2017/18 were:

Significant items approved/discussed by the Finance Committee 2017/18
Finance Report to Governing Body - Base Budgets for 2017/18
NHS Erewash Constitution Targets Performance Report
Operational Plan 2017/18
Derbyshire CCGs Financial Recovery Approach and Resources

The Committee is scheduled to meet monthly and met 9 times during 2017/18. The meetings were quorate and in accordance with its Terms of Reference.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee was established in 2015 following the CCG taking full delegated responsibility for the commissioning of Primary Care Medical Services. The Primary Care Commissioning Committee functions as a corporate decision-making body for the management of the delegated functions and the exercise of delegated powers. The co-commissioning of Primary Care will assist in ensuring whole system integration to support the delivery of a single out of hospital health and well-being network.

The Committee has been established in accordance with statutory provisions to enable the committee members to make collective decisions on the review, planning and procurement of

Primary Care services in Erewash under delegated authority from NHS England. 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. The role of the committee is to carry out the functions relating to the commissioning of Primary Medical Services under Section 83 of the NHS Act. Primary Care Commissioning supports the progression of the CCG objectives as outlined in our five year strategic plan. Conflicts of interest, actual and perceived, are managed robustly and carefully within the Committee and the whole of the CCG.

The CCG has limited GP input into this Committee.

The Primary Care Commissioning Committee meets at least quarterly and has met five times during 2017/2018. All meetings were quorate and in accordance with its terms of reference.

Managing conflicts of interest appropriately is essential to protect the integrity of our decision making processes. We recognise as Commissioners that we need the highest levels of transparency to demonstrate that conflicts of interest are managed in a way that cannot undermine the probity and accountability of the organisation.

The composition of the Primary Care Commissioning Committee is as follows:

Primary Care Commissioning Committee Membership
Lay Member for Governance (Voting) Chair
Lay Member Audit and Conflicts of Interest Guardian (Voting)
Lay Members for Patient and Public Engagement and Freedom to Speak up Guardian (Voting)
Chief Executive Officer
Chief Finance Officer
Interim Director Corporate Governance
Chief Nursing Officer
1 GP Lead – Non Voting
Primary Care Lead – Non Voting

Significant items that were discussed and approved during 2017/18 were:

Significant items approved/discussed by the Primary Care Commissioning Committee 2017/18
Healthwatch Reports
Complaints
Primary care risks
Contract updates
Serious Untoward Incidents

Quality Assurance Committee

The Quality Assurance Committee is established in order to ensure effective management of risk and to manage and address clinical governance issues. The Committee has oversight of process and compliance issues concerning Serious Incidents Requiring Investigation (SIRIs) as well as patient safety aspects. The Committee is scheduled to meet bi monthly and met 4 times during 2017/18.

The composition of the Quality Assurance Committee is as follows:

Quality Assurance Committee Membership
GP (Chair)
Lay Members for Patient and Public Involvement and Freedom to Speak up Guardian
Chief Nurse and Director of Quality
Head of Quality and Medicines Devices Safety Officer
Medicines Safety Officer
GP Representative NHS Erewash CCG GP Lead – Non Voting
Clinical Quality Facilitator NHS Erewash CCG – Non Voting
Public Member – Patient Participation Group
Patient Experience Lead – Non Voting
Infection Prevention and Control Lead Nurse – Non Voting
Safeguarding Lead – Non Voting

Significant items that were discussed and approved during 2017/18 were:

Significant items approved/discussed by the Quality Assurance Committee 2017/18
Patient and Public Engagement Reports
Patient Safety
Medicines Management
Safeguarding
Serious Untoward Incidents

Governance Committee

The CCG has established a Governance Committee. The Committee provides an independent and objective view of the CCGs governance systems and processes, compliance with laws, regulations and directions in so far as they relate to governance. The Committee is chaired by a Lay Member.

The composition of the Governance Committee is as follows:

Governance Committee Membership
Lay Member for Governance (Chair)
Lay Member for Audit and Conflicts of Interest Guardian
Lay Members for Patient and Public Engagement and Freedom to Speak up Guardian (Voting)
Chief Finance Officer
Interim Director Corporate Governance
Head of Governance

Significant items that were discussed and approved during 2017/18 were:

Significant items approved/discussed by the Governance Committee 2017/18
Business Continuity / EPRR
Information Governance including IGTK and any breaches / learning the lessons

Significant items approved/discussed by the Governance Committee 2017/18
Corporate Risks and associated processes
Health & Safety
Human Resources
Equality issues
Staff Survey

Health and Safety Fire & Security Committee

The CCG has established a Health & Safety Fire & Security Committee. The Committee provides guidance on all matters relating to Health & Safety legislation including security. The Committee is chaired by the Assistant Chief Officer & Corporate Director and has a Lay Member as part of the Committee. The Committee is scheduled to meet quarterly and met twice during 2017/18.

The composition of the Health and Safety Fire & Security Committee is as follows:

Health and Safety Fire & Security Committee Membership
Interim Director Corporate Governance (Chair)
Lay Member for Audit and Conflicts of Interest Guardian
Head of Governance
Office Manager – Secretary to the Committee
Local Security Management Specialist
Employee Representatives
GP Representative
Competent H&S Representative

Significant items that were discussed and approved during 2017/18 were:

Significant items approved/discussed by the Health and Safety Fire & Security Committee 2017/18
Local Security Management including improvement plans
CCG Internal Health & Safety Assessments and Inspections - Action Plan
Year-end Annual Assurance report
Training and Compliance including Fire Warden and First Aid

The Governing Body received assurance on the effectiveness of its committees / groups through reports from the work carried out at each of the meetings with direct reports to the Governing Body. The Governing Body also received approved minutes from its committees groups.

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Corporate Governance Code. 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 CCG and best practice.

The Governance Statement is intended to demonstrate how the CCG has regard to the principles set out in the Code considered appropriate for CCG's for the financial year ended 31st March 2018.

For the financial year ended 31st March 2018, and up to the date of signing this statement, the CCG had regard to the provisions set out in the Code. All aspects that NHS Erewash CCG must reference within this statement are fully compliant.

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. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk Management arrangements and effectiveness

The CCG Risk Management Strategy was reviewed and approved in xxxx. The strategy outlines the CCG's approach to risk and the manner in which it seeks to eliminate or control all significant risks. It is supplemented by a Risk Management Framework. Staff at all levels of the organisation are responsible for identifying and recording risk, with appropriate levels of staff trained to evaluate risks and treat them accordingly.

The Risk Management Strategy details the CCG's statement of intent in relation to risk management:

'Risk Management is not just the responsibility of one role or person within an organisation; it's everyone's responsibility'

Risk management is embedded in the activities of the organisation. Through its main Committees and line management structures, the CCG is able to ensure accountability for risk at all levels of the organisation.

The CCG identifies, assesses, manages and governs risk in line with widely available standards and guidance, and specifically in line with ISO 31000:2009. In summary, the risk management process as it applies to the CCG is as follows:

- the context within which risk is to be managed is properly identified and understood. In this instance, the context is the entire range of activities carried out within the CCG, including all activities associated with commissioning patient care and treatment;
- risks are identified;
- risks are assessed in terms of their likelihood, or probability, and potential consequences or severity of impact, should they materialise;
- a clear and shared understanding of the CCG's "appetite" for risk enables agreement on which risks can be accepted (tolerated) and which require management through action plans, so that they are either eliminated, transferred or properly controlled;

- there is proper communication and consultation with relevant stakeholders about all aspects of risk management; and
- all aspects of the risk management system are regularly monitored and reviewed to ensure the system is working effectively.

By ensuring that all staff are aware of their responsibilities for managing risk, good progress has been made towards ensuring ownership of risk both by staff and by the wider Membership of each of the Governing Body Committees. The Committees are provided with the Risk Register at every meeting and the Audit Committee and Governing Body receive an exception report with details of all 'extreme' risks (scores of 15 and above) and any 'high' risks (scores of 8–12) that have been newly identified or for which the risk rating has increased during the month.

Staff are encouraged to identify and report risks arising from business cases, equality due regard, quality impact assessments, performance reports, contract meetings, incident reports and complaints registers, both within the CCG itself and its key providers.

Stakeholder involvement in managing risks

Governing Body membership has always been made inclusive to ensure diverse public stakeholders and other stakeholders voices help inform CCG decision-making and can assist in highlighting risks at Governing Body level. The Governing Body has a strong Lay Membership for Audit, Governance, and Public and Patient Engagement, other Governing Body members include Public Health and Local Authority representation. A patient story is a standing item on the public meeting agenda, where the patient or member of the public tells their story.

Public events including Stakeholder Forums and 21C #JoinedUpCare Transformation Forums and Community Forums have taken place throughout the year with population and community groups. These provide the opportunity to engage with the public and highlight areas of risks. There have also been specific engagement events including the Young People Forum, and listening events which actively engage with the public.

Prevention and deterrence of risk

The CCG has strong processes in place to assist in the prevention and deterrents to risks arising. All reports to Governing Body, and other committees have a mandatory risk assessment section and equality analysis and "due regard" section. The Governing Body continually keeps up-to-date on matters of strategic risk and controls related to challenges within the local health economy and changes to national policy.

The CCG has a mature Serious Incident reporting system and this is continually being improved, the Serious Incident Policy has been reviewed and strengthened during the year. Staff are trained in carrying out systematic Root Cause Analysis investigations in line with the National Patient Safety Agency guidance. Any serious incidents which have occurred are reported to NHS England and other appropriate bodies. Serious Incidents are also reported through the Strategic Executive Information System (STEIS). Any breaches of Information Governance which meet the level 2 criteria of the Information Commissioners Office (ICO) will be reported using the Information Governance Toolkit to the ICO as appropriate.

360 Assurance (Internal Audit) provide specialist advice with regard to Counter Fraud and guidance on the Good Governance Institute.

NHS Erewash CCG continues to work closely with neighboring CCG's, Local Authorities, Local Health Resilience Partnership other partnership groups and has an established

relationship with NHS England in respect of Emergency Preparedness Resilience and Response (EPRR). NHS Erewash CCG received *Full Assurance* for the 2017/18 EPRR Core Standards Assessment from NHS England together with Hardwick, North Derbyshire and Southern Derbyshire CCG.

Capacity to Handle Risk

The accountabilities, roles and responsibilities for Risk Management are detailed within the CCG Risk Management Framework, in brief:

- Governing Body – oversight and holding management to account
- Governance Committee – development and implementation of risk management processes
- Audit Committee – reviews the effectiveness of the Board Assurance Framework and risk management systems
- Accountable Officer – responsible for having an effective risk management system in place and for meeting all statutory requirements
- Executive Team – support the Accountable Officer and are collectively and individually responsible for the management of risk
- Head of Governance – responsible for the development, implementation and maintenance of the risk management arrangements for the CCG

The Board Assurance Framework has been presented to the Audit Committee, Governance Committee and Governing Body during 2017/18 for scrutiny. Following consultation with Audit Committee and the Executive Team, the Board Assurance Framework was refreshed and developed to allow for a more in-depth review of the strategic risks to the CCG.

Risks to the CCG are reported and discussed at every Governing Body and Committee meeting. Communication is two-way, with the Committees escalating concerns to the Governing Body, and the Governing Body delegating actions to relevant Committees where appropriate. Monthly Performance Reports are also scrutinised by the Governing Body and Governance Committee.

As Accountable Officer, I have ultimate responsibility for risk management within the CCG. Day to day responsibility for risk management is delegated to the Executives of the Governing Body with executive leadership being vested in the Chief Finance Officer.

In conjunction with these structures all appropriate staff are provided with training in the principles of risk management and assessment in order for them to manage and treat appropriate levels of risk within their designated authority and day to day duties. Detailed procedures and guidelines are set out in the CCG Risk Management Strategy and supporting Risk Management Framework providing executives, managers and staff with the appropriate tools to identify, score and treat risk properly.

The Governing Body and the Audit Committee fully support the Risk Management Framework within the CCG. There has been continuous improvement and refinement throughout the year, taking into account comments from members, resulting in processes and documents which are easy to read and readily accessible.

Feedback from the Quarterly Assurance meetings with NHS England has been positive. The results of the Quarter Four meeting are not yet known; however there has been no indication from NHS England that the CCG's current Assurance rating of Good will not be retained.

The CCG has co-ordinated the risk management processes and systems of internal control, ensuring that all staff and committee members are fully aware of their responsibilities within the Risk Management Framework of the CCG.

The Head of Internal Audit gave an opinion of significant assurance in 2013/14, 2014/15, 2015/16, 2016/17 and the CCG has continued to build and embed good practice in 2017/18.

Risk Assessment

The CCG's Corporate Objectives for 2017/18 underpin the CCG's Strategic and Operational Plans. The Board Assurance Framework sets out the key risks to the achievement of these Objectives and those risks assessed as *"Extreme"* in the Quarter 4 Board Assurance Framework are set out below, together with the controls and assurances in place to mitigate and manage them.

The design of the annual Internal Audit Plan is linked to the key risks identified within the Board Assurance Framework. Internal Audit reports are reviewed by the CCG's Audit Committee and actions and recommendations are followed up.

Internal Audit reports rate the level of assurance given by systems of internal control as Full, Significant, Limited or No Assurance.

Areas in which the CCG has identified high level risks are as follows:

Significant risks identified during 2017/18

Risk Reference	FIN01				
Title of Risk	Failure to achieve financial duty and balance as a result of failure to address change in health system.				
Directorate	Finance, Contracting and Information				
Primary Risk Owner	Charlotte Allen-Neale				
Associated Risk Owner(s)	Dr Avi Bhatia				
Clinical Lead (if applicable)	Dr Arvind Mistry				
Risk Score (Consequence x Likelihood)	**Red=Extreme 15-25 Orange=High 8–12 Yellow=Moderate 4-6 Green=Low 1–3**	**Consequence**	**Likelihood**	**Score**	**Target Score**
		4	**3**	**12**	**10**
Description of Risk	Failure to achieve financial duty and balance as a result of failure to address change in health system will impact on future NHS England assurance and sustainability of the CCG.				

Risk Reference	CORP01				
Title of Risk	Potential for external Information Governance (IG) breaches including Cyber Security attacks				
Directorate	All Directorates				
Risk Score (Consequence x Likelihood)	Red=Extreme 15-25 Orange=High 8-12 Yellow=Moderate 4-6 Green=Low 1-3	Consequence	Likelihood	Score	Target Score
		5	5	25	10
Description of Risk	**If** a Cyber-attack on CCG/GP takes place **Then** a Breach of patient identifiable or sensitive personal data may occur **Leading to** reputational damage and a possible reportable incident.				

Risk Reference	CORP02				
Title of Risk	Workforce stability including effects of transformational change resulting in lack of internal and external resources.				
Directorate	Corporate				
Risk Score (Consequence x Likelihood)	Red=Extreme 15-25 Orange=High 8-12 Yellow=Moderate 4-6 Green=Low 1-3	Consequence	Likelihood	Score	Target Score
		4	5	20	5
Description of Risk	Due to the ongoing transformational change in Derbyshire - as a consequence of Sustainability Transformation Plan (STP),Multispecialty Community Provider (MCP) CSU re-procurement and the CCG SOC. This could result in instability within the workforce leading to loss of staff in key roles, disillusionment and lack of direction.				

Other Sources of Assurance

Internal Control Framework

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

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

As Accountable Officer, I am responsible for the system of Internal Control within the CCG. Responsibility for specific elements of the Internal Control Framework is delegated to individual members of the senior management team, who will establish the controls relevant to the key business functions, in line with the risks implicit in those functions. I receive assurance on the adequacy of those controls both in their design and their performance from the CCG's Internal and External Auditors. The Audit Committee is charged with receiving reports on the operation of key controls and ensuring that risks identified are appropriately mitigated and that actions are completed.

The CCG fulfils its duties in relation to the Equality Act 2010 and the Public Sector Equality Duty (PSED) contained within that Act, through a robust equality analysis of all policies, procedures and decisions. This ensures that due regard is given to Equality, Inclusion and

Human Rights with the aim of eliminating discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations. The CCG adopts the Derbyshire-wide Quality Schedule, which includes explicit reference to compliance with the PSED, enabling a robust and auditable process going forward.

The CCG is committed to maximising public involvement through the use of the Patient Reference Group, Stakeholder Groups and Public Events. During 2017/18, the Joined up Care programme of work across the south of Derbyshire has ensured that patients and the public from the area are fully represented. The CCG is committed to ensuring that patients and the public are fully involved at all levels of the CCG's activity and have a meaningful impact on commissioning decisions, as required by the public involvement duty in section 14Z2 of the Act.

The CCG engages the services of Counter Fraud Specialists via 360 Assurance and uses their input to ensure that appropriate policies and procedures are in place to mitigate the risks posed by Fraud, Bribery and Corruption. The CCG has also engaged a Local Security Management Specialist via 360 Assurance, to provide appropriate advice and support.

Annual Audit of Conflicts of Interest Management

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

The management of conflicts of interest and potential conflicts of interest is a high priority for the CCG to ensure complete transparency in its decision making process. During 2016/17 enhanced systems and process for identifying, recording, reporting and dealing with conflicts of interest were introduced based on the revised guidance from NHS England. During 2017/18 these systems and processes have been further embedded within all business transacted. Quarterly reports and a final end of year report on the management of conflicts of interest are sent to NHS England to demonstrate effective management of conflicts of interest.

For 2018/19 and ongoing there is a requirement for decision making staff and Governing Body members to undertake Conflicts of Interest training at a level relevant to their seniority and or decision making responsibilities. The CCG has taken the decision to require all staff to undertake the training regardless of their position to ensure a more robust approach and augment everyone awareness and understanding.

360 Assurance carried out an annual internal audit of the CCG management of conflicts of interest during 2017, the outcome of which was an overall **Significant assurance**.

Data Quality

Data quality is crucial and the availability of complete, relevant, accurate and accessible and timely data is important in supporting patient care, clinical governance, management and service agreements for healthcare planning and accountability. We have a Data Quality Policy in place which sits alongside the regular monitoring of data standards which are a requirement of the NHS Information Governance Toolkit.

Since the Health and Social Care Act 2012 was established on 1st April 2013, the CCG has been unable to use Patient Confidential Information (PCD) under section 251 for purposes other than direct care. As a result the CCG has been unable to use PCD for the purpose of invoice validation. This has created challenges in order to satisfy our statutory duties regarding financial probity and to demonstrate scrutiny for public expenditure.

To provide the management of information necessary to manage commissioned activities, since 2013 we commissioned our Business Intelligence Information Services from Arden & GEM CSU. During 2017/18 the Derbyshire CCGs re-procured this service and we have commissioned from North of England Commissioning Services (NECS) since October 2017. During 2017/18 CCG Leads have worked with the team at AGEM CSU and NECS to develop the reports provided to the CCG to ensure that the information provided is fit for purpose. This has involved the delivery of a significantly enhanced monthly Performance Report to Governing Body, Finance Committee and Quality Committee.

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 organisation's and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring that there are robust Information Governance systems and processes in place to help protect patient and corporate information. We place high importance on ensuring there are robust IG systems and processes in place to help protect patient and corporate information. Working closely with Arden & Greater East Midlands CSU and other local CCG's we have developed and established an Information Governance Committee across Derbyshire, with membership from each of the CCG SIRO's, Caldicott Guardians and Information Governance Leads. Also in attendance are representatives from Arden & Greater East Midlands CSU IT Services department to advise on data security issues with a particular emphasis on cyber security controls.

The Information Governance Committee supports and drives the broader IG agenda, including ensuring that risks relating to IG including Cyber Risk are identified and managed. The Committee meets monthly.

We have ensured all staff have undertaken annual IG training relevant to their role with more comprehensive training for the SIRO, Deputy SIRO, Caldicott Guardian and Information Asset Owners. The CCG have implemented a staff IG Handbook, a range of staff guidance and briefing documents along with a Code of Conduct on Confidentiality and Information security to ensure staff are aware of their IG roles and responsibilities and how they can access further information and support.

The CCG also appoints a Caldicott Guardian who plays a key role in ensuring that the organisation satisfies the highest practical standards for handling patient identifiable information. Dr Markus Henn - local GP and Deputy Chair of the Governing Body is the Caldicott Guardian for the CCG.

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

The CCG has not had any data loss during 2017/18 which has required reporting to the Information Commissioners Office.

The CCG's internal auditors, 360 Assurance, reviewed the Information Governance Toolkit evidence in February 2018 giving Significant Assurance' on compliance with the standards of the Information Governance Assurance Framework. The audit report did not have any recommendations or highlight any areas for improvement.

For 2017/18 the CCG submitted to NHS Digital its self-assessment to comply with the Information Governance Toolkit.

Data Security

The new General Data Protection Regulation (GDPR) takes effect during May 2018 and replaces the current Data Protection Act which has been in place since 1998. It places new obligations on organisations which process data and in readiness the CCG has been taking steps to ensure it complies by updating its policies, processes and procedures. As part of the changes the CCG will be appointing a Data Protection Officer.

Business Critical Models

In line with the best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, the CCG does not use any models that it considers to be Business Critical. All models used are subject to full quality assurance processes.

Third Party Assurances including Service Auditor Reports

A range of services are provided by third party providers. These include:

Service	Provider	Assurances
Commissioning Support	AGEM CSU/ NECS	Service Auditor Report
Payroll	SBS	Service Auditor Report
Internal Audit	360 Assurance	Head of Internal Audit Opinion
External Audit	KPMG	Annual Audit Letter
Primary Care transactions	NHS England	Service Auditor Report
Oracle Ledger	SBS	Service Auditor Report

The CCG keeps all contracts under review in order to ensure efficiency and value for money.

Control Issues

The CCG completed the Annual Report Certification Template during month 9 for the Annual Governance Statement and provided a nil return for any reportable issues.

Review of Economy, Efficiency & Effectiveness of the Use of Resources

The CCG is charged with ensuring that it achieves economy, efficiency and effectiveness in its use of resources.

The review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. The comments from external auditors in their annual audit letter and other reports are also taken into consideration.

The CCG prepares an annual Finance Plan that sets out the financial resources available to the organisation and the means by which these will be used to deliver the CCG's objectives. Monthly financial performance is reported to and scrutinised by the Governing Body. Internal and External Audit arrangements give assurance to the Governing Body on the delivery of the CCG's statutory financial responsibilities and the achievement of value for money.

The CCG has benchmarked its performance with similar organisations. It uses expert commissioning support to ensure the delivery of best value through procurement. It develops QIPP schemes that enable it to use its resources effectively and efficiently through improving patient pathways which make best use of available healthcare resources and reduce the use of expensive acute care where more convenient and better value local alternatives are available.

The CCG regularly reviews performance across its practices; facilitates the comparison of relative performance in the use of resources as well as in health outcomes; and provides opportunities for practices to share best practice and develop initiatives for wider roll-out. Performance reports are reviewed at Governing Body and Finance Committee.

The CCG also has a Running Cost allowance that it must operate within, ensuring that as much resource as possible is concentrated on the commissioning and delivery of services to patients. In achieving this, the CCG uses Commissioning Support services to deliver economies in the provision of back-office and similar services.

The CCG Board Assurance Framework provides evidence that the effectiveness of the controls that manage risks to the CCG achieving its principle objectives have been reviewed. The Governing Body, Audit Committee and Governance Committee regularly review the Board Assurance Framework, advising on the effectiveness of the system of internal control, plans to address weaknesses and ensuring continuous improvement of the system are in place.

In July, every CCG in the country received their 2016/17 Improvement and Assessment Framework (IAF) rating from NHS England. These ratings are given on an annual basis and provide each CCG with a headline assessment that helps them measure their performance against the objectives and priorities as set out in NHS England's Five Year Forward View. The ratings are given as either outstanding, good, requires improvement or inadequate; NHS Erewash CCG was rated as good.

Delegation of Functions

The CCG keeps its governance structures under constant review with the aim of delegating decision-making responsibility where this enables the Governing Body to devote more time to strategy and optimises the use of clinical leadership. All such arrangements are set out in the CCG's Scheme of Delegation.

The CCG has two external delegation chains:

- delegated responsibility for Primary Medical Care from NHS England (NHSE). This responsibility is led by the Primary Care Co Commissioning Committee under specific Terms of Reference common to all CCGs who have taken full delegated powers; and
- the Derbyshire Better Care Fund (BCF) under the authority of the Health and Well-Being Board.

Although the CCG has taken on delegated powers for the commissioning of Primary Medical Care, the detailed financial transactions are processed by NHSE into the CCG ledger from the Exeter/ NHAIS system. Capita is responsible for primary care support services at all NHS sites and the CCG is aware that the Capita Service Auditor Report will not give the required assurance over primary care services for 2017/18. As a result the CCG has been working closely with NHSE and external auditors to obtain sufficient evidence to assure itself that primary medical care expenditure in the ledger is complete and accurate. The CCG attends the BCF Finance and Performance Sub-Group and the BCF Programme Board.

Through attendance at these monthly meetings the CCG is fully aware of the performance of the BCF and any associated risks.

Counter Fraud Arrangements

The CCG Chief Officer and Chief Finance Officer are jointly responsible for ensuring adherence to the NHS Protect Anti-Crime Strategy for countering fraud, bribery and corruption and the application of the related NHS Protect Standards for Commissioners. The Chief Finance Officer is also responsible for the completion of a Self-Assessment Review Toolkit (SRT) in relation to these Standards which is submitted annually to NHS Protect.

During 2017/18 the CCG's Fraud, Corruption & Bribery Policy was reviewed by the CCG's Accredited Counter Fraud Specialist and made available to all staff. Counter fraud awareness including a Counter Fraud Awareness Week has also taken place and regular updates including distribution of the publication "Fraudulent Times" are made available.

The Accredited Counter Fraud Specialist attends meetings of the Audit Committee and provides comprehensive updates on progress towards completion of the Annual Work plan and compliance with the Standards for Commissioners.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

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 (GBAF) in the year to date, the outcome of individual assignments completed and your response to recommendations made.

It should be noted however that the breadth of the actual work undertaken to date is not as extensive as that originally anticipated on the agreement of the 2017/18 internal audit plan during the course of the year. Changes to the plan have been brought to the Audit Committees attention in the year to reflect the CCG's changing priorities and risks, particularly as a consequence of the joint working arrangements being established across Derbyshire.

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.

During the year, Internal Audit, 360 Assurance issued the following reports:

Area of Audit	Level of Assurance Given
Payroll Expenditure, Budgetary Control and Financial reporting and Integrity of the GL and control Environment	Significant
QIPP Governance and Monitoring	Significant
Governance and Risk Management	Significant
Information Governance	Full
Conflicts of Interest	Significant
Development and Delivery of Commissioning plans	Significant

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

My review of the effectiveness of governance, risk management and internal control is informed by the work of the internal auditors, executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their 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 this review by the Governing Body, Audit Committee, Finance Committee, Governance Committee and Quality Committee, and have addressed weaknesses during the year and ensure continuous improvement of the system are in place.

The effectiveness of the governance, risk management and internal control is reviewed by the Audit Committee which scrutinises and challenges the reports provided by the CCG. In addition, the reports in relation to the programme of work in the Internal Audit Plan are presented to the Audit Committee. An Audit Tracker of recommendations from the Internal Audit Reports is maintained and reported to each Audit Committee meeting.

My review is also informed via assurances provided by:

- The Governing Body
- The Audit Committee
- NHS England - Improvement and Assessment Framework (IAF), MyNHS. MyNHS is a website which reports on all elements of the CCG IAF and allows users to compare the CCG position against other CCGs
- 360 Assurance - Internal Audit reviews and Head of Internal Audit Opinion
- KPMG - External Audit
- Commissioning Support Unit - contract monitoring meetings
- Sub Committees of the Governing Body
- No reportable Information Governance breaches during the year
- Lay Members
- CCG Membership
- Emergency Preparedness Resilience & Response plans along with “FULL” compliance assessment by NHS England
- Self-Assessment Review against the NHS Protect Security Standards
- Self-Assessment reviews including Emergency Preparedness (Full Compliance) and NHS Protect Security Management Self-Assessment Review
- Management of Conflicts of Interest and Gifts and Hospitality
- Executive Team
- Collaborative and joint working with associate CCGs

Conclusion

No significant internal control weaknesses have been identified during the year. The CCG has received Significant assurance from the Head of Internal Audit Opinion and this, in conjunction with other sources of assurance including scrutiny and challenge from the Audit Committee, feedback from the Governing Body, the membership, Lay Members and senior staff leads the CCG to conclude that it has a robust system of control.

Remuneration and Staff Report

Remuneration Committee

The CCG has established a Remuneration Committee. The committee makes recommendations on determinations about the remuneration, fees and other allowances for employees and for people/organisations providing services to the Group. The Committee is chaired by a lay member.

The Remuneration Committee is comprised of the following members:

NHS Erewash Remuneration Committee	
Position	**Name**
Chair	Andrew Booth
Lay Member	Pam Watson
Lay Member	Ian Shaw

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation and the median remuneration of the organisation's workforce. For the Pay multiples disclosure the Clinical Commissioning Group includes non-executive directors and agency and interim staff. This follows the guidance provided in the Hutton report. There are a number of staff, including three executive directors, that are shared across the Derbyshire Clinical Commissioning Groups (Erewash Clinical Commissioning Group receives an apportioned charge for its share of the costs). However for the purpose of pay multiple calculations, the annual full-time equivalent salaries have been used, rather than the apportioned shares (this methodology has been applied to all shared staff).

The banded remuneration of the highest paid director/member in NHS Erewash Clinical Commissioning Group for the financial year 2017-18 was £140,000 - £145,000 (2016-17, £110,000 - £115,000). This was 3.67 times (2016-17, 2.77) the median remuneration of the workforce, which was £38,845 (2016-17, £40,578). Dr Chris Clayton is the highest paid director, however the actual cost to the organisation is £13k due to sharing arrangements across the Derbyshire Clinical Commissioning Groups.

In 2017-18, zero (2016-17, zero) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £16,902 to £142,500 (2016-17 £16,488 to £113,639).

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

The ratio has increased by 0.90 (32.3%) since 2016/17. This increase is due partly to the decrease in median salary, as a result of bringing some support services staff in-house (most staff of which are on lower than median salaries). These staff were previously employed by the local Commissioning Support Unit and are now shared by the Derbyshire Clinical Commissioning Groups. Additionally, appointment of a shared Chief Executive Officer, with the other Derbyshire Clinical Commissioning Groups, resulted in the highest paid director cost increasing. (As previously noted, the cost of the Chief Executive Officer to the organisation is much less than the full-time equivalent salary, due to the sharing arrangements in place.

Policy on the remuneration of senior managers

For the purpose of this section the phrase 'senior managers' include all those individuals who influence the decisions of the CCG, as listed in the Remuneration tables later in this report. The Remuneration Committee is responsible for determining the remuneration of all individuals who are non-employees and engaged under the Contracts for Services. Remuneration for these positions is informed by local and national pay benchmarking. Their remuneration is reviewed periodically to ensure that it keeps pace with increasing demands on the time of the individuals in those positions. In order to avoid any conflict of interest, in respect of Lay Members who constitute the majority of the membership of the Remuneration Committee their own remuneration is set directly by the Governing Body.

Remuneration of Very Senior Managers

Employment terms for Very Senior Managers (VSM), or members of the CCGs Executive Team are determined separately and where appropriate the principles of Agenda for Change are applied to these employees to ensure equity across the CCG. There is no national body to determine remuneration for VSM employees so a robust process is in place within the CCG. The independent Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises independent representatives from the Governing Body and their decisions are informed by independent local and national benchmarking to ensure the best use of public finds and help recruitment and retention. Their decisions also take into consideration annual Agenda for Change pay circulars to ensure parity where appropriate.

In addition, the Remuneration Committee applies the following principles to those VSM employees who are also members of the Governing Body.

The Chief Executive Officer and Chief Finance Officer are remunerated in line with the CCG Remuneration Guidance (updated) issued by the NHS Commissioning Board in late 2012 as adjusted to take account of the previous remuneration of the staff members concerned.

Senior Manager Remuneration (including salary and pension entitlements)

Senior manager total salaries for 2017/18 can be found in the following tables:

Salaries and Allowances 2017/18

			2017-18					
Name	Title	Note	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 * £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Chris Clayton	Chief Executive Officer	1, 3	5 - 10	0	0	0	37.5 - 40.0	45 - 50
Rakesh Marwaha	Chief Officer	4	260 - 265	35	0	0	95.0 - 97.5	360 - 365
Louise Bainbridge	Chief Finance Officer	1, 3	0 - 5	0	0	0	50.0 - 52.5	55 - 60
Charlotte Allen-Neale	Chief Finance Officer	4	190 - 195	0	0	0	17.5 - 20.0	205 - 210
Falu Bharmal	Assistant Chief Officer and Corporate Director		85 - 90	0	0	0	20.0 - 22.5	105 - 110
Jayne Stringfellow	Interim Chief Nurse & Quality Officer	1, 3	0 - 5	0	0	0	122.5 - 125.0	125 - 130
Heidi Scott-Smith	Chief Nurse and Quality Officer		15 - 20	0	0	0	47.5 - 50.0	65 - 70
Samantha Milbank	Chief Transformation Officer		30 - 35	0	0	0	80.0 - 82.5	110 - 115
Andrew Spring	Interim Turnaround Director		60 - 65	0	0	0	0	60 - 65
Dr Avi Bhatia	Clinical Chair		40 - 45	0	0	0	0	40 - 45
Dr Markus Henn	GP Member (Vice Clinical Chair)		30 - 35	0	0	0	0	30 - 35
Dr Arvind Mistry	GP Member		10 - 15	0	0	0	0	10 - 15
Andrew Booth	Lay Member, Audit		5 - 10	0	0	0	0	5 - 10
Prof Ian Shaw	Lay Member, Governance		5 - 10	0	0	0	0	5 - 10
Pam Watson	Lay Member, Public & Patient Involvement		5 - 10	0	0	0	0	5 - 10
Sharon Mellors	Healthwatch Representative	5	0	0	0	0	0	0
Simon Stevens	Local Authority Representative	5	0	0	0	0	0	0

* Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

Notes to Salaries and Allowances – 2017/18

1. Chris Clayton, Louise Bainbridge and Jayne Stringfellow are Executives shared between NHS Erewash CCG, Hardwick CCG, North Derbyshire CCG and Southern Derbyshire CCG. The salaries reported in the table above represent NHS Erewash CCG's share of salary. The total salaries received from all four CCGs during 2017/18, in salary bands of £5,000, were: Chris Clayton £70,000-£75,000 (1 October 2017 to 31 March 2018); Louise Bainbridge £50,000 - £55,000 (1 November 2017 to 31 March 2018); and Jayne Stringfellow £105,000 - £110,000 (1 April 2017 to 31 March 2018. Started with Erewash CCG from 3 July 2017).
2. 'All Pension related benefits' shows the increase in 'lifetime' pension which has arisen in 2017/18. The sum reported reflects the amount by which the annual pension received on retirement age has increased in 2017/2018, multiplied by 20 (the average number of years a pension is paid to members of the NHS scheme following retirement). 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
3. The 'All Pension related benefits' identified for Chris Clayton, Louise Bainbridge and Jayne Stringfellow, represent the total benefits across all four Derbyshire CCGs.
4. Rakesh Marwaha received a redundancy payment of £160,000 and payment in lieu of notice of £41,494, for loss of office. Charlotte Allen-Neale also received a redundancy payment of £118,919, for loss of office (see note 4.4 of the accounts for further details of the exit packages). These payments were calculated using the NHS redundancy terms and conditions and are included in the salaries reported above. NHS Erewash CCG received £240,000 income from the other Derbyshire CCGs as a contribution towards the costs (reported in note 4.1.2 of the accounts).
5. No payments were made to the Representatives nor were recharges made by their employers.
6. Taxable benefits relate to the provision of a leased motor vehicle. This is disclosed in £ hundreds.
7. No annual performance or long term performance related bonuses were paid in 2017/18.
8. The following table identifies the changes occurring in the Governing Body membership during 2017/18:

Name	Title	Start Date	End Date
Andrew Spring	Interim Turnaround Director	May-17	Mar-18
Heidi Scott-Smith	Chief Nurse and Quality Officer		Jul-17
Jayne Stringfellow	Interim Chief Nurse & Quality Officer	Jul-17	
Samantha Milbank	Chief Transformation Officer		Jul-17
Rakesh Marwaha	Chief Officer		Sep-17
Chris Clayton	Chief Executive Officer	Oct-17	
Louise Bainbridge	Chief Finance Officer	Nov-17	
Charlotte Allen-Neale	Chief Finance Officer		Mar-18

Salaries and Allowances 2016/17

Name	Title	Note	2016-17 (a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 * £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Rakesh Marwaha	Chief Officer		105 - 110	0	0	0	30.0 - 32.5	140 - 145
Charlotte Allen-Neale	Chief Finance Officer		75 - 80	0	0	0	20.0 - 22.5	95 - 100
Falu Bharmal	Assistant Chief Officer and Corporate Director		85 - 90	0	0	0	47.5 - 50.0	135 - 140
Heidi Scott-Smith	Chief Nurse and Quality Officer	2	65 - 70	0	0	0	47.5 - 50.0	115 - 120
Samantha Milbank	Chief Transformation Officer	3	100 - 105	0	0	0	0.00	100 - 105
Dr Avi Bhatia	Clinical Chair		40 - 45	0	0	0	0	40 - 45
Dr Markus Henn	GP Member (Vice Clinical Chair)		25 - 30	0	0	0	0	25 - 30
Dr Arvind Mistry	GP Member		5 - 10	0	0	0	0	5 - 10
Andrew Booth	Lay Member, Audit		5 - 10	0	0	0	0	5 - 10
Prof Ian Shaw	Lay Member, Governance		5 - 10	0	0	0	0	5 - 10
Pam Watson	Lay Member, Public & Patient Involvement		5 - 10	0	0	0	0	5 - 10
Dr Asrar Rashid	Secondary Care Doctor (Interim)		0 - 5	0	0	0	0	0 - 5
Sharon Mellors	Healthwatch Representative	4	0	0	0	0	0	0
Simon Stevens	Local Authority Representative	4	0	0	0	0	0	0

* Note: Taxable expenses and benefits in kind are expressed to the nearest £100.

Notes to Salaries and Allowances – 2016/17

1. 'All Pension related benefits' shows the increase in ‘lifetime’ pension which has arisen in 2016/17. The sum reported reflects the amount by which the annual pension received on retirement age has increased in 2016/2017, multiplied by 20 (the average number of years a pension is paid to members of the NHS scheme following retirement). 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
2. Heidi Scott Smith became "Chief Nurse and Quality Officer" on a permanent basis 1 July 2016, having previously been the "Acting Chief Nurse and Quality Officer".
3. Samantha Milbank was employed permanently as Chief Transformation Officer as of 19 February 2016 but was not added to payroll until April 2016. The arrears element of pay had been accrued in 2015/16 but paid in 2016/17 and is included in the table above.
4. No payments were made to the Representatives nor were recharges made by their employers.
5. Taxable benefits relate to the provision of leased motor vehicles. This is disclosed in £ hundreds.
6. No annual performance or long term performance related bonuses were paid in 2016/17.
7. The following table identifies the changes occurring in the Governing Body membership during 2016/17:

Name	Title	Start Date	End Date
Simon Stevens	Local Authority Representative	Apr-16	
Dr Asrar Rashid	Interim Secondary Care Doctor	Jul-16	Jan-17

Pension benefits as at 31st March 2018

Pension Benefits

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2017 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employers contribution to stakeholder pension £000
Chris Clayton	Chief Executive Officer	0.0 - 2.5	0	15 - 20	35 - 40	211	13	239	0
Rakesh Marwaha	Chief Officer	2.5 - 5.0	0.0 - 2.5	30 - 35	75 - 80	409	44	501	0
Louise Bainbridge	Chief Finance Officer	0.0 - 2.5	0.0 - 2.5	15 - 20	40 - 45	229	19	278	0
Charlotte Allen-Neale	Chief Finance Officer	0.0 - 2.5	0	20 - 25	55 - 60	295	32	332	0
Falu Bharmal	Assistant Chief Officer and Corporate Director	0.0 - 2.5	0.0 - 2.5	30 - 35	80 - 85	485	48	538	0
Jayne Stringfellow	Interim Chief Nurse & Quality Officer	2.5 - 5.0	12.5 - 15.0	45 - 50	140 - 145	838	131	1023	0
Heidi Scott-Smith	Chief Nurse and Quality Officer	0.0 - 2.5	0.0 - 2.5	20 - 25	50 - 55	287	10	329	0
Samantha Milbank	Chief Transformation Officer	0.0 - 2.5	2.5 - 5.0	25 - 30	75 - 80	465	35	575	0

Notes to Pension Benefits

Chris Clayton, Louise Bainbridge and Jayne Stringfellow are Executives shared between NHS Erewash CCG, Hardwick CCG, North Derbyshire CCG and Southern Derbyshire CCG. The pensions data reported in the table above, summarises their total NHS pension benefits. The real increase in pension, lump sum and cash equivalent transfer value reflects an apportionment of their total pension benefits for the period employed by NHS Erewash CCG.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by the number at a particular point in time. The benefits valued are the member's accrued benefits and contingent spouses'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. CETV's are calculated within the guidance and framework prescribed by the institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

Two payments were made during the year in respect of early retirement or loss of office.

Payments to past members

No such payments have been proposed or paid during the year.

Staff Report

Number of Senior Managers

	Male	Female	Total
Executive Members	1	2	3
Band 8c	1	2	3
Band 8b	0	2	2
Band 8a	1	3	4
Other Banded CCG Employees	2	18	20
Total CCG Employees	5	27	32
Other Non Permanent Engagements including non-executive directors and lay members	7	3	10
Total	**12**	**30**	**42**

The staff costs are shown in the following table:

Employee Benefits 2017-18

Employee Benefit	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
Salaries and wages	1,775	1,511	264	602	540	62	1,173	971	202
Social security costs	175	175	0	67	67	0	108	108	0
Employer Contributions to NHS Pension scheme	197	197	0	79	79	0	118	118	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	320	320	0	320	320	0	0	0	0
Gross employee benefits expenditure	2,467	2,203	264	1,068	1,006	62	1,399	1,197	202
Less recoveries in respect of employee benefits (note 4.1.2)	(548)	(548)	0	(250)	(250)	0	(298)	(298)	0
Total - Net admin employee benefits including capitalised costs	1,919	1,655	264	818	756	62	1,101	899	202
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	1,919	1,655	264	818	756	62	1,101	899	202

Employee benefits 2016-17

	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
Salaries and wages	1,678	1,412	266	636	601	35	1,042	811	231
Social security costs	156	156	0	67	67	0	89	89	0
Employer Contributions to NHS Pension scheme	193	193	0	84	84	0	109	109	0
Other pension costs	0	0	0	0	0	0	0	0	0
Apprenticeship Levy									
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	2,027	1,761	266	787	752	35	1,240	1,009	231
Less recoveries in respect of employee benefits (note 4.1.2)	(103)	(103)	0	0			(103)	(103)	0
Total - Net admin employee benefits including capitalised costs	1,924	1,658	266	787	752	35	1,137	906	231
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	1,924	1,658	266	787	752	35	1,137	906	231

Staff numbers and costs

The average number of staff employed by the CCG, excluding Non-Executive members and Lay Members, is:

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**38**	**34**	**4**	**36**

Sickness Absence Data

The average number of working days lost during 2017/18 is shown below:

	2017/18 Number	2016/17 Number
Total days lost	127.3	81.0
Average number of permanent employees for the year	32.7	31.8
Average working days lost	3.9	2.5

The staff sickness absence is based on the calendar year and uses the formula in the Department of Health & Social Care guidance to adjust for weekends and bank holidays.

The Clinical Commissioning Group has restated the 2016/17 prior year comparator to ensure consistency with the national methodology. Previously it was reported that 63 working days were lost to sickness, resulting in 2 average working days lost.

Staff Policies

The CCG remains committed to employing, supporting and promoting disabled people in our workplace, which is reflected in our 'Disability Confident' employer status. This means we actively look to attract and recruit disabled people by providing a fully inclusive and accessible recruitment process, outlined in the CCG's Recruitment and Selection Policy.

Our recruitment process is fair, transparent and free from bias and our vacancies are accessible and available to the widest population possible.

Once appointed, and throughout an employee's employment, where necessary the CCG's Occupational Health service will be consulted to advise on any reasonable adjustments which need to be made. This may include changes to working patterns, adaptations to premises or equipment and provision of support packages to ensure disabled workers are not disadvantaged when applying for and doing their jobs. We are also happy to work in Partnership with outside support agencies, such as Access to Work, where necessary.

We have also signed up to the Mindful Employer charter to demonstrate our commitment to

increasing the awareness of mental health, providing strong support networks and information, and making it healthier for our employees to talk about mental ill health without fear of rejection or prejudice. In addition, Mental Health Awareness workshops (both for individuals and managers) have been introduced.

All our HR policies have been developed to ensure due regard to the Equality Act 2010 duties and includes an Equality Commitment Statement which is designed to ensure that through the implementation of these policies no person is treated less favourably due to any of the protected characteristics. Additionally, our Equality Strategy 216-19 outlines our strategic direction in Equality, Inclusion and Human Rights (EHIR), including how this relates to workforce.

All staff have received training on equality and diversity and the duties in the equalities legislation.

Derbyshire and Nottinghamshire CCG's are part of a regional Joint Partnership Working Forum which represents the interests of all CCG employees from across the two counties. The Forum meets every quarter and is used as a vehicle to discuss and consult on matters with the recognised trade union organisations and staff within each separate CCG. The established Partnership Agreement describes the way in which the CCGs and recognised trade unions work together.

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires public sector organisations to report on trade union time in their organisation. Organisations with more than 49 employees are required to publish the relevant information on their website by 31 July 2018, however due to the number of employees; this requirement is not applicable to Erewash CCG.

Our Health and Safety at work responsibilities are given equal priority along with our other statutory duties and objectives. To assist us in fulfilling our statutory obligations, expertise and advice is provided to the four Derbyshire CCGs by a private professional company called Penninsula, which is a specialist Human Resources, employment law and Health and Safety team. They provide us with a Health and Safety Policy supported by a Health and Safety Management System suite of procedures designed to ensure that we are compliant with relevant legislation.

Expenditure on Consultancy

The expenditure on consultancy for 2017/18 for the CCG was zero.

Off-payroll Engagements

In line with HM Treasury guidance the CCG is required to disclose information about 'Off payroll Engagements'

The information relating to the CCG is provided in the following table:

Table 1: Off-payroll engagements longer than 6 months

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

	Number
No. of existing engagements as of 31 March 2018	0
Of which…	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one & two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 2: New Off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months:

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

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board 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.	17

Exit packages, including special (non-contractual) payments or any other departures

Rakesh Marwaha, Chief Officer, left the CCG, 30 September 2017 and received a redundancy payment of £160,000 and payment in lieu of notice of £41,494, for loss of office. These payments were subject to approval by the Remuneration Committee. Charlotte Allen-Neale, Chief Finance Officer, left the CCG, 7 March 2018 and received a redundancy payment of £118,919, for loss of office. These payments were calculated using the NHS redundancy terms and conditions and are included in the senior manager's salaries and allowances table. These exit packages are also identified in table 4.4 of the accounts and the numbers disclosed are subject to audit.

Parliamentary Accountability and Audit Report

NHS Erewash CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payment, gifts and fees and charges are included where applicable as notes in the Financial Statement of this report. An audit certification is also included in this report after the financial statements.

NHS EREWASH CCG
FINANCIAL STATEMENTS 2017/2018

Dr Chris Clayton

Accountable Officer

NHS Erewash CCG

23 May 2018

CONTENTS

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	(1,855)	(2,886)
Other operating income	2	(579)	(272)
Total operating income		**(2,434)**	**(3,158)**
Staff costs	4	2,467	2,027
Purchase of goods and services	5	145,382	143,361
Depreciation and impairment charges	5	0	0
Provision expense	5	41	(96)
Other Operating Expenditure	5	118	135
Total operating expenditure		**148,008**	**145,427**
Net Operating Expenditure		**145,574**	**142,269**
Finance income			
Finance expense	10	(3)	(2)
Net expenditure for the year		**145,571**	**142,267**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**145,571**	**142,267**
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		**145,571**	**142,267**

The notes on pages 92 to 114 form part of this statement.

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	1,282	938
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	43	81
Total current assets		**1,325**	1,019
Non-current assets held for sale	21	0	0
Total current Assets		**1,325**	1,019
Total assets		**1,325**	1,019
Current liabilities			
Trade and other payables	23	(10,484)	(10,572)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(115)	(72)
Total current liabilities		**(10,599)**	(10,644)
Total Assets less Current Liabilities		**(9,274)**	(9,625)
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	(157)	(162)
Total non-current liabilities		**(157)**	(162)
Assets less Liabilities		**(9,431)**	(9,787)
Financed by Taxpayers' Equity			
General fund		(9,431)	(9,787)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(9,431)**	(9,787)

The notes on pages 92 to 114 form part of this statement.

The financial statements on pages 88 to 114 were approved by the Audit Committee on 23 May 2018 and signed on its behalf by

Dr Chris Clayton
Chief Executive Officer

Louise Bainbridge
Chief Finance 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	(9,787)	0	0	**(9,787)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 01 April 2017	**(9,787)**	**0**	**0**	**(9,787)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(145,571)			(145,571)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(145,571)**	**0**	**0**	**(145,571)**
Net funding	145,927	0	0	145,927
Balance at 31 March 2018	**(9,431)**	**0**	**0**	**(9,431)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	(11,558)	0	0	**(11,558)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 01 April 2016	**(11,558)**	**0**	**0**	**(11,558)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(142,267)			(142,267)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(142,267)**	**0**	**0**	**(142,267)**
Net funding	144,038	0	0	144,038
Balance at 31 March 2017	**(9,787)**	**0**	**0**	**(9,787)**

The notes on pages 92 to 114 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		(145,571)	(142,267)
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		(2)	12
Unwinding of Discounts		(3)	(2)
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(344)	(403)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(88)	(1,239)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	43	(108)
Net Cash Inflow (Outflow) from Operating Activities		**(145,965)**	(144,007)
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		**(145,965)**	(144,007)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		145,927	144,038
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		**145,927**	144,038
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(38)**	31
Cash & Cash Equivalents at the Beginning of the Financial Year		**81**	50
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		**43**	81

The notes on pages 92 to 114 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.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis.

The issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014 does not prevent the adoption of the going-concern principle, as the provision of service and its funding continues.

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

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

1.2 **Accounting Convention**

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

1.3 **Acquisitions & Discontinued Operations**

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

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

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

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 **Charitable Funds**

Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.6 **Pooled Budgets**

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the Clinical Commissioning Group is in a "jointly controlled operation", the Clinical Commissioning Group recognises:

· The assets the Clinical Commissioning Group controls;
· The liabilities the Clinical Commissioning Group incurs;
· The expenses the Clinical Commissioning Group incurs; and,
· The Clinical Commissioning Group's share of the income from the pooled budget activities.

If the Clinical Commissioning Group is involved in a "jointly controlled assets" arrangement, in addition to the above, the Clinical Commissioning Group recognises:

· The Clinical Commissioning Group's share of the jointly controlled assets (classified according to the nature of the assets);
· The Clinical Commissioning Group's share of any liabilities incurred jointly; and,
· The Clinical Commissioning Group's share of the expenses jointly incurred.

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

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

1.7.1 **Critical Judgements in Applying Accounting Policies**

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

· The Clinical Commissioning Group has assessed the pooled element of the Better Care Fund as being a lead commissioning arrangement under IFRS 11 – Joint Arrangements. The Clinical Commissioning Group will report balances with the lead commissioner (local authority) only and not the providers with which the local authority contracts.

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:
· None

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

1.9 **Employee Benefits**

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

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

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**
Property, plant and equipment is capitalised if:
· It is held for use in delivering services or for administrative purposes;
· It is probable that future economic benefits will flow to, or service potential will be supplied to the Clinical Commissioning Group;
· It is expected to be used for more than one financial year;
· The cost of the item can be measured reliably; and,
· The item has a cost of at least £5,000; or,
· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
· Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.
Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Valuation**
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.
Land and buildings used for the Clinical Commissioning Group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
· Land and non-specialised buildings – market value for existing use; and,
· Specialised buildings – depreciated replacement cost.
HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

Notes to the financial statements

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

1.12 **Intangible Assets**
The Clinical Commissioning Group owns no intangible assets.

1.13 **Depreciation, Amortisation & Impairments**
Freehold land, properties under construction and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.
At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

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

1.14 **Donated Assets**
The Clinical Commissioning Group has no donated assets.

1.15 **Government Grants**
The Clinical Commissioning Group has received no government grants.

1.16 **Non-current Assets Held For Sale**
The Clinical Commissioning Group has no assets held for sale.

1.17 **Leases**
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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

1.17.2 **The Clinical Commissioning Group as Lessor**
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Clinical Commissioning Group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Clinical Commissioning Group's net investment outstanding in respect of the leases.
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 **Private Finance Initiative Transactions**
The Clinical Commissioning Group has no Finance leases, PFI or LIFT Schemes.

1.19 **Inventories**
The Clinical Commissioning Group holds no inventories.

1.20 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Clinical Commissioning Group's cash management.

1.21 **Provisions**
Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
· Timing of cash flows (0 to 5 years inclusive): **Minus 2.42%** (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%)

Notes to the financial statements

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.22 **Clinical Negligence Costs**
NHS Resolution (formerly known as the NHS Litigation Authority) operates a risk pooling scheme under which the Clinical Commissioning Group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Clinical Commissioning Group.

1.23 **Non-clinical Risk Pooling**
The Clinical Commissioning Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Clinical Commissioning Group pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.24 **Continuing Healthcare Risk Pooling**
In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme Clinical Commissioning Groups previously contributed annually to a pooled fund, which is used to settle the claims. The contributions ceased in 2016-17 but the settlements are still ongoing.

1.25 **Carbon Reduction Commitment Scheme**
The Clinical Commissioning Group does not participate in the Carbon Reduction Commitment Scheme.

1.26 **Contingencies**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

1.27 **Financial Assets**
Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:
· Financial assets at fair value through profit and loss;
· Held to maturity investments;
· Available for sale financial assets; and,
· Loans and receivables.
The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.27.1 **Financial Assets at Fair Value Through Profit and Loss**
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.
The Clinical Commissioning Group does not have any financial assets at fair value through profit and loss.

1.27.2 **Held to Maturity Assets**
Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.27.3 **Available For Sale Financial Assets**
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.
The Clinical Commissioning Group does not have any financial assets available for sale.

1.27.4 **Loans & Receivables**
Loans and receivables are non-derivative financial assets with fixed or determinable payments, which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
The Clinical Commissioning Group considers that the fair values of financial assets and liabilities are materially the same as the carrying value and therefore no valuations have been undertaken.
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.

Notes to the financial statements

1.27.5 **Impairment**
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.
The Clinical Commissioning Group considers that the fair values of financial assets and liabilities are materially the same as the carrying value and therefore no valuations have been undertaken.

1.28 **Financial Liabilities**
Financial liabilities are recognised on the statement of financial position when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.
The Clinical Commissioning Group considers that the fair values of financial liabilities are materially the same as the carrying value and therefore no valuations have been undertaken.

1.28.1 **Financial Guarantee Contract Liabilities**
Financial guarantee contract liabilities are subsequently measured at the higher of:
· The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
· The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.28.2 **Financial Liabilities at Fair Value Through Profit and Loss**
Embedded derivatives that have different risks and characteristics to their host contracts and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Clinical Commissioning Group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.
The Clinical Commissioning Group does not have any financial liabilities at fair value through profit and loss.

1.28.3 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.29 **Value Added Tax**
Most of the activities of the Clinical Commissioning Group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.30 **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.

1.31 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Clinical Commissioning Group has no beneficial interest in them.

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

1.33 **Subsidiaries**
Material entities over which the Clinical Commissioning Group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Clinical Commissioning Group or where the subsidiary's accounting date is not co-terminus.
Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 **Associates**
Material entities over which the Clinical Commissioning Group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Clinical Commissioning Group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Clinical Commissioning Group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Clinical Commissioning Group from the entity.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 **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'.

Notes to the financial statements

1.36 **Joint Operations**

Joint operations are activities undertaken by the Clinical Commissioning Group in conjunction with one or more other parties but which are not performed through a separate entity. The Clinical Commissioning Group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.37 **Research & Development**

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

1.38 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

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

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

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

2 Other Operating Revenue

	2017-18			2016-17
	Total	**Admin**	**Programme**	Total
	£'000	**£'000**	**£'000**	£'000
Recoveries in respect of employee benefits	548	250	298	103
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	63	0	63	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	27	0	27	106
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	1,792	17	1,775	2,886
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	4	4	0	63
Total other operating revenue	**2,434**	**271**	**2,163**	**3,158**

3 Revenue

	2017-18			2016-17
	Total	**Admin**	**Programme**	Total
	£'000	**£'000**	**£'000**	£'000
From rendering of services	2,434	271	2,163	3,158
From sale of goods	0	0	0	0
Total	**2,434**	**271**	**2,163**	**3,158**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total £'000	**2017-18 Permanent Employees £'000**	**Other £'000**
Employee Benefits			
Salaries and wages	**1,775**	1,511	264
Social security costs	**175**	175	0
Employer Contributions to NHS Pension scheme	**197**	197	0
Other pension costs	**0**	0	0
Apprenticeship Levy	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**320**	320	0
Gross employee benefits expenditure	**2,467**	**2,203**	**264**
Less recoveries in respect of employee benefits (note 4.1.2)	**(548)**	(548)	0
Total - Net admin employee benefits including capitalised costs	**1,919**	**1,655**	**264**
Less: Employee costs capitalised	**0**	0	0
Net employee benefits excluding capitalised costs	**1,919**	**1,655**	**264**

4.1.1 Employee benefits

	Total £'000	2016-17 Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	1,678	1,412	266
Social security costs	156	156	0
Employer Contributions to NHS Pension scheme	193	193	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	2,027	1,761	266
Less recoveries in respect of employee benefits (note 4.1.2)	(103)	(103)	0
Total - Net admin employee benefits including capitalised costs	1,924	1,658	266
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	1,924	1,658	266

4.1.2 Recoveries in respect of employee benefits

	Total £'000	**2017-18 Permanent Employees £'000**	**Other £'000**	2016-17 Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(244)**	(244)	0	(81)
Social security costs	**(29)**	(29)	0	(10)
Employer contributions to the NHS Pension Scheme	**(35)**	(35)	0	(12)
Other pension costs	**0**	0	0	0
Other post-employment benefits	**0**	0	0	0
Other employment benefits	**0**	0	0	0
Termination benefits	**(240)**	(240)	0	0
Total recoveries in respect of employee benefits	**(548)**	**(548)**	**0**	**(103)**

4.2 Average number of people employed

	Total Number	**2017-18 Permanently employed Number**	**Other Number**	2016-17 Total Number
Total	**38**	**34**	**4**	36
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

No persons retired on ill health grounds (2016/17, nil) and there were £nil additional pension liabilities accrued in the year (2016/17 £nil).
Ill health retirement costs are met by the NHS Pension Scheme.

For staff sickness absence information, see the sickness absence section of the Remuneration and Staff Report.

4.4 Exit packages agreed in the financial year

	2017-18					
	Compulsory redundancies		**Other agreed departures**		**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	1	41,494	1	41,494
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	1	118,919	0	0	1	118,919
£150,001 to £200,000	1	160,000	0	0	1	160,000
Over £200,001	0	0	0	0	0	0
Total	**2**	**278,919**	**1**	**41,494**	**3**	**320,413**

	2016-17					
	Compulsory redundancies		**Other agreed departures**		**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		2016-17	
	Departures where special payments have been made		**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		2016-17	
	Other agreed departures		**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	1	41494	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	**1**	**41494**	**0**	**0**

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

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

Redundancy and other departure costs relate to two persons and have been paid in accordance with the provisions of the NHS Redundancy scheme (the remuneration report includes the disclosure of exit payments paid to these individuals). Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Additional pension costs resulting from early retirement, are met by the employer, not the NHS Pension Scheme. NHS Erewash CCG does not have any early retirements.

Ill-health retirement costs are met by the NHS Pension Scheme. NHS Erewash CCG does not have any ill-health retirements.

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 £193,296 were payable to the NHS Pensions Scheme (2016-17: £194,638) at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1. (Note 4.1.1 reports a higher employer's contribution of £196,713 (rounded to £197 in £000's). This is because it includes pension contributions for staff shared by the CCG but which are employed by other NHS bodies. These pension costs are paid directly to NHS Pensions and recovered by the employer through a recharge to the CCG).

5. Operating expenses

	Total £'000	2017-18 Admin £'000	Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	1,726	455	1,271	1,476
Executive governing body members	741	613	128	551
Total gross employee benefits	**2,467**	**1,068**	**1,399**	**2,027**
Other costs				
Services from other CCGs and NHS England	1,193	548	645	1,139
Services from foundation trusts	61,807	0	61,807	61,231
Services from other NHS trusts	27,781	0	27,781	27,920
Sustainability Transformation Fund	0	0	0	0
Services from other WGA bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	23,138	0	23,138	23,052
Purchase of social care	15	0	15	3
Chair and Non Executive Members	115	91	24	126
Supplies and services – clinical	0	0	0	0
Supplies and services – general	2,011	237	1,774	1,655
Consultancy services	0	0	0	7
Establishment	169	33	136	135
Transport	6	3	3	12
Premises	948	47	901	666
Impairments and reversals of receivables	0	0	0	0
Inventories written down and consumed	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	45	45	0	57
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	13,604	0	13,604	13,743
Pharmaceutical services	63	0	63	67
General ophthalmic services	26	0	26	31
GPMS/APMS and PCTMS	14,379	0	14,379	13,401
Other professional fees	44	44	0	30
Legal fees	59	11	48	32
Grants to Other bodies	0	0	0	0
Clinical negligence	1	1	0	1
Research and development (excluding staff costs)	2	0	2	8
Education and training	94	20	74	75
Change in discount rate	(2)	(2)	0	12
Provisions	43	9	34	(108)
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions	0	0	0	105
Non cash apprenticeship training grants	0	0	0	0
Other expenditure	0	0	0	0
Total other costs	**145,541**	**1,087**	**144,454**	**143,400**
Total operating expenses	**148,008**	**2,155**	**145,853**	**145,427**

Admin expenditure refers to costs incurred that do not relate to direct payments for the provision of healthcare or healthcare services.

NHS Erewash Clinical Commissioning Group commissioned internal audit services from 360 Assurance (hosted by Leicestershire Partnership NHS Trust). Internal audit expenditure for 2016/17 was included in "Services from other NHS trusts". Mapping of the 2017/18 internal audit services expenditure has been adjusted by NHS England, so that it is included in "Other professional fees".

The audit fees in the operating expenses note include VAT. During 2017/18 the fees were £35,000 (exc. VAT) and there was also an additional fee charge of £2,404 (exc. VAT), relating to additional audit of 2016/17 primary care co-commissioning expenditure. In 2016/17 the fees were £45,000 (exc. VAT) and there was an additional fee charge of £2,300, relating to additional audit of 2015/16 primary care co-commissioning expenditure.

6.1 Better Payment Practice Code

Measure of compliance	2017-18		2016-17	
	Number	**£'000**	Number	£'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	1,884	18,447	1,670	19,786
Total Non-NHS Trade Invoices paid within target	1,866	18,373	1,619	19,625
Percentage of Non-NHS Trade invoices paid within target	**99.04%**	**99.60%**	96.95%	99.19%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,055	99,435	1,977	96,790
Total NHS Trade Invoices Paid within target	2,048	99,424	1,974	96,746
Percentage of NHS Trade Invoices paid within target	**99.66%**	**99.99%**	99.85%	99.95%

The Better Payment Practice Code requires the Clinical Commissioning Group 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 target is 95.0% across all indicators which has been achieved.

The Clinical Commissioning Group is signed up to the Prompt Payment Code, administered by the Chartered Institute of Credit Management.

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
NHS Erewash Clinical Commissioning Group does not undertake any income generation activities (2016/17 £nil).

8. Investment revenue
NHS Erewash Clinical Commissioning Group received £nil investment revenue in the year (2016/17 £nil).

9. Other gains and losses
NHS Erewash Clinical Commissioning Group had £nil gains or losses in the year (2016/17 £nil).

10. Finance costs

	2017-18 £'000	2016-17 £'000
Interest		
Interest on loans and overdrafts	0	0
Interest on obligations under finance leases	0	0
Interest on obligations under PFI contracts:		
· Main finance cost	0	0
· Contingent finance cost	0	0
Interest on obligations under LIFT contracts:		
· Main finance cost	0	0
· Contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest	**0**	**0**
Other finance costs	0	0
Provisions: unwinding of discount	(3)	(2)
Total finance costs	**(3)**	**(2)**

11. Net gain/(loss) on transfer by absorption
There were no transfers of assets or liabilities by absorption to NHS Erewash Clinical Commissioning Group and hence there was £nil resultant gain or loss (2016/17 £nil).

12. Operating leases

12.1 As lessee
NHS Erewash Clinical Commissioning Group has a 10 year operating lease with Erewash Borough Council for the Toll Bar House building used as its headquarters. The building is permitted for use as offices. The lease expires 29 April 2024 and there was a breakpoint in the contract 29 April 2017. Thereafter 6 months written notice to the Landlord is required to terminate the agreement. The only precondition affecting the right to determine is that the annual rent must be paid up to the date of determination. NHS Erewash Clinical Commissioning Group also has a license to occupy the car park, with a nominal peppercorn rent.

NHS Erewash Clinical Commissioning Group receives charges from NHS Property Services Limited and Community Health Partnerships Limited for the void space and subsidies in the property portfolio covering NHS Erewash Clinical Commissioning Group locality such as Ilkeston Health Centre, Long Eaton Health Centre and GP practice buildings. Even though no formal lease contract is in place between NHS Erewash Clinical Commissioning Group, NHS Property Services Limited and Community Health Partnerships Limited, the transactions involved do convey the right of NHS Erewash Clinical Commissioning Group and the General Practitioners to use the properties.

NHS Erewash Clinical Commissioning Group did have a single lease car contract for use by one of its employees. The lease lasts for a period of three years and the cost of the car is shared between the employer and employee. Terms and conditions of the lease car is agreed prior to commencement of the lease and fixed for the whole three year term. The employer's contribution is fixed according to pre-determined criteria linked to the role of the employee. However this employee left NHS Erewash Clinical Commissioning Group during the year. Therefore at the 31 March 2018, NHS Erewash Clinical Commissioning Group had no such lease cars. There is also a salary sacrifice lease car scheme, lasting three years but this is charged fully to the employee through payroll deductions and hence these are not included in this financial statement (currently two members of staff are signed up to the scheme).

NHS Erewash Clinical Commissioning Group also has an operating lease for the use of three multi-functional photocopiers located at its headquarters at Toll Bar House, Ilkeston. This contract was procured under the Crown Commercial Service contract agreement for Multifunctional Devices and Services Managed Print Services in March 2015. The contract has a term of 5 years and expires 16 March 2020.

12.1.1 Payments recognised as an Expense

	2017-18				2016-17			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	0	881	8	**889**	0	512	8	520
Contingent rents	0	0	0	**0**	0	0	0	0
Sub-lease payments	0	0	0	**0**	0	0	0	0
Total	**0**	**881**	**8**	**889**	0	512	8	520

Whilst the Clinical Commissioning Group's arrangements with Community Health Partnerships 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 these arrangements only.

12.1.2 Future minimum lease payments

	2017-18				2016-17			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	0	44	4	**48**	0	44	4	48
Between one and five years	0	0	4	**4**	0	0	8	8
After five years	0	0	0	**0**	0	0	0	0
Total	**0**	**44**	**8**	**52**	0	44	12	56

The Clinical Commissioning Group has a break clause in the operating lease contract with Erewash Borough Council, which enables the Clinical Commissioning Group to terminate the lease following 29 April 2017 at any time, requiring a 6 month written notice. Therefore the minimum lease payment for 2017/18 has been calculated as 6 months from the date following the accounting period reported (31 March 2018).

12.2 As lessor
NHS Erewash Clinical Commissioning Group was not a lessor in the year (2016/17 nil).

13. Property, plant and equipment
NHS Erewash Clinical Commissioning Group had £nil property, plant and equipment in the year (2016/17 £nil).

14. Intangible non-current assets
NHS Erewash Clinical Commissioning Group did not have any non-current assets (2016/17 nil).

15. Investment property
NHS Erewash Clinical Commissioning Group had £nil investment property in the year (2016/17 £nil).

16. Inventories
NHS Erewash Clinical Commissioning Group had £nil inventories in the year (2016/17 £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	383	0	89	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	409	0	442	0
NHS accrued income	23	0	189	0
Non-NHS and Other WGA receivables: Revenue	252	0	38	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	195	0	152	0
Non-NHS and Other WGA accrued income	1	0	13	0
Provision for the impairment of receivables	0	0	0	0
VAT	19	0	15	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	**1,282**	**0**	**938**	**0**
Total current and non current	**1,282**		**938**	

There were no prepaid pension contributions in 2017/18 (2016/17 £nil).

The majority of trade is with NHS bodies. As the NHS bodies are mainly funded through Government funding no credit scoring of them is considered necessary.

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	89	231	20
By three to six months	66	1	0
By more than six months	37	0	1
Total	**192**	**232**	**21**

Subsequent to the statement of financial position date, the following overdue receivables have been recovered by 17 May 2018: £229,401.89 (overdue by less than three months); and £10,420.83 (overdue by more than 6 months).

NHS Erewash Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2018 (31 March 2017 £nil).

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	0	0	0
Amounts written off during the year	0	0	0
Amounts recovered during the year	0	0	0
(Increase) decrease in receivables impaired	0	0	0
Transfer (to) from other public sector body	0	0	0
Balance at 31 March 2018	**0**	**0**	**0**

18. Other financial assets

NHS Erewash Clinical Commissioning Group had £nil other financial assets in the year (2016/17 nil).

19. Other current assets

NHS Erewash Clinical Commissioning Group had £nil other current assets in the year (2016/17 £nil).

20 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	81	50
Net change in year	(38)	31
Balance at 31 March 2018	**43**	**81**
Made up of:		
Cash with the Government Banking Service	43	81
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	**43**	**81**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**43**	**81**

NHS Erewash Clinical Commissioning Group held no patients monies (2016/17 £nil).

21. Non-current assets held for sale

NHS Erewash Clinical Commissioning Group held £nil non-current assets for sale in the year (2016/17 £nil).

22. Analysis of impairments and reversals

NHS Erewash Clinical Commissioning Group had £nil impairments or reversals in the year (2016/17 £nil).

23 Trade and other payables	**Current 2017-18 £'000**	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	836	0	12	0
NHS payables: capital	0	0	0	0
NHS accruals	3,798	0	4,501	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	0	0	284	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	3,975	0	3,984	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	22	0	23	0
VAT	0	0	0	0
Tax	53	0	19	0
Payments received on account	0	0	0	0
Other payables and accruals	1,800	0	1,749	0
Total Trade & Other Payables	**10,484**	**0**	**10,572**	**0**
Total current and non-current	**10,484**		**10,572**	

NHS Erewash Clinical Commissioning Group does not have any liabilities included above for arrangements to buy out the liability for early retirement over 5 years (2016/17 £nil).

Other payables include £117,951 outstanding pension contributions at 31 March 2018 (£126,544 at 31 March 2017). Other payables include GP pensions.

24. Other financial liabilities
NHS Erewash Clinical Commissioning Group had £nil other financial liabilities in the year (2016/17 £nil).

25. Other liabilities
NHS Erewash Clinical Commissioning Group had £nil other liabilities in the year (2016/17 £nil).

26. Borrowings
NHS Erewash Clinical Commissioning Group had £nil borrowings (2016/17 £nil).

27. Private finance initiative, LIFT and other service concession arrangements
NHS Erewash Clinical Commissioning Group had £nil LIFT or PFI schemes (2016/17 £nil).

28. Finance lease obligations
NHS Erewash Clinical Commissioning Group had £nil finance lease obligations as a lessee (2016/17 £nil).

29. Finance lease receivables
NHS Erewash Clinical Commissioning Group had £nil finance lease obligations as a lessor (2016/17 £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	42	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	1	0	0	0
Continuing care	0	0	0	0
Other	72	157	72	162
Total	**115**	**157**	**72**	**162**
Total current and non-current	**272**		**234**	

	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**	**0**	**234**	**234**
Arising during the year	0	0	42	0	0	0	1	0	0	43
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	(3)	(3)
Change in discount rate	0	0	0	0	0	0	0	0	(2)	(2)
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**	**42**	**0**	**0**	**0**	**1**	**0**	**229**	**272**
Expected timing of cash flows:										
Within one year	0	0	42	0	0	0	1	0	72	115
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	157	157
Balance at 31 March 2018	**0**	**0**	**42**	**0**	**0**	**0**	**1**	**0**	**229**	**272**

Under the terms of the lease for Toll Bar House building, NHS Erewash Clinical Commissioning Group is required at the end of the lease (29 April 2024 or sooner if the agreement is terminated earlier), to ensure that the building is left in a similar state as when the lease terms were first entered. The Clinical Commissioning Group has a provision known as 'dilapidation costs' of £136.5k (and that has been discounted until 29 April 2024, using the applicable HM Treasury discount rates), to cover the contractual obligation that was entered into at the inception of the lease, as required by the Landlord.

An additional provision was created in 2015/16, for settlement of HMRC liabilities and settlement was expected during 2016/17. The on-going HMRC review has still not been concluded and therefore the Clinical Commissioning Group has maintained the £72k provision for correction in taxation treatment of off-payroll engagements. Settlement of this liability is now expected sometime during 2018/19.

As a result of the re-organisation of the four Derbyshire Clinical Commissioning Groups' executive management structure to a shared one, a provision of £42k has been established for associated costs expected to materialise in the early part of 2018/19. This represents the apportioned costs for NHS Erewash Clinical Commissioning Group. The other Derbyshire Clinical Commissioning Groups have likewise set up a provision for their share of the costs.

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them. NHS Resolution disclosed that one claim is currently lodged for NHS Erewash Clinical Commissioning Group and the likely financial impact of £1k, to the Clinical Commissioning Group is identified in the table above.

Under the Accounts direction issued by NHS England on 24 February 2015, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However the legal liability remains with the Clinical Commissioning Group. The total value of legacy provisions accounted for by NHS England on behalf of the Clinical Commissioning Group at 31 March 2018 is £137k (£132k at 31 March 2017). All of this relates to NHS Continuing Healthcare legacy provisions. The risk pooling arrangement from which NHS England settles these claims, is described in note 1.24.

Pension payments are made quarterly and amounts are known. Pension provisions are based on life expectancy. No pension provisions have been advised by NHS Pensions Agency.

31. Contingencies
NHS Erewash Clinical Commissioning Group has one contingent liability of £87k, relating to the re-organisation of the executive management structure; and £nil contingent assets (£nil contingent liabilities or contingent assets in 2016/17).

32. Commitments
NHS Erewash Clinical Commissioning Group had £nil capital commitments or other financial commitments (2016/17 £nil).

33 Financial instruments

33.1 Financial risk management

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

As the 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 Clinical Commissioning Group and internal auditors.

33.1.1 Currency risk

The 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 Clinical Commissioning Group has no overseas operations 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 has no borrowings and therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

As the majority of the Clinical Commissioning Group revenue is Parliamentary funding, the 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.

33.1.4 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	2017-18			
	At 'fair value through profit and loss'	**Loans and Receivables**	**Available for Sale**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	406	0	406
· Non-NHS	0	253	0	253
Cash at bank and in hand	0	43	0	43
Other financial assets	0	1	0	1
Total at 31 March 2018	**0**	**703**	**0**	**703**

	2016-17			
	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	£'000	£'000	£'000	£'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	278	0	278
· Non-NHS	0	51	0	51
Cash at bank and in hand	0	81	0	81
Other financial assets	0	0	0	0
Total at 31 March 2017	**0**	**410**	**0**	**410**

33.3 Financial liabilities

	2017-18		
	At 'fair value through profit and loss'	**Other**	**Total**
	£'000	**£'000**	**£'000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	4,634	4,634
· Non-NHS	0	5,775	5,775
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**	**10,409**	**10,409**

	2016-17		
	At 'fair value through profit and loss'	Other	Total
	£'000	£'000	£'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	4,513	4,513
· Non-NHS	0	6,017	6,017
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**10,530**	**10,530**

33.4 Maturity of financial liabilities
NHS Erewash Clinical Commissioning Group's financial liabilities identified in note 33.3 are due in one year or less.

33.5 The entity's exposure to risk
NHS Erewash Clinical Commissioning Group is not exposed to any significant credit, liquidity, market or foreign currency risk.

34. Operating segments
NHS Erewash Clinical Commissioning Group considers it has only one operating segment: commissioning of healthcare services.

35. Pooled budgets

The Derbyshire Better Care Fund (BCF) started in 2015. NHS Erewash Clinical Commissioning Group is a partner to the fund, along with NHS Hardwick, NHS North Derbyshire, NHS Southern Derbyshire and NHS Tameside & Glossop, Clinical Commissioning Groups, along with Derbyshire County Council. The operation of the pool is ultimately managed by the Derbyshire Health and Wellbeing Board represented by members from each of the partners. The Fund operates as a Section 75 pooled budget and total agreed contributions to the pool are £88,776,000 including iBCF funding (£70,558,000 excluding iBCF).

The BCF aims to improve the provision of health and social care. All partners contribute to a pooled fund and the overarching objective of the fund is to support the integration of health and social care and align commissioning as agreed between the partners.

In April 2017 the Improved Better Care Fund (iBCF) commenced. This is a direct grant to local government, with a condition that it is pooled into the local BCF plan. Derbyshire County Council received an additional £18,218,000 of funding direct from the Government in 2017-18 with the aim of:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

The Clinical Commissioning Group's contribution towards the pool is £7,199,000 (8.11%). In 2016-17 it was £7,129,000 (10.97%).

NHS Erewash Clinical Commissioning Group is also a partner of the "Children and Young People with Complex Needs" pooled budget, along with NHS Hardwick, NHS North Derbyshire, NHS Southern Derbyshire, Clinical Commissioning Groups and Derbyshire County Council. This pool is also hosted by Derbyshire County Council.

The "Better Care Fund" and "Children and Young People with Complex Needs" funds are pooled individually under the Section 75 arrangements of the NHS Act 2006. The total of both pools are as follows:

Total of all Pooled Budgets

	2017-18 £000	2016-17 £000
Income	7,460	7,361
Expenditure	(7,460)	(7,361)
Net position for pooled budgets	**0**	0

The memorandum account for the "Better Care Fund" pooled budget is:

	2017-18 £'000	**Pool Share %**	2016-17 £'000	Pool Share %
Income				
NHS Erewash CCG	7,199	8.11	7,129	10.97
NHS Hardwick CCG	12,447	14.02	8,179	12.58
NHS North Derbyshire CCG	21,289	23.98	21,324	32.82
NHS Southern Derbyshire CCG	19,170	21.59	18,809	28.94
NHS Tameside and Glossop CCG	2,252	2.54	2,212	3.40
Derbyshire County Council	26,419	29.76	7,338	11.29
Total Income	**88,776**	**100.00**	64,991	100.00

Expenditure	**£'000**	£'000
CCG schemes aimed at reducing non elective activity	31,870	24,739
CCG schemes - wheelchairs	0	2,899
Derbyshire County Council schemes	5,966	5,481
ICES (Integrated Community Equipment Service)	6,123	6,716
Reablement	8,046	7,706
7 Day working	1,346	1,477
Administration, Performance and Information Sharing	490	491
Care Bill	2,058	2,058
Delayed Transfer of Care	5,481	4,859
Carers	1,962	1,962
Integrated Care	1,500	1,590
Workforce Development	2,570	2,570
Dementia Support	981	1,001
Autism and Mental Health	2,165	1,442
iBCF	18,218	0
Total Expenditure	**88,776**	64,991
Net position for Pool	**0**	0

35. Pooled budgets Continued

The memorandum account for the "Children and Young People with Complex Needs" pooled budget is:

	2017-18	**Pool Share**	2016-17	Pool Share
	£'000	**%**	£'000	%
Income				
NHS Erewash CCG	261	4.57	232	4.57
NHS Hardwick CCG	305	5.35	272	5.35
NHS North Derbyshire CCG	755	13.22	672	13.23
NHS Southern Derbyshire CCG	563	9.86	501	9.86
Derbyshire County Council	3,824	67.00	3,404	66.99
Total Income	**5,708**	**100.00**	5,081	100.00
Expenditure	**£'000**		£'000	
Purchase of Equipment	5,708		5,081	
Total Expenditure	**5,708**		5,081	
Net position for Pool	**0**		0	

36. NHS LIFT investments

NHS Erewash Clinical Commissioning Group had £nil NHS LIFT investments (2016/17 £nil).

37. Related party transactions

During the year none of the Governing Body Members or parties related to them have undertaken any material transactions with NHS Erewash Clinical Commissioning Group, other than those set out below (transactions identified were not with the member but between the Clinical Commissioning Group and the related party):

		2017-18			
Governing Body Member	**Related Party**	**Payments to Related Party £000**	**Receipts from Related Party £000**	**Amounts owed to Related Party £000**	**Amounts due from Related Party £000**
Falu Bharmal	Browne Jacobson Solicitors	2	0	0	0
Jayne Stringfellow	Chesterfield Royal Hospital NHS Foundation Trust	192	(13)	4	(1)
Andrew Booth	Derby Teaching Hospitals NHS Foundation Trust	30,779	(166)	871	(539)
Simon Stevens	Derbyshire County Council	7,570	(47)	54	(44)
Dr Avi Bhatia, Dr Markus Henn, Dr Arvind Mistry	Erewash Health (Erewash GP Provider Ltd)	479	(138)	0	0
Dr Arvind Mistry	Gladstone House Surgery	697	0	0	0
Professor Ian Shaw	Health Education East Midlands	0	(50)	0	0
Dr Markus Henn	Littlewick Medical Centre	2,525	0	0	0
Dr Avi Bhatia	Moir Medical Centre	1,594	0	0	0
Charlotte Allen-Neale, Heidi Scott-Smith	NHS Arden & GEM CSU	653	(12)	1	0
Louise Bainbridge, Dr Chris Clayton, Jane Stringfellow	NHS Hardwick CCG	204	(19)	167	(10)
Louise Bainbridge, Dr Chris Clayton, Jane Stringfellow	NHS North Derbyshire CCG	424	(66)	2,607	(6)
Louise Bainbridge, Dr Chris Clayton, Jane Stringfellow	NHS Southern Derbyshire CCG	620	(172)	93	(2)
Falu Bharmal, Dr Avi Bhatia, Andrew Spring	Nottingham University Hospitals NHS Trust	23,201	0	321	0

All transactions have been at arm's length as part of NHS Erewash Clinical Commissioning Group's healthcare commissioning.

During 2017/18 shared management and working arrangements were developed between NHS Erewash; NHS Hardwick; NHS North Derbyshire; and NHS Southern Derbyshire, Clinical Commissioning Groups. This included the appointment of shared executive directors. Although the four organisations are separate statutory organisations, they are working together collaboratively. The transactions with the other Clinical Commissioning Groups are therefore reported in the table above for each of the shared executive directors.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England including: NHS Arden & GEM Commissioning Support Unit
- NHS Foundation Trusts including: Derbyshire Community Healthcare Services NHS Foundation Trust; Derbyshire Healthcare NHS Foundation Trust; and Derby Teaching Hospitals NHS Foundation Trust
- NHS Trusts including: East Midlands Ambulance Service NHS Trust; and Nottingham University Hospitals NHS Trust
- NHS Resolution; and,
- NHS Business Services Authority

NHS Erewash Clinical Commissioning Group also has material transactions with all the GP Practices within its locality and membership.

In addition, NHS Erewash Clinical Commissioning Group has had a number of material transactions with other Government departments and other central and local government bodies. Most of these transactions have been with Derbyshire County Council in respect of joint enterprises.

During 2016/17 the following related party transactions were made with NHS Erewash Clinical Commissioning Group (transactions identified were not with the member but between the Clinical Commissioning Group and the related party):

		2016-17			
Governing Body Member	Related Party	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Falu Bharmal	Browne Jacobson Solicitors	12	0	0	0
Pam Watson	Central Nottinghamshire Clinical Services	1	0	0	0
Andrew Booth	Derby Teaching Hospitals NHS Foundation Trust	29,310	0	989	(19)
Simon Stevens	Derbyshire County Council	6,876	(739)	34	(20)
Dr A Bhatia; Dr M Henn; Dr A Mistry	Erewash GP Provider Ltd	138	0	0	0
Dr Arvind Mistry	Gladstone House Surgery	597	0	0	0
Dr Markus Henn	Littlewick Medical Centre	2,649	0	0	0
Dr Avi Bhatia	Moir Medical Centre	1,641	0	0	0
Charlotte Allen-Neale; Heidi Scott-Smith	NHS Arden & GEM CSU	1,167	(16)	22	(11)
Dr Avi Bhatia; Falu Bharmal	Nottingham University Hospitals NHS Trust	24,051	0	0	(185)
Dr Asrar Rashid	Sheffield Children's NHS Foundation Trust	10	0	0	0
Falu Bharmal	Touch Design Ltd	17	0	0	0

38. Events after the end of the reporting period
There are no post balance sheet events, which will have a material effect on the financial statements of NHS Erewash Clinical Commissioning Group.

39. Losses and special payments
NHS Erewash Clinical Commissioning Group had no losses or special payments in the year, £nil (2016/17 no cases, £nil).

40. Third party assets
NHS Erewash Clinical Commissioning Group had no losses or special payments in the year, £nil (2016/17 no cases, £nil).

41. Financial performance targets
NHS Erewash Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended). Performance against those duties was as follows:

	2017-18			2016-17		
	Target £'000	**Performance £'000**	**Duty Achieved?**	Target £'000	Performance £'000	Duty Achieved?
Expenditure not to exceed income	148,018	148,005	Yes *	148,106	145,425	Yes *
Capital resource use does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue resource use does not exceed the amount specified in Directions	145,584	145,571	Yes *	144,948	142,267	Yes *
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	12,693	12,844	Information only	12,458	12,295	Information only
Revenue administration resource use does not exceed the amount specified in Directions	2,119	1,881	Yes	2,121	1,858	Yes

* NHS Erewash Clinical Commissioning Group achieved an in-year, £13k surplus on performance versus target, resulting in a £2.694m cumulative surplus. The 2016-17 numbers reported are the cumulative position against which the Clinical Commissioning Group was performance managed by NHS England (£2.681m cumulative surplus). The 2016-17 in-year position was breakeven compared to £13k in-year surplus in 2017-18.

The expenditure performance of £148.005m (£145.425m in 2016/17) and revenue administration resource performance of £1.881m (£1.858m in 2016/17), are both net of the £3k finance cost credit (£2k finance cost credit in 2016/17). The finance cost credit is identified on the Statement of Comprehensive Net Expenditure for the year and relates solely to administration finance.

The "Revenue resource use on specified matter(s)" relates to primary care co-commissioning, delegated to NHS Erewash Clinical Commissioning Group. Primary care co-commissioning resource and expenditure are also included in the financial performance targets: "Expenditure not to exceed income"; and "Revenue resource use does not exceed the amount specified in directions".

42. Impact of IFRS
There were no impacts on NHS Erewash Clinical Commissioning Group as the result of IFRS treatment (2016/17 £nil).

43. Analysis of charitable reserves
NHS Erewash Clinical Commissioning Group had £nil charitable funds (2016/17 £nil).

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS EREWASH CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Erewash 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

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.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 52, 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 52, 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 Erewash 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 Erewash CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Bostock
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants

One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

24 May 2018

APPENDICES

Better Care Fund Dashboard - Derbyshire County Council

		Exception Report	Data Source	Period	Actual / Plan	Q1 Apr	Q1 May	Q1 Jun	Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Q4 Jan	Q4 Feb	Q4 Mar	Trend
Non-Elective Admissions - Monthly Performance	Non-Elective Admissions (General & Acute) - Number of Spells		Monthly Activity Return	2014/15	Actual	7704	8130	7852	8283	7635	7688	8410	7871	8030	7935	7065	7840	
				2015/16	Actual	7840	7647	7664	7527	7597	7239	7307	7606	7300	7880	7678	7461	
	Non-Elective Admissions (Specific Acute) - Number of FFCEs		Secondary Uses Service	2016/17	Actual	7334	7401	7152	7294	7083	7102	7261	7451	7423	7645	6917	7879	
					Plan	7240	7240	7240	7133	7133	7133	7388	7388	7388	7142	7142	7142	
				2017/18	Monthly	7214	7530	7359	7393	7591	7357	7703	7760	7870	8138			
					Quarterly	22103			22341			23333						
					Plan	22075			22235			21974			21648			

		Exception Report	Data Source	Period	BCF Plan	Q1	Q2	Q3	Q4	Trend
Admissions to residential and nursing care homes	Permanent admissions of older people (aged 65 & over) to residential and nursing care homes per 100,000 population		Adult Social Care Outcomes Framework Data Submitted Quarterly by Local Authorities	2014/15	688.4	707	677	703	745.4	
				2015/16	664.9	790.51	749.04	619.72	722.2	
				2016/17	743.6	756.4	722	668.5	688	
				2017/18	683.4	173.5	172.3	115.1		
Reablement/ rehabilitation services	Proportion of Older People (65 & Over) Who Were Still At Home 91 Days After Discharge From Hospital Into Reablement / Rehabilitation Services		Adult Social Care Outcomes Framework Data Submitted Quarterly by Local Authorities	2014/15	81.7%	81.6%	86.8%	79.0%	87.1%	
				2015/16	82.5%	84.1%	89.4%	82.4%	73.6%	
				2016/17	85.3%	88.4%	86.0%	84.8%	83.2%	
				2017/18	84.9%	83.4%	79.6%	76.6%		

		Exception Report	Data Source	Period	Actual / Plan	Q1 Apr	Q1 May	Q1 Jun	Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Q4 Jan	Q4 Feb	Q4 Mar	Trend
Delayed Transfer of Care - Quarterly Performance Against Plan	Delayed transfer of care from hospital per 100,000 (average number of days delayed per month)		Delayed Transfers Of Care data released monthly by NHS England - Part B - Days Delayed	2014/15	Actual	859.3			703.8			644.6			605.0			
					BCF Plan	991.8			975.8			1007.7			968.2			
				2015/16	Actual	645.4			598.9			659.2			839.8			
					BCF Plan	961.8			953.9			985.7			964.0			
				2016/17	Actual	825.4			845.3			982.9			890.6			
					BCF Plan	710.0			710.0			710.0			710.1			
				2017/18	NHS	101.1	166.4	155.4	163.9	156.5	120.5	148.0	115.9	241.9	183.6			
					Social	90.3	95.5	85.1	86.3	61.8	52.1	50.2	17.5	91.5	54.6			
					Both	0.0	5.7	3.8	6.6	2.0	4.2	1.4	1.6	30.4	5.2			
					Total	191.4	267.5	244.2	256.8	220.3	176.8	199.6	134.9	363.7	243.4			
					BCF Plan				268.8	265.7	254.3	262.8	252.9	261.4	261.4	236.1	261.4	

Appendix one

Appendix two

Erewash CCG Attendance at Meetings 2017/2018

	Governing Body	Audit Committee	Finance Committee	Governance Committee	Remuneration Committee	Primary Care Commissioning Committee	Quality Assurance Committee	Health & Safety Fire a & Security Committee
Dr Chris Clayton Chief Executive Officer-Derbyshire CCGs (From 02.11.2017)	4					0		
Charlotte Allen-Neale Chief Finance Officer (To 07.09.2017)	3	4	7	2	3	1		
Louise Bainbridge Chief Finance Officer–Derbyshire CCGs (From 02.11.2017)	3	1	1			0		
Jayne Stringfellow Interim Chief Nurse & Director of Quality-Derbyshire CCGs	5					0	0	
Falu Bharmal Interim Director Corporate Governance-Derbyshire CCGs	6	5	4	4		4		1
Dr Avi Bhatia GP Moir Medical Centre	7				0			
Andrew Booth Lay Member (Audit) & Conflicts of Interest Guardian	6	5	7	2	3	3		1
Dr Markus Henn GP Littlewick Medical Centre & Caldicott Guardian	4							
Nicola MacPhail Interim Deputy Chief Nurse (From 07.09.2017)	2						4	
Rakesh Marwaha Accountable Officer Erewash CCG (To 07.09.2017)	5		2		1	0		

	Governing Body	Audit Committee	Finance Committee	Governance Committee	Remuneration Committee	Primary Care Commissioning Committee	Quality Assurance Committee	Health & Safety Fire a & Security Committee
Samantha Milbank Chief Transformation Officer	2		2					
Dr Arvind Mistry GP- Gladstone House Surgery	11		8			3	4	
Heidi Scott-Smith Chief Nursing Officer Erewash CCG (To 06.07.2017)	4		1			0	0	
Prof. Ian Shaw Lay Member (Governance)	8	3	8	4	1	2		
Andy Spring Interim Turnaround Director (From 06.07.2017)	6		1					
Simon Stevens Local Authority Representative	1							
Pam Watson Lay Member (Patient and Public Involvement) & Freedom to Speak up Guardian	10	3	7	3	3	4	3	
Ian Morris Local Counter-Fraud Specialist – 360 Assurance		2						
John Cotterill Assistant Director 360 Assurance		5						
Jon Gorrie Director KPMG		3						
Richard Heaton Head of Governance Erewash CCG				3				2
Karen Rhodes Human Resources Partner Arden & GEM CSU					1			
Steve Wright Human Resources Partner Arden & GEM CSU					1			
Melanie Foster-Green Primary Care Lead						4		
Dr Kath Markus						0		

	Governing Body	Audit Committee	Finance Committee	Governance Committee	Remuneration Committee	Primary Care Commissioning Committee	Quality Assurance Committee	Health & Safety Fire a & Security Committee
LMC Representative								
David Knight NHS England						4		
Joe Lunn NHS England						1		
Carolin Shearer Healthwatch Rep						0		
Dave Stevens Deputy Chief Finance Officer						2		
Dr Anna Allaway Named Safeguarding GP							1	
Sally Bestwick Lead Nurse Infection, Prevention & Control							1	
Dr Joanne Cartwright GP							4	
Rachael Murfin Patient Experience Lead							3	
Temi Omorinoye Acting Head of Medicines Management							2	
Ed Ronayne Safeguarding Adults Representative							3	
Delores Williams Clinical Quality Facilitator							2	1
Bill Nicol Head of Adult Safeguarding								
Kathleen Cox Administrator Infection, Prevention & Control								1
Victoria Carter Office Manager								2
Dr Kate Bagshaw								
Dr Duncan Gooch								

Glossary

A&E	Accident and Emergency
AfC	Agenda for Change
AHP	Allied Health Professional
AQP	Any Qualified Provider
Arden & GEM CSU	Arden & Greater East Midlands Commissioning Support Unit
ARP	Ambulance Response Programme
ASD	Autistic Spectrum Disorder
BAF	Board Assurance Framework
BCCTH	Better Care Closer to Home
BCF	Better Care Fund
BME	Black Minority Ethnic
bn	Billion
BPPC	Better Payment Practice Code
BSL	British Sign Language
CBT	Cognitive Behaviour Therapy
CAMHS	Child and Adolescent Mental Health Services
CCE	Community Concern Erewash
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile
C-DIFF	Clostridium difficile
CETV	Cash Equivalent Transfer Value
Cfv	Commissioning for Value
CHC	Continuing Health Care
CHP	Community Health Partnership

CMP	Capacity Management Plan
CiC	Committees in Common
CNO	Chief Nursing Officer
COP	Court of Protection
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuing Professional Development
CPN	Contract Performance Notice
CQC	Care Quality Commission
CQN	Contract Query Notice
CQUIN	Commissioning for Quality and Innovation
CPN	Contract Performance Notice
CPRG	Clinical & Professional Reference Group
CRG	Clinical Reference Group
CSE	Child Sexual Exploitation
CSU	Commissioning Support Unit
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CTR	Care and Treatment Reviews
CVD	Chronic Vascular Disorder
CYP	Children and Young People
D2AM	Derbyshire Dis-charge to address and manage
DAAT	Drug and Alcohol Action Teams
DCC	Derbyshire County Council
DCCPC	Derbyshire Affiliated Clinical Commissioning Policies
DCHS	Derbyshire Community Health Services
DCHSFT	Derbyshire Community Healthcare Services NHS Foundation Trust
DCO	Designated Clinical Officer

DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHSC	Department of Health & Social Care
DHU	Derbyshire Health United
DNA	Did not attend
DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DRRT	Dementia Rapid Response Service
DSN	Diabetic Specialist Nurse
DTHFT	Derby Teaching Hospitals NHS Foundation Trust
DTOC	Delayed Transfers of Care – the number of days a patient deemed medically fit is still occupying a bed.
D2AM	Discharge to Assess and Manage
ED	Emergency Department
EDEN	Effective Diabetes Education Now
EDS2	Equality Delivery System 2
EIHR	Equality, Inclusion and Human Rights
EIP	Early Intervention in Psychosis
EMAS	East Midlands Ambulance Service
EMAS Red 1	The number of Red 1 Incidents (conditions that may be immediately life threatening and the most time critical) which resulted in an emergency response arriving at the scene of the incident within 8 minutes of the call being presented to the control room telephone switch.
EMAS Red 2	The number of Red 2 Incidents (conditions which may be life threatening but less time critical than Red 1) which resulted in an emergency response arriving at the scene of the incident within 8 minutes from the earliest of; the chief complaint information being obtained; a vehicle being assigned; or 60 seconds after the call is presented to the control room telephone switch.
EMAS A19	The number of Category A incidents (conditions which may be immediately life threatening) which resulted in a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner, arriving at the scene within 19 minutes of the request being made.
EMLA	East Midlands Leadership Academy

ENT	Ear Nose and Throat
EOL	End of Life
EPRR	Emergency Preparedness Resilience and Response
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIRST	Falls Immediate Response Support Team
FRP	Financial Recovery Plan
GAP	Growth Abnormalities Protocol
GBAF	Governing Body Assurance Framework
GP	General Practitioner
GPSI	GP with Specialist Interest
HCAI	Healthcare Acquired Infections
HDU	High Dependency Unit
HSJ	Health Service Journal
GBAC	Governing Body Assurance Committee
GBAF	Governing Body Assurance Framework
GDPR	General Data Protection Regulation
GNBSI	Gram Negative Bloodstream Infection
GPFV	General Practice Forward View
GPWSI	GPs with a special interest
GPSOC	GP System of Choice
HCAI	Healthcare Associated Infection
HLE	Healthy Life Expectancy
HSJ	Health Service Journal
HWB	Health & Well-being Board
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies

ICM	Institute of Credit Management
ICO	Information Commissioner's Office
ICS	Integrated Care Service
ICU	Intensive Care Unit
IGC	Information Governance Committee
IGT	Information Governance Toolkit
IP&C	Infection Prevention & Control
IT	Information Technology
IWL	Improving Working Lives
JAPC	Joint Area Prescribing Committee
JSAF	Joint Safeguarding Assurance Framework
JSNA	Joint Strategic Needs Assessment
k	Thousand
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked after Children
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LGB&T	Lesbian, Gay, Bi-sexual and Trans-gender
LHRP	Local Health Resilience Partnership
LMC	Local Medical Council
LMS	Local Maternity Service
LOC	Local Optical Committee
LPC	Local Pharmaceutical Council
LPF	Lead Provider Framework
m	Million
MAPPA	Multi Agency Public Protection arrangements
MASH	Multi Agency Safeguarding Hub

MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MH	Mental Health
MHIS	Mental Health Investment Standard
MIG	Medical Interoperability Gateway
MIUs	Minor Injury Units
MMT	Medicines Management Team
MoM	Map of Medicine
MoMO	Mind of My Own
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MTD	Month to Date
NDCCG	NHS North Derbyshire Clinical Commissioning Group
NECS	North of England Commissioning Services
NEPTS	Non-emergency Patient Transport Services
NHAIS	National Health Application and Infrastructure Services
NHSE	NHS England
NHS e-RS	NHS e-Referral Service
NICE	National Institute for Health and Care Excellence
NOAC	New oral anticoagulants
NUH	Nottingham University Hospitals NHS Trust
OJEU	Official Journal of the European Union
OOH	Out of Hours
ORG	Operational Resilience Group
PAD	Personally Administered Drug
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System

PCCC	Primary Care Co-Commissioning Committee
PCD	Patient Confidential Information
PCDG	Primary Care Development Group
PEARS	Primary Eye care Assessment Referral Service
PEC	Patient Experience Committee
PHB's	Personal Health Budgets
PHSO	Parliamentary and Health Service Ombudsman
PIR	Post-Infection Review
PLCV	Procedures of Limited Clinical Value
POA	Power of Attorney
POD	Point of Delivery
PPG	Patient Participation Groups
PPP	Prescription Prescribing Division
PRIDE	Personal Responsibility in Delivering Excellence
PSED	Public Sector Equality Duty
PSO	Paper Switch Off
PwC	Price, Waterhouse, Cooper
QA	Quality Assurance
QAG	Quality Assurance Group
Q1	Quarter One reporting period: April – June
Q2	Quarter Two reporting period: July – September
Q3	Quarter Three reporting period: October – December
Q4	Quarter Four reporting period: January – March
QIPP	Quality, Innovation, Productivity and Prevention
QUEST	Quality Uninterrupted Education and Study Time
QOF	Quality Outcome Framework
RAP	Recovery Action Plan
RCA	Root Cause Analysis

REMCOM	Remuneration Committee
RTT	Referral to Treatment
RTT Admitted	The percentage of patients waiting 18 weeks or less for treatment of the patients on admitted pathways
RTT Non-admitted	The percentage if patients waiting 18 weeks or less for treatment of the patients on non-admitted pathways
RTT Incomplete	The percentage of patients waiting 18 weeks or less of the patients on incomplete pathways at the end of the period
SAAF	Safeguarding Adults Assurance Framework
SAR	Service Auditor Reports
SAT	Safeguarding Assurance Tool
SBS	Shared Business Services
SDCCG	Southern Derbyshire CCG
SDMP	Sustainable Development Management Plan
SEND	Special Educational Needs and Disabilities
SHFT	Stockport NHS Foundation Trust
SFT	Stockport Foundation Trust
SNF	Strictly no Falling
SOC	Strategic Outline Case
SPA	Single Point of Access
SQI	Supporting Quality Improvement
SRG	Systems Resilience Group
SIRO	Senior Information Risk Owner
SRT	Self-Assessment Review Toolkit
STEIS	Strategic Executive Information System
STHFT	Sheffield Teaching Hospital Foundation Trust
STOMPLD	Stop Over Medicating of Patients with Learning Disabilities
STP	Sustainability and Transformation Plan
TCP	Transforming Care Partnership
TDA	Trust Development Authority

T&O	Trauma and Orthopaedics
TWG	Transition Working Group
UEC	Urgent and Emergency Care
YTD	Year to Date
111	The out of hours service delivered by Derbyshire Health United: a call centre where patients, their relatives or carers can speak to trained staff, doctors and nurses who will assess their needs and either provide advice over the telephone, or make an appointment to attend one of our local clinics. For patients who are house-bound or so unwell that they are unable to travel, staff will arrange for a doctor or nurse to visit them at home
52WW	52 week wait