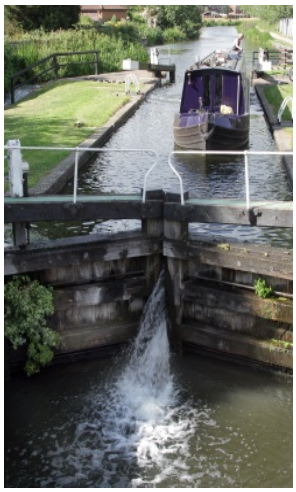
NHS
Erewash
Clinical Commissioning Group

NHS Erewash CCG

Annual Report & Accounts




2018 – 2019

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FOREWORD

On the 1st April 2019, the four Clinical Commissioning Groups (CCGs) comprising Erewash, North Derbyshire, Southern Derbyshire and Hardwick will join together to become one strategic commissioner for Derbyshire and will be known as NHS Derby and Derbyshire CCG. I am proud and privileged to have been Chair of NHS Erewash CCG since its inception in 2013 and particularly proud of the track record of success and innovation that we bring to the newly formed CCG.

The merger is the culmination of the progressive joining together of the four CCGs over the last two years and particularly since the appointment of one Chief Executive Officer, Chief Finance Officer and Executive Team for Derbyshire CCGs in late 2017. This aligns with our role as a key partner in Joined Up Care Derbyshire, the Sustainability and Transformation Partnership (STP) as we move towards a system approach for the county. The concept of 'place', which is central to this, will also ensure that we maintain a strong and consistent approach in terms of localism.

Over the last year we have addressed significant challenges and successfully and simultaneously delivered a financial savings plan and £44m control total, an internal reorganisation and restructure together with a successful merger. The new CCG will start the 2019/2020 financial year in a strong position and ready to face the challenges that the year will bring as we deliver our savings plan and our ambitious service transformation plans for Derbyshire as we work to improve the lives of our patients across the county.

To do this we will be building upon the principles and approaches that we have adopted in Erewash. As I reflect upon the successes we have delivered in recent years there are many that spring to mind but it is the ability to think ahead and innovate that has seen NHS Erewash CCG testing and implementing new approaches long before other parts of the country.

For example, the Prime Minister's Challenge Fund back in 2014 responded to patient feedback regarding the need to improve access to GP services. There were 250 bids for a share of the £50m fund. Our collaborative Derbyshire bid was one of the 20 pilot areas that were successful and we secured £1.2m for Erewash. That really helped us to test some innovative ways of working and we can still see the impact of those on the way we work today. I remember the visit from the Right Honourable Jeremy Hunt as one of the milestones for our CCG. Another example that stands out is the Multispecialty Community Provider (MCP) Vanguard pilot which we secured in 2015. Key elements included the Building Community and Personal Resilience programmes with the three themes of houses, jobs and friends and also the Primary and Integrated services model.

Many of the initiatives we have created in Erewash have captured the interest of the media and other health organisations locally, regionally, nationally and internationally. Examples include the *On-Day Service*, *Brilliant Erewash* and the smoking in pregnancy *Love Bump campaign* which has since been taken up by others across the country. Working in partnership has been a theme throughout and the *Time Swap* initiative was delivered in together with the Local Authority and it continues as a self-sustaining initiative.

All these examples form part of the legacy of NHS Erewash CCG and there are many others, including the Care Home Service, Extended Hours Hubs, Acute Home Visiting Service, Frailty and Care Home Service and the development of General Practice as a provider. There are many

others but I hope that these help to give a picture of the work delivered by the CCG and the reasons that colleagues involved are rightly proud of the legacy they have helped to create.

As I move from my NHS Erewash CCG Chair role into my new role as Chair of NHS Derby and Derbyshire CCG I will be looking to build upon the strengths of each of the previous CCG areas and as Erewash we have a tremendous amount to contribute. On a personal note I would like to thank the staff, our GP membership and Governing Body colleagues together with our patients, the wider public, our partners, stakeholders and many others for your input and support over the last six years, I look forward to working with you as we move forward.

Best wishes,

Dr Avi Bhatia
Chair
NHS Erewash Clinical Commissioning Group

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Erewash CCG

23 May 2019

Chief Executive Officer's Statement

Welcome to the 2018/19 Annual Report and Accounts for NHS Erewash CCG which covers the period from the 1st April 2018 to the 31st March 2019.

Before we look back on some of the key developments and successes of NHS Erewash CCG, I would like to thank our staff, GP membership, Governing Body, public and patients, together with our wider partners and stakeholders for their tremendous input and support during a year which has seen significant challenge and change. NHS Erewash CCG has a strong track record of achievement, particularly with an innovative approach to service delivery which our Chair, Dr Avi Bhatia describes in his foreword.

When the reporting year started on the 1st April 2018 we were already working closely at an operational level with NHS Hardwick, NHS North Derbyshire and NHS Southern Derbyshire CCGs. At that point the Derbyshire CCGs were four statutory bodies with one Chief Executive Officer, one Chief Finance Officer and one Executive Team, with operational Teams working closely together to maximise efficiency. We still had four separate Governing Bodies and over the course of the year they started to operate as Governing Bodies in Common. This meant that they met together and any decisions made required the agreement and approval of four quorate Governing Bodies.

As we reach the end of this year on the 31st March 2019, NHS Erewash CCG will be formally merging with the other three CCGs in the county to form NHS Derby and Derbyshire CCG, which will be the single, statutory CCG for the county. It will comprise a budget of over £1.6bn and 116 GP practices serving a population of 1,055,000 people. It will have a single constitution, one Executive Team, one Governing Body and a single, unified governance structure to support decision making.

The journey to the point of merger has seen NHS Erewash CCG play a fundamentally important role in responding to the unprecedented level of challenge faced by the Derbyshire CCGs during 2018/19. This included the achievement of a £44m control target and accompanying savings plan, the delivery of an internal reorganisation and the development and achievement of a complex and comprehensive merger plan.

The year has also seen the successful conclusion of the Erewash Vanguard pilot. Some of the learning and legacy can be seen in the approaches and schemes already in operation at a county level and also some of those which we are currently developing.

NHS Erewash CCG has also made an important contribution to the increasing momentum of the Sustainability Transformation Partnership (STP) through Joined Up Care Derbyshire as we increasingly move towards a "one system" approach for health and care in our county.

'Place' is central to this and the CCG has worked on the principles since its inception in 2013 and again has played an important role in the learning and development of 'Place' across Derbyshire. I would like to reassure the public and patients of Erewash that 'Place' is the focal point of our future plans and whilst we are moving to one CCG to drive efficiencies and to address avoidable duplication, we will be working to ensure a strong sense of localism through 'Place.'

As NHS Erewash CCG prepares to merge we will be taking forward the strategic principles and priorities that the CCG has subscribed to, alongside our other Derbyshire CCGs and these include:

- reducing health inequalities by improving the physical and mental health of the people of Derbyshire;
- taking the strategic lead in planning and commissioning care for the population of Derbyshire;
- making best use of available resources, which includes achieving our statutory financial duties; and
- delivering improvements in communications, including to all patients and stakeholders.

These will form the cornerstone of our strategic approach as we move forward.

Finally, I would like to reiterate the personal commitment and assurance that I made last year which is 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.

Best wishes,

Dr Chris Clayton
MA MB BChir DRCOG PGCGPE MRCGP
Chief Executive Officer
NHS Erewash Clinical Commissioning Group

23 May 2019

Performance Overview

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

Purpose and Activities of the CCG

NHS Erewash Clinical Commissioning Group 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 people.

NHS Erewash CCG's vision is "to continuously improve the health and wellbeing of the people of Derbyshire, using all resources as fairly as possible".

The CCG is striving to achieve this by:

- providing local clinical leadership to the NHS, and working with everybody who can contribute to our aims;
- being open and accountable to our patients and communities, ensuring they are at the heart of everything we do;
- understanding our population and addressing inequalities so that services are in place to meet needs;
- planning services that best meet those needs now and in the future;
- aiming to secure the best quality, best value health and social care services we can afford;
- using our resources fairly and effectively.

There are clear health inequalities within the CCG area. Working together with partner organisations is part of the whole system approach to tackle them, as articulated in our Derbyshire Sustainability and Transformation Plan. The latest update on developments can be found at: https://joinedupcarederbyshire.co.uk/

We were allocated £150m of public money, split between £148m to spend on health services and £2m for running costs. The running cost allocated amounts to £21 per head of population. This report will explain how this has been used to support your care and how this fits in to the second year of a five-year plan to meet key priorities.

Patients in our area have access to services from a wide range of providers, including Nottingham University Hospitals NHS Trust, Derbyshire Community Health Services NHS Foundation Trust, Derbyshire Healthcare NHS Foundation Trust and East Midlands Ambulance Service NHS Trust. Our largest contract is with University Hospitals of Derby and Burton NHS Foundation Trust, which was formed following a merger of Derby Teaching Hospitals NHS Foundation Trust and Burton Hospitals NHS Foundation Trust in 2018 and accounts for approximately 21% of our funding spend.

The Derbyshire CCGs' Governing Body Meetings in Common uses an annual Assurance Framework to test our performance and capability. Part of this framework measures performance against what we say we need to deliver and whether these demonstrate improved outcomes for our patients, including how services and quality are delivered and improved. This includes measuring progress in how we have delivered the requirements set out to us by the Government in the NHS Mandate and the NHS Constitution pledges.

Our 12 member practices lie in the heart of Erewash (detailed on page 66). We also work with our fellow CCGs in Derbyshire (Hardwick, Erewash and North Derbyshire); together we cover a total population of over one million people.

Key Issues and Risks that could affect the CCG delivering its objectives

The key issues and risks to the organisation achieving its objectives are described in the Governance Statement section of this report. In summary, the key risks identified during 2018/19 were:

Risk 001. The CCG resource allocation impacts on effective commissioning decisions which prevents the Derbyshire CCGs improving health and reducing health inequalities
Risk 002. Lack of capacity and capability to deliver the objectives of the CCG. This will impact on the delivery of transformation to support and improve health outcomes and health inequalities
Risk 003. There is a risk that Commissioners (Place) and providers deliver poor quality care and patient safety which do not meet constitutional standards, resulting in reduced health outcomes and experiences of the Derbyshire population
Risk 004. Poor planning of resources (staff and money) has an adverse impact on the planning and commissioning of care for all the population of Derbyshire
Risk 005. The Derbyshire health economy may not be sustainable unless there is a delivery of transformational change through the Derbyshire Sustainability and Transformation Partnership
Risk 006. Failure to effectively manage demand, activity and cost pressures across the health system may impact on delivery of the CCG's financial plan
Risk 007. Inability to invest in service transformation which may impact on patient outcomes
Risk 008. Failure to engage with patients and stakeholders could risk poor decision making that does not meet the needs of the recipients of services
Risk 009. Failure to engage with patients and stakeholders could risk a challenge to process, and reputational damage with local relationships

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), there 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 into doubt if that body is subject to a report under Section 30 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. The CCG has confirmed with its Auditors, that the adoption of the going concern approach is appropriate for 2018/19.

Key Developments during 2018/19

This section will provide an overview of the key developments during 2018/19 against each of the following areas:

Quality, Innovation, Prevention and Productivity Programme

The CCG's Quality, Innovation, Prevention and Productivity (QIPP) programme is established to ensure that the organisation is focused on delivering the best possible outcomes for the population, from the highest quality services with the resources available. This is achieved through a regular review of the value and efficiency of commissioned care.

QIPP is a central framework for the CCG and is at the heart of good commissioning practice. The programme is clinically-led and approved.

The 2018/19 QIPP programme was developed at a time of significant financial change across the four CCGs in Derbyshire. This year represented the first time that a single aligned QIPP programme has been produced across Derbyshire; and a primary focus for this programme has been to support the financial recovery required across the CCGs. The QIPP programme was developed alongside the emerging (now agreed) five strategic priorities for the CCG and the following workstreams have been deployed to support the development and implementation of our QIPP Programme:

1. Urgent Care
2. Primary Care
3. Planned Care
4. Continuing Healthcare (CHC)
5. Mental Health
6. Medicines Management
7. Service Benefit Review
8. Long Term Conditions/Disease Management
9. Place
10. Organisational Efficiency

The Derbyshire CCGs required an ambitious QIPP programme to continue the transformation of care and meet the financial and statutory duties placed upon it. The programme was established to generate £51m of efficiency savings. This was to be achieved in three ways:

1. reducing variation in commissioning across Derbyshire under a single commissioning leadership;
2. ensuring the appropriate quality and cost for existing services;
3. initiating transformation schemes to impact on activity and outcomes.

The CCGs delivered £45m of the QIPP programme in 2018/19, through both non-recurrent and recurrent schemes. These included:

1. establishing a new pathway to support people with musculoskeletal and joint pain through early access to physiotherapy assessment and review, reducing the requirement for patients to travel to hospital;
2. the implementation of National Institute of Health and Care Excellence (NICE) policies in partnership with our local acute hospitals to ensure the best practice prescribing and interventions for positive health gain; and
3. improved processes to deliver CHC assessments in line with the national framework, working with clients to access support when most needed.

Voluntary Sector

As part of our recovery plan this year we have had to make some difficult decisions about the services we fund. From April to December 2018 we carried out a consultation to understand the services we fund through the voluntary sector and gave service providers, stakeholders and service users the opportunity to provide feedback on current provision and ideas for future provision. To understand how we can provide a better offer for infrastructure Voluntary Care Sector (VCS) organisations in Derbyshire, we undertook case studies, interviews, local events and discussion groups. An online survey was developed along with undertaking feedback forums.

During the engagement, people told us:

- there are a range of services that are identified as Social Care and without a direct impact on health across Derbyshire;
- some services were identified as clinical pathway essentials and as such much are maintained and reviewed to meet the needs identified through the review;
- it was stated that there was a need to maintain a strong infrastructure in Derbyshire to support the grant-maintained organisations; and
- it was noted that the offer for infrastructure needs to change and there needs to be more ‘joined up’ work at this level.

As a result of the feedback received the following outcomes were achieved:

- the range of discretionary grants being offered has changed to reflect clinical pathways and patient need, in the following ways:
- jointly working with Derbyshire County Council to ensure that Social Care grants are now part of their package of services;
- a review of grant services with a view to moving to a commissioned and contracted service model, creating more stability for the provider than the grants offer model; and
- a review of the infrastructure offer, jointly with Derbyshire County Council, to ensure that it meets the needs of smaller grant-maintained organisations.

Delivering Urgent Care

The demand for urgent care services increases year on year, and there have been significant pressures across Derbyshire, in line with increases been seen across the country.

In 2018/19 a Derbyshire-wide Winter Plan was developed, in which additional resource was invested to increase support to deliver the plan. There are schemes that have also been put in place to help support hospitals and the community, over the winter period.

Visibility of operational pressure

We continue to work as a system through the Operational Resilience Group, which enabled us to effectively manage delivery of services during times of pressure.

To support operational planning, a system flow management process has been developed to manage flow through non-elective pathways across Derbyshire. This captures, collates and influences discussion to correct the issues which arise on a weekly basis using a robust continuous improvement approach. This has been a winter funded initiative but is in the process of becoming part of 'business as usual' activities for the Operational Resilience Group.

In addition, in 2018 the Operational Resilience Group developed a new online reporting tool to highlight performance and pressure in real time. This online system is updated by all system partners seven days a week and provides key insight for all partners on locally agreed indicators, as well as providing information for on-call Directors and reporting requirements for NHS England.

Urgent Care governance

The Urgent Care Strategy has been developed with the CCG and Chief Operating Officers from across the system to assess current urgent care services (in hours and out of hours), access points, deprivation, and equity of access for all of our population. The Urgent Care Transformation Board has oversight of the strategy and system-wide workstreams that sit below this.

In 2018, the urgent care governance structure was refreshed to ensure clarity and greater focus on both performance and transformation. There are now two Boards:

- The Urgent Care Transformation Board – focusing on strategy and longer term transformation; and
- The Accident and Emergency Delivery Board – focusing on the 'here and now' and operational performance.

The relevant Committees and groups feeding into the Boards have been refreshed to align to the new governance routes. As such, the Operational Resilience Group has re-structured to allow focused discussion and problem solving of the biggest operational issues in a more efficient and targeted way. All Committees have become Derbyshire-wide, to avoid duplication and ensure whole system learning and collaboration.

Reducing attendances at the Emergency Department (ED)

A three month pilot ran from November 2018 to January 2019 where patients calling NHS 111 with a disposition of 'attend ED' have been offered a call back from a clinician within 15 minutes and offered a telephone clinical consultation with the aim to "consult and complete" thus negating the need for an Accident and Emergency (A&E) attendance.

Calls are completed with the right clinical advice to avoid unnecessary visits to other NHS services thereby relieving the burden on A&E departments by resolving those matters that can be satisfactorily resolved over the telephone and only sending patients to A&E when that is the best location for them.

This has had a significant impact on the number of referrals to ED from NHS 111 and as such, this is continuing and being extended to become part of the core service.

Please see the Performance Analysis section for more detailed information.

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 2018/19 the Derbyshire Primary Care teams worked collaboratively to develop a more consistent approach to both the commissioning and quality of Primary Care commissioned services for the population of Derbyshire.

Care Quality Commission Inspections of Primary Care

Delivering high quality services in Primary Care is an important part of managing the health of Derbyshire's population. Every Derbyshire GP practice has been visited by the Care Quality Commission (CQC) and has received an inspection rating of either:

- Outstanding;
- Good;
- Requires Improvement; or
- Inadequate.

The table below identifies the ratings awarded to practices by the CQC for the reporting period up to the 31st December 2018:

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

NHS Hardwick CCG	
Outstanding	1 practice
Good	13 practices
Requires Improvement	1 practice
Inadequate	0 practices

NHS North Derbyshire CCG	
Outstanding	10 practices
Good	23 practices
Requires Improvement	1 practice
Inadequate	0 practices

NHS Southern Derbyshire CCG	
Outstanding	12 practices
Good	42 practices
Requires Improvement	1 practice
Inadequate	0 practices

- 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.
- '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 available on the CQC website. Full reports for each practice can be reviewed by following this link: www.cqc.org.uk/content/publications#cqc-solr-search-theme-form

The CCG continues to support and work with general practice to deliver continuous quality improvement; this is undertaken in a variety of ways, as detailed in the section below.

Support for Quality Improvement Visits

Supporting Quality Improvement (SQI) visits are now undertaken on a rolling programme across Derbyshire; to date 30 have been undertaken. The visits support member practices to review current healthcare 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 CCG’s commitment to continuously improving the quality of healthcare for the population with a focus on the needs of the registered population of our member practices.

The visits continue to be a mechanism for encouraging practice development and sharing good practice.

Clinical Governance Leads meetings

Clinical Governance Leads meetings provide the opportunity for the CCG to share and exchange clinical information with the lead GP for Clinical Governance from every practice. These forums promote shared learning opportunities, clinical interface and clinical debate between individual clinicians and CCG officers. These meetings have now been extended across the county.

Quality Education Support

The CCG has continued to support and promote the delivery of education sessions across the county for general practice staff. These include forum focused subject events and the opportunity for education to be delivered locally at individual practices or ‘Places’.

Five-Year General Practice Forward View

The General Practice Forward View (GPFV) sets outs some clear priorities for General Practice nationally and we have been working collaboratively with practices and other agencies to ensure we implement these in Derbyshire for the benefit of our patients.

During 2018/19 the four Derbyshire CCGs (Erewash, Hardwick, North Derbyshire and Southern Derbyshire) have continued to work with member practices and to plan how the requirements of the GPFV will be delivered for the population of Derbyshire.

A delivery plan was submitted and approved by NHS England outlining the Derbyshire Vision for General Practice for 2017 to 2021. The key objectives of the plan are:

- delivery of the GPFV targets;
- investment of local and national funding in general practice; and
- support of general practice transformation.

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

- improve population health, particularly amongst those at risk of illness or injury;
- manage short term, non-urgent episodes of minor illness or injury;
- manage and co-ordinate the health and care of those with long-term conditions;
- manage urgent episodes of illness or injury; and
- manage and coordinate care of those who are at the end of their lives.

Investing in the Primary Care Workforce

We have set up a GP Workforce Steering Group to begin to develop new roles and models of care. The Steering Group has implemented a co-ordinated, structured and targeted approach to GP recruitment and retention, working collaboratively with Health Education East Midlands and the Local Medical Committee.

We are implementing a co-ordinated, structured and targeted approach to retention that builds on the existing successful initiatives and begins to test and introduce innovative approaches using the Local GP Retention Funding, through the following schemes:

- GP wellbeing, mentoring and coaching;
- GP Aspire flexible working;
- Recruiting for retention;
- Workload/work-life balance;
- Early Career – supporting retention; and
- Exit Interview pilot.

We have recruited more clinicians to training schemes and retained GP trainees, continued to work with local Universities to fill trainee placements across Derbyshire and identified two migrant GPs – matching them to a Derbyshire GP Practice for prospective placement.

We have also developed attractive packages for a portfolio career within at-scale working (offering GPs the time and flexibility to apply learning outside of clinical hours), continuous professional development, mentoring, and safe and supportive places to work through our retention schemes (with 63 GPs having benefitted from these schemes).

In 2018 we trained 313 practice staff in ‘Active Signposting’ – a course for reception and clerical staff to provide effective signposting to patients. 100% of Derbyshire GP practices have been offered a blended learning opportunity to support workflow optimisation within their Practice, compiling of face to face workshops delivered at Place-level, webinars and ongoing e-learning, (with a validated tool to monitor key outcomes post training).

Practice Managers work in the heart of practices to provide good leadership and management training, through which healthcare teams create a positive culture that will enable high standards for staff and impact positively on patient relations. Recognising this pivotal role, we have worked with the Derby and Derbyshire Local Medical Committee to run a series of events, which have been over-subscribed by Practice Managers. The events covered topics such as Finance and Claims, Property Management, Contracts, Procurement, Care Quality Commission and the East Midlands Leadership Academy leadership courses. We have also explored the development needs of the Primary Care Networks and other Practice federation models, having worked with them to identify and deliver leadership needs for advancing new models of care.

We have created a dashboard using the available Primary Care workforce data, to produce information for groups of Practices (at Place-level) to support the development of new models of

care and workforce plans. The dashboard has been used to produce tailored reports for our Place Alliances. Further engagement work to model future workforce requirements along with community providers, has also commenced with City Place Alliance, with the hope to roll this out across other Places in 2019/20.

Improving and Extending Access

From April 2018 Primary Care services were made available on a *planned* and a *request on the day* basis from 8am until 8pm, Monday to Friday; supporting increased access to urgent on-the-day appointments and planned appointments.

As part of our commitment to the General Practice Forward View, extended access for patients to Primary Care has been rolled out across all of Derbyshire and has significantly increased access to Primary Care since October 2018. 14 geographically-based hubs are operating additional appointments daily between 6.30pm–8pm and Saturday and Sunday mornings, including Bank Holidays. This equates to an additional 108,264 appointments per annum. Work is also ongoing to enable NHS 111 to directly book into the Extended Access appointments to ensure patients are seen in the right place, first time.

NHS e-Referral Service (NHS e-RS)

Utilisation of the NHS e-RS (electronic booking and referral system for GP referrals to first outpatient consultant-led services) is now firmly embedded in both the GP and acute contracts.

GPs and practices across the Derbyshire CCGs continue to strive to maximise utilisation of the NHS e-RS, which 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.

Since October 2018, following the introduction of a new Contract Service Condition in the standard contract, Secondary Care providers now have to receive GP referrals to Consultant-led first outpatient services electronically. GPs and practices across Derbyshire fully engaged with NHS England's 'paper switch off' programme, enabling its success. Work continues with providers to evaluate NHS e-RS utilisation, understand what services should be available and support Practices to find the right service, first time.

A dedicated NHS e-RS Manager for all Derbyshire Practices supports GPs, GP Practices and acute providers in all aspects relating directly or indirectly to the electronic referral and booking service.

Enhanced Care Home Service

NHS England have recently announced in '*Investment and evolution: A five-year framework for GP contract reform to implement The NHS Long Term Plan'. (*January 2019) that a new Enhanced Health in Care Homes service will be commissioned from Primary Care Networks (PCNs), from April 2020, to implement the good practice and learning generated from the Care Home Vanguard sites. It has been agreed that the Enhanced Care Home Service will continue to be commissioned from practices until April 2020. However, in order to prepare practices for the new service in April 2020, there will be some modifications made to the existing service from October 2019. The service specification modifications will focus on:

- encouraging practices to work together collaboratively within their emerging PCNs;
- implementing personalised, proactive care planning in line with a Comprehensive Geriatric Assessment style approach;

- building in multi-disciplinary team working with other health and social care professionals to support residents; and
- supporting care homes with their educational/training needs and implementing local pathways as a way of avoiding urgent care episodes.

It is anticipated that these changes will build on the excellent work that has already been carried out by practices. Residents in care homes will continue to receive enhanced support in line with national best practice and in readiness for changes coming into effect from April 2020.

Primary Care-based Dermatology

In 2017/18, a 'proof of concept' scheme was commissioned by both NHS North Derbyshire and NHS Hardwick CCGs to deliver a Primary Care-based dermatology service within local communities; the service was commissioned for a period of three years. The service has continued to demonstrate excellent outcomes and experience for patients, who have been able to be seen and treated closer to home and it 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 who have been accredited to provide the service. Plans are in place to review this on a Derbyshire-wide basis during 2019.

Ophthalmology

Direct Cataract Referral Service

This 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.

Glaucoma Referral Refinement Service

This was commissioned during 2016/17 and is still in place for three of the Derbyshire CCGs (with plans to expand to the fourth proposed from 2019) and continues to allow patients to attend their Community Optometrists (high street opticians) and be assessed for the 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.

Minor Eye Conditions Service

This is a 'proof of concept' scheme which has been approved for an 18 month period. It will enable patients who present to their Optician with a Minor Eye Condition (such as red or dry eyes or those experiencing flashers and floaters for example) to be seen in Primary Care to reduce the need for appointments in hospital and attendance at hospital Emergency Departments/Eye Casualties. If it is found that they require referring to Secondary Care, Opticians will be able to do this directly as opposed to the patient requiring an additional appointment with their GP for onward referral. The scheme is due to commence in the summer of 2019.

Digital Services

Digital services and information technology are set to play an ever more vital role in developing and managing new methods of healthcare delivery over the coming years. This is driven by the increasing sophistication of patients using on-line services in all aspects of their daily life, such as social media, on-line banking and many other applications. The NHS long term plan has put improving digital services at the heart of improving patient services.

The CCG has fully recognised the importance of this area and responded to the challenge by creating a new Digital Services team, working within the Medical Directorate, to tackle this critical and demanding function. Led by a senior director, the team is focussed on the following tasks and activities:

- developing a strategic approach to delivering innovative services for the people of Derbyshire, improving health outcomes through the use of modern technology;
- managing the existing IT resources available to the commissioning function to get maximum value for money from existing investments in IT;
- working closely with providers and Joined Up Care Derbyshire colleagues to ensure that maximum cooperation and coordination of IT services delivers the best possible outcomes;
- exploring and developing advanced technologies and services, for a new generation of health care services.

Key areas of work that have been undertaken during 2018/19 include the following:

- improving the IT services available to Primary Care – a major investment programme is underway to transform the facilities available to General Practice in Derbyshire, improving speed and availability of clinical systems;
- implementing a new generation of on-line consultation systems, allowing patients to access the right services from their smartphones or home PCs;
- supporting the GP Extended Access programme – allowing practices to work together to provide services at weekends and in the evening;
- strengthening vital but often unsung ‘back office’ functions, modernising a wide range of key infrastructure systems;
- ensuring that the CCG organisational merger IT requirements were supported appropriately;
- making preparations to deal with cyber-attacks, maintaining the safety and integrity of the confidential information entrusted to the CCG; and
- dealing with the many operational issues that occur on a day-to-day basis in supporting the work of a major commissioning organisation.

Planned Care

Transforming Cancer Care

Public Health data regarding cancer rates in Derbyshire reveals in 2016 there were a total of 6,290 new diagnoses of cancer in Derbyshire. Of those cancers, 1,859 could have been considered preventable through improved lifestyle choices.

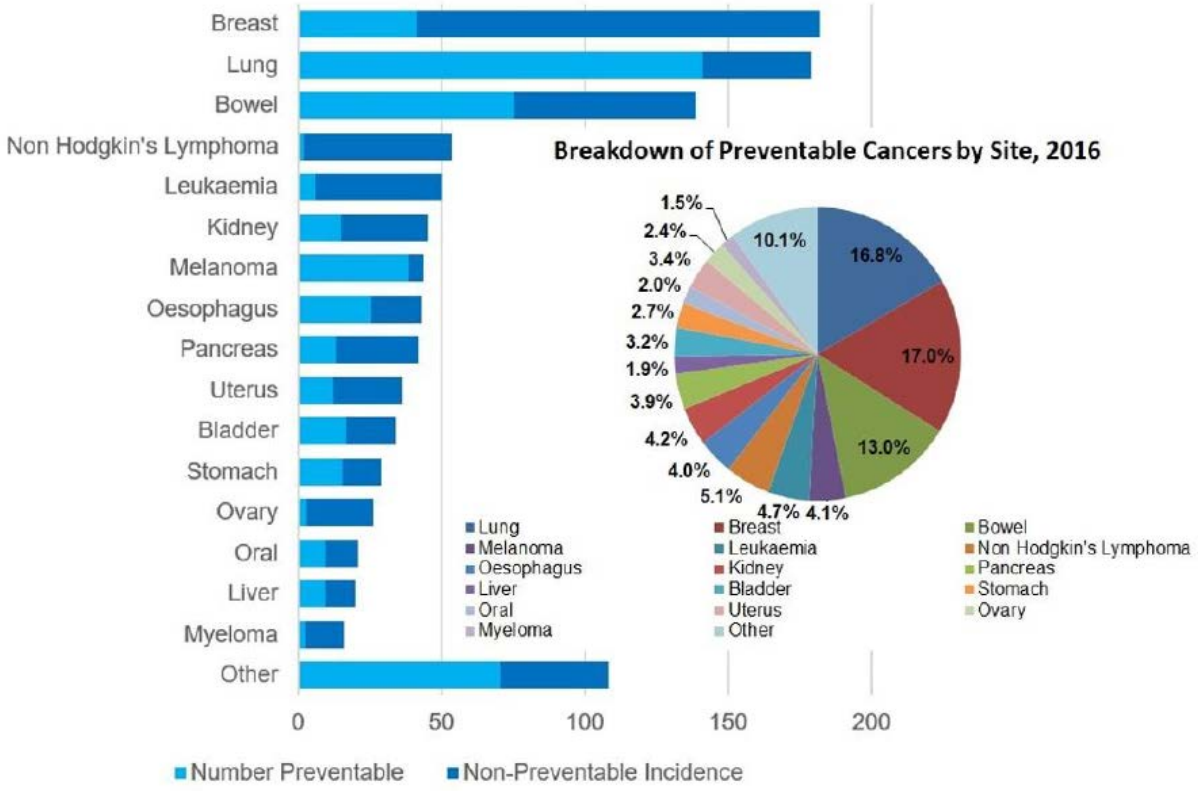
Derbyshire CCGs have been working to transform cancer services to improve care and outcomes for our patients. We are working to improve the prevention, early diagnosis and treatments of cancer and support patients to live well for longer in the community.

Bowel cancer has been identified as a particular priority in Derbyshire to increase the levels of improved outcomes for patients. As part of a national initiative, we have been an early adopter of a new test to help identify possible signs of bowel disease at an early stage. This test is called a Faecal Immunochemical Test, which is a stool test designed to identify possible signs of bowel disease or rule out disease and will help patients to have better outcomes.

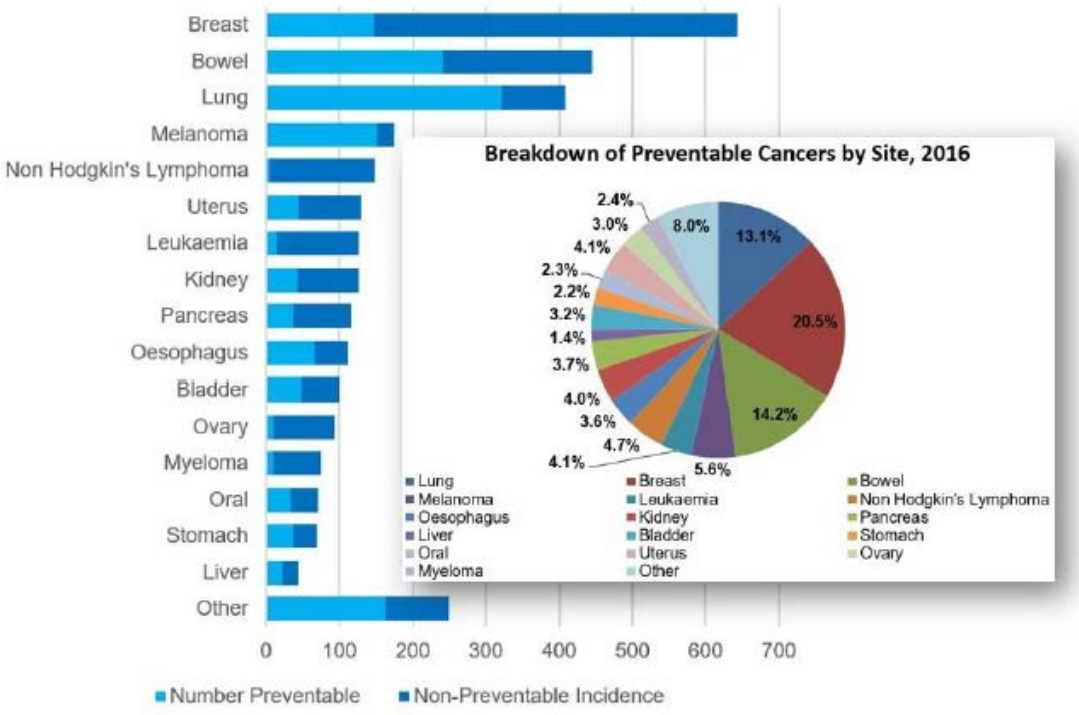
We have also been working on new cancer pathways for patients referred into lung cancer and prostate pathways. This is to reassure patients faster if they have not got cancer, reducing anxiety, as well as helping to diagnose cancer earlier in patients to ensure they receive faster treatment.

Further information about our Cancer performance results can be found on page 41.

Breakdown of Preventable Cancer in Derby



Breakdown of Preventable Cancer in Derbyshire



Diabetes

"One in 15 people in the UK has diabetes,
including one million people who have Type 2...
...but haven't been diagnosed."

Supporting Type 2 Diabetics

Supporting patients with Type 2 diabetes to manage their condition well continues to be a priority in Derbyshire. Our X-PERT Type 2 diabetes structured education programme delivery is now in its third year across NHS Erewash CCG and NHS Southern Derbyshire CCG.

The six-week courses are held in the form of group sessions, organised to meet referral demand from particular areas. The programme is complemented with goal setting, to help individuals work towards their personal targets (e.g. reduce blood pressure, cholesterol and blood glucose levels, reduce their weight, Body Mass Index (BMI) or manage any associated complications).

From April 2018 to February 2019 a total of 781 new patients in Southern Derbyshire has been referred to the XPERT programme, whilst Erewash saw 136 new patient referrals.

The programme is continually being updated in line with national guidance and evidence base, to support individuals to best manage their lifestyle choices and consequently improve their diabetes condition.

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

Preventing the Onset of Type 2 Diabetes

In Derbyshire, we are in the third year of rolling out the NHS Diabetes Prevention Programme; a national programme led by NHS England, Public Health England and Diabetes UK. The Derbyshire Sustainability and Transformation Plan was identified as one of the pilot sites and has been running the 'Healthier 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.

From July 2018 to February 2019 there were 1,048 referrals to the prevention programme, which converted into 870 initial assessments, of which:

- 44% were male and 61% were aged less than 70 years;
- 5% were black, Asian, mixed or other ethnicity;
- 13% were from the most deprived quintile compared to 21% from the least deprived; and
- 16% are of normal weight (BMI 18–24.9), 33% overweight (BMI 25–29.9) and 50% obese (BMI 30).

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

Engaging Different Communities

Diabetes is particularly prevalent in South Asian communities and recognising the diverse population in Derby city we worked closely with our inner city practices (Peartree Medical Centre, Derby Family Medical Centre, St. Thomas Road Surgery and Lister House Surgery) to encourage take up of the National Diabetes Prevention Programme 'Healthier You' structured education programme by the local South Asian diabetic community.

During Diabetes Prevention Week, we commissioned Diabetes charity Silverstar to carry out some targeted engagement work in the Normanton area of Derby city (see picture, right) and Chesterfield area of the county.

Their presence was promoted through local and social media and patients were able to have their risk assessed, and if high went on to have a blood test done to check whether they were pre-diabetic. If their test results showed they were, patients were signposted to their GP practice and encouraged to attend the Healthier You course to reduce their risk of going on to develop the disease.

Over the course of the week 255 people in Derbyshire had their diabetes risk assessed at the roadshows (158 in Normanton and 97 in Chesterfield). 76 people were identified as being at high risk of diabetes following point of care HbA1c blood test (59 in Normanton and 17 in Chesterfield).

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. We have commissioned the Cambridge Diabetes Education programme, an online education resource which clinicians from all disciplines and grades from across all providers can access to improve their knowledge and skills in diabetes.

Musculoskeletal Medicine

Musculoskeletal (MSK) Medicine includes over 200 different conditions affecting joints, bones, muscles and soft tissues, as well as back and neck pain. MSK services also deal with shoulder, elbow, wrist, knee, ankle and foot problems. MSK conditions can be a major burden on individuals.

First Contact Practitioner

As part of the NHS England national mandate on High Impact Interventions issued in June 2018 to all Sustainability and Transformation Partnerships (STP) to support the Elective Care Transformation Plan, each STP is required to implement a pilot for a First Contact Practitioner (FCP) service. FCPs are qualified Physiotherapists who are placed within Primary Care at the beginning of a patient pathway, providing an alternative to an appointment with a GP. By being part of the GP team, the FCP enhances the quality of care provided by the Primary Care workforce through better MSK management and aims to reduce referrals into Secondary Care.

Derbyshire CCGs launched the FCP service pilot in six GP practices in the Long Eaton area of Erewash in November 2018.

When a patient calls their GP practice requiring an urgent appointment relating to a MSK condition, the Clinical Navigator (Receptionist) will offer an appointment with the FCP as an alternative option to a GP appointment. The Physiotherapist will assess the patient, provide advice and guidance and refer to the most appropriate service if they require additional treatment.

This pilot involves a shift from the traditional provision of community or hospital-based therapy services to physiotherapists being part of the frontline general practice team. They can be accessed directly by self-referral or staff in GP practices can direct patients to them.

It is estimated that 10% of all patients currently seen by a GP are related to an MSK condition. The implementation of the FCP service aims to reduce GP workload and ensure better health outcomes for patients. It offers appropriate patients rapid-access to a fully trained MSK practitioner and ensures that patients are provided expert assessment, individual advice and guidance and referral to appropriate treatment.

First Contact Practitioner Patient Quotes:

"Very informative. Would have preferred to be seen here first rather than by GP as better information was given"

"Really pleased with the service I received. Went online and filled out the non-urgent clinical advice form. Had a call a day after and appointment day after. Helpful, excellent service"

"Fantastic service. I was able to see someone directly linked to my pain. This not only ensured I got the best service but also that I was not taking a GP appointment that could be used by someone else"

"The physio was very helpful and taught me things I didn't know that I was doing that was making me feel at ease. She was very warm, knowledgeable and made me feel at ease. I would definitely come again if needing a physio appointment. It's nice that is local"

"My visit today has helped me with regaining my strength and confidence following a slipped disc."

"Brilliant to get these problems nipped in the bud by an MSK specialist"

"Prefer to see a physio quickly on the NHS rather than see a GP or go private"

**shared by service provider, DCHS and taken from their patient survey*

Between December 2018 and February 2019, a total of 299[1] patients have accessed the FCP service pilot. Evaluating the pilot (including reviewing health outcomes of the patients accessing the service) and consideration of the expansion across Derbyshire will form part of the CCG work plan for 2019/20.

MSK Clinical Assessment and Treatment Service

Historically MSK triage services have been commissioned separately which has led to inequitable service provision and inconsistent patient pathways across the county. As a consequence, Derbyshire spends considerably more on MSK elective procedures than other comparative CCGs but with poorer patient outcomes:

- 8.7% of CCG allocation spent on activity is directly attributable to MSK services;
- activity and spend excludes MSK activity/expenditure in Primary Care (30% of all GP appointments), prescribing, A&E/Minor Injuries Unit activity, 111/Out of Hours activity, podiatry, medical non elective admissions with a MSK contributing condition etc.; and
- there is a potential (RightCare data) opportunity to reduce spend on MSK by £4m+ per year (including £3m+ on elective activity).

For 2017/2018 NHS England requested that all CCGs implement a triage service for MSK, where all referrals that would usually be sent to hospital for a MSK-related condition, or diagnostics for an MSK-related condition, would be reviewed by a clinical MSK specialist to see if the patient could be treated elsewhere.

In Derbyshire, this is the MSK Clinical Assessment and Treatment Service (CATS) and has been commissioned across the whole of Derbyshire. Since implementation in 2018, MSK CATS has implemented:

- a consistent and more clinically effective MSK service across Derbyshire CCGs – incorporating both specialist MSK services and general outpatient physiotherapy; and
- an MSK referral management service which requires triage of all referrals by an appropriate trained clinician.

The outcomes of the service are to:

- improve health outcomes for patients with a MSK condition;
- ensure that GPs and other clinicians are supported to make the right choice and access the most appropriate services to manage the patients' MSK condition;
- ensure that all patients have equity of access to MSK services and are supported to make an informed choice on their treatment options; and
- optimise the number of patients who are referred to Secondary Care when there may be more appropriate clinical options available.

<u>Numbers accessing the service</u>

Between July 2018 and January 2019, over 9,000 referrals were reviewed by MSK CATS.

As a result of implementing MSK CATS, from October 2018 to March 2019 (compared to the same time period last year) our providers have seen a significant reduction in first outpatient appointments this year, 15% across all our providers. Our two main acute providers saw a 14%

[1] Taken from NHSE data submissions for Dec 18/Jan 19/Feb 19

reduction at University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and 16% reduction at Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) as detailed in the table below.

Total first outpatient Attendances	Oct-Mar 2017-18	Oct-Mar 2018-19	% change
All Providers	29093	24792	-15%
CRHFT	4643	3917	-16%
UHDB	14979	12827	-14%

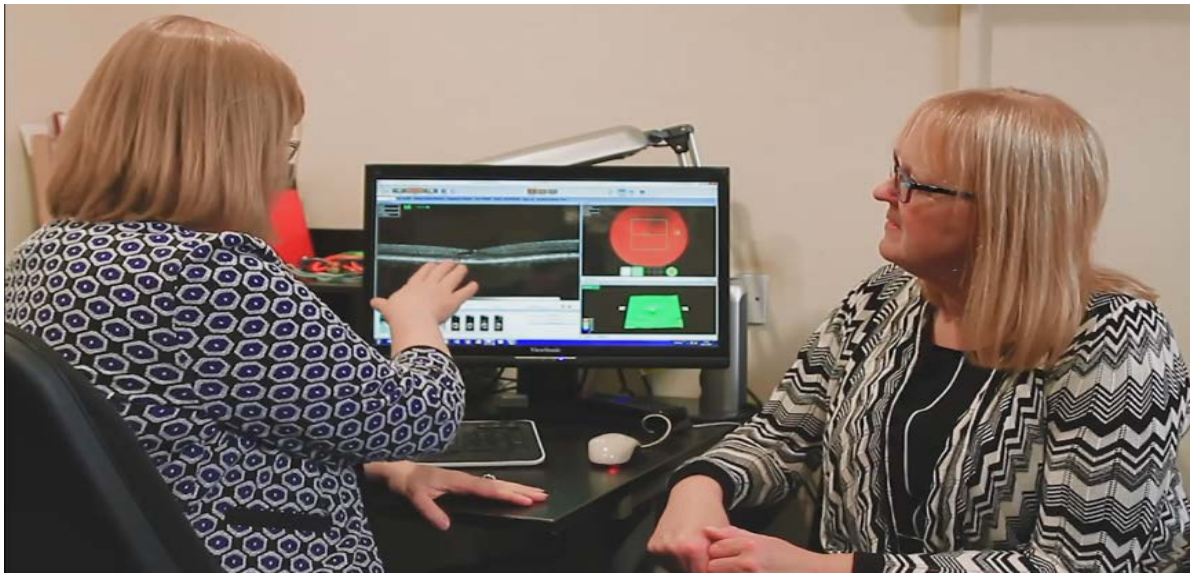
The service not only ensures that patients referred into secondary care are appropriate, but also ensures that patients receive the right treatment, at the right place, at the right time.

Teleophthalmology

Teleophthalmology enables Optometrists who identify uncertain pathology to email, via a secure NHS.net e-mail account, scans, photos and/or videos to a Secondary Care Consultant Ophthalmologist for review and advice. Requests for advice only, without the necessity to send images, can also be made. This scheme applies to referrals from Optometrists only. The service is now operating Derbyshire-wide and roll out to the north of Derbyshire commenced in October 2018.

Work has been ongoing to further optimise the service by:

- education events for community Optometrists/Secondary Care Consultants;
- creation of a video of the Teleophthalmology process and FAQs; and
- recruitment of three Training Facilitators to provide support to optometry practices in getting set up on the service.



Watch the film at: https://www.youtube.com/watch?v=xESa7WaOaIU

Patient experience data has revealed that patients are happy with the service as they receive more care closer to the patients home, it reduces worry/anxiety by providing swift feedback on their condition and there is a reduction in the number of patient contacts.

There are also benefits to Derbyshire's local healthcare system, which include a reduction in patients visiting hospital and its associated secondary cost. As a direct consequence, there has also been an improved attainment of the Referral to Treatment target as Secondary Care capacity is released for patients who require consultant support.

Numbers accessing the service

Currently the Royal Derby Hospital receives an average of 49 Teleophthalmology referrals per month and of those patients an average of 62% avoid an outpatient appointment referral.

Teleophthalmology has been operating at Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) since October 2018. CRHFT currently receive an average of 10 referrals per month and of those patients an average of 58% avoid an outpatient appointment referral.

Feedback received from one of our community optometrists:

"The service is an asset to us as practice to be able to provide a service to patients and also support our professional capacity and confidence."

Ambulance and 111 Commissioning

Reduction in Conveyance

East Midlands Ambulance Service NHS Trust (EMAS) have been working with local commissioners to support a reduction in the number of avoidable conveyances to the Emergency Department (ED). Within Derbyshire the EMAS division have been working closely with Place colleagues to identify pathways to support reducing avoidable conveyance. Commissioners in Derbyshire supported the introduction of a clinical navigator working at the acute trusts which also facilitated reductions in conveyance by encouraging crews to identify alternatives to conveyance.

Paramedic rotation scheme

EMAS Derbyshire and Lincolnshire Divisions have been part of phase two of a national pilot supported by Health Education England whereby specialist paramedics work with GP colleagues and integrated community teams to support the care of patients within the community and avoid the need to convey patients to the ED, whilst still employed by the ambulance service.

Performance standards

In 2018 EMAS delivered the national response time standards for Category 1 90th centile and Category 4 90th centile, the standards for which are 15 minutes and three hours respectively.

Category 3 ambulance validation

DHU 111 have been completing clinical validation of Category 3 ambulance dispositions throughout the year, whereby instead of an ambulance being auto-dispatched to EMAS, DHU 111 clinicians call the patient to ensure the most appropriate outcome is reached. Approximately 70% of validated calls with Category 3 dispositions are given a different outcome.

NHS 111 Online

During 2018 NHS 111 Online was launched, meaning that people have access to a 111 service via a website as well as the usual process of calling 111. Much progress has been made and continues to be made to ensure that the patients' journey is appropriate to their needs regardless of whether they choose the telephony or online route.

Mental Health

Achieving parity of esteem for people with mental health needs remains one of the core priorities to the NHS and is written into the Health and Social Care Act 2012, the Mental Health Five Year Forward View and NHS Long Term Plan. This means that we are committed to giving equal attention to services which support people with a mental health issue, as well as those aimed at supporting physical health.

A Joint Severe Mental Illness and Physical Group was formed to develop plans to improve the health of people with mental health problems and we are working with mental health service receivers to find out what is important to them in terms of finding ways to improve their health.

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 £105bn 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 Therapies (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. Derbyshire CCGs are exceeding the target of over 50% of people being seen within two weeks of the referral – which will rise to 60% by 2020/21.

CCG Name	Q4 2018/19 (Target = 50%)
NHS Erewash CCG	100%
NHS Hardwick CCG	100%
NHS North Derbyshire CCG	100%
NHS Southern Derbyshire CCG	83%

The national 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 Mental Health Five Year Forward View 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 being treated in IAPT services and this is set to rise to 30% in 2023. By January 2019 the CCG access rates were as follows:

CCG Name	By Jan 2019 (Target = 25%)
NHS Erewash CCG	28%
NHS Hardwick CCG	23%
NHS North Derbyshire CCG	26%
NHS Southern Derbyshire CCG	23%

This figure exceeded our set target for the year and furthermore, the CCG has been recognised nationally as a 'high performer'. 24.5% of patients Derbyshire-wide accessed the service. A further target is for 50% of patients who enter therapy to move into a 'recovery' phase. By January 2019 the CCG had again exceeded the target:

CCG Name	By Jan 2019 (Target = 50%)
NHS Erewash CCG	53%
NHS Hardwick CCG	57%
NHS North Derbyshire CCG	54%
NHS Southern Derbyshire CCG	55%

Derbyshire patients entered the recovery stage, whilst the Derbyshire-wide figure was 55.2%. The target for EIP is for 50% of patients referred to be seen within two weeks:

CCG Name	Q4 2018/19 (Target = 50%)
NHS Erewash CCG	100%
NHS Hardwick CCG	100%
NHS North Derbyshire CCG	100%
NHS Southern Derbyshire CCG	83%
Derbyshire average	95.75%

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 with an increased expenditure on mental health care in line with the CCG's uplift and investing in children and young people's mental health services.

Jointly commissioned with Derbyshire County Council, we launched new services including a Recovery and Peer Support service and Community Advocacy services.

During 2018/19, the CCGs, Local Authorities and service providers continued to work together on a Mental Health Transformational Plan on behalf of Joined Up Care Derbyshire. This focuses on four main programme areas where we wish to make progress: Primary Care mental health, responsive community mental health and in-patient services, dementia and delirium, complex case and forensic services. There are project groups working in all of the four areas concentrating on improved care pathways both in Primary and Secondary Care.

The Derbyshire 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 at Chesterfield Royal Hospital NHS Foundation Trust 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.

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 a reduction in the use of the Police holding power – the Mental Health Act section 136.

Perinatal mental health services have been expanded to increase access and consistency of the offer across the county and joint clinics with maternity services have been successful.

Our memory assessment service has increased access by 30% this year and diagnosis rates have increased and are consistently and significantly, higher than the national indicator and national average, which is around 68%:

CCG Name	Performance against national average
NHS Erewash CCG	81%
NHS Hardwick CCG	77%
NHS North Derbyshire CCG	72%
NHS Southern Derbyshire CCG	69%
England	68%

NHS Hardwick and North Derbyshire CCGs are in the highest performing quartile, whilst our other two Derbyshire CCGs are in the intermediate range.

We have launched increased access to post diagnostic support, education and training (living well programme) in the north of the county and will be doing so in the south of the county from April 2019.

We are also extending individual placement support schemes across Derbyshire to enable people with mental health problems to gain access to employment, training and/or meaningful activity that will have a positive effect on mental health and wellbeing.

Support for people with Learning Disabilities and/or Autism

Over the last three years the CCGs have been working to deliver the nationally defined Transforming Care Programme which aims to reduce the reliance on inpatient care for people with a Learning Disability and/or Autism within mental health or challenging behaviour units. At the start of the Transforming Care Programme, Derbyshire (City and County) were providing hospital inpatient care for 60 individuals, of which 31 were receiving care within a secure hospital. As at the end of March we had reduced this to 43 individuals of which 20 are receiving care within a secure hospital and we are still working hard to ensure that we are protecting the human rights of all individuals by ensuring that people are receiving the care and support they need as close to home as possible in the least restrictive setting.

Since the programme began in 2016 we have monitored and supported 213 discharges. Many of these discharges were from acute mental health hospital beds for whom health and social care colleagues arranged additional support and care to help individuals to stay safe and well when they returned home. Some of the people we supported had been in hospital for a long time within secure or locked rehabilitation environments and we worked with them to plan and arrange the specialist care, accommodation and support they identified they needed to help them move into their new home.

As the national programme comes to an end, Derbyshire is seeking to continue to embed the changes, including continuation of care and treatment reviews, and will maintain a focus on improving mental health service responses for people with Learning Disabilities/Autism Spectrum Disorders.

Derbyshire was an early adopter of the national Learning Disability Mortality Review Programme which aims to review all deaths of people with a learning disability to identify any health inequalities and areas for service development and improvement. During 2018/19, 28 reviews were completed and the findings reviewed by our local mortality panels and shared with all service providers across Derbyshire.

Integrating Patient Care

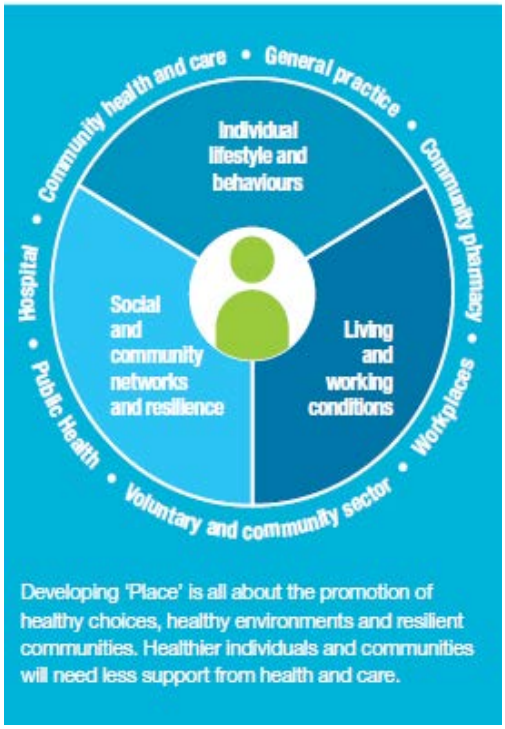
Integrated care means the care someone receives should be:

- **Person-centred** – the priority is to meet the needs of the person, not just delivering a service; and
- **Coordinated** – when 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 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.

Place can be described by the diagram opposite.



Place Development

Central to our strategy in Derbyshire is the development of Place. 'Place' can be defined as empowering people to live a healthy life for as long as possible through joining up health, care and community support for people and local communities. It is an alliance of commissioners, community services providers, Local Authority, Primary Care, the voluntary sector and other community stakeholders that collaborate to meet the needs of a defined population.

There are eight Place Alliances across Derbyshire:

- Amber Valley (population 133,959)
- Bolsover and North East Derbyshire (population 174,014)
- Chesterfield (population 112,712)
- Derby City (population 334,167)
- Derbyshire Dales (population 80,243)
- Erewash (population 97,545)
- High Peak (population 60,430)
- South Derbyshire (population 54,953)

This structure of eight Place Alliances was agreed by the Sustainability and Transformation Partnership (STP) Place Board and CCG Governing Bodies as it:

- is broadly coterminous with District/Borough Councils;
- is not at odds with any working practices of partner organisations;
- broadly reflects acute flows, to ensure joint reactive care service delivery is feasible at Place-level;
- gives providers sufficient scale to reflect service planning and delivery;
- takes into account the preferences of individual Places; and
- not all Place Alliances are co-terminus with existing CCG boundaries:
    - Derbyshire Dales Place Alliance spans NHS North Derbyshire CCG and NHS Southern Derbyshire CCG boundaries;
    - Bolsover and North East Derbyshire Place Alliance spans NHS Hardwick CCG and NHS North Derbyshire CCG boundaries.

A merger of the CCGs will support more effective decision making and operational transformation in these areas.

Roles and Responsibilities of Place Alliances

Place Alliances are responsible for collaborating to develop services and initiatives to best meet the needs of their population within available resources. They will shift the focus of health and care services to enable citizens to take responsibility to maximise their health and wellbeing.

They are being developed to support the following commissioning functions:

- understanding the Place population health and care needs;
- jointly reviewing local performance and outcomes, driving improvement in these where needed;
- ensuring equitable services for the Place population;
- using information and local knowledge to drive service change;
- understanding Place population resource usage and ensuring this is used as effectively as possible;
- holding each other to account for service development and delivery; and
- being active participants in the development of clinical models, pathways and initiatives.

They will also develop the following provider functions:

- developing robust links between services at a local level;
- co-ordination and delivery of high quality care and support in the community and in people's homes, working across organisational boundaries;
- planned and case managed care for people at high risk of hospital and care home admission;
- providing targeted support for people with frailty and other long-term conditions;
- helping people remain in good health through screening and provision of advice and other forms of support; and
- enabling people to die in the place of their choice.

The Place Alliances are overseen by the Derbyshire STP Place Development Board which has set the main priority in 2018/19 for Place as better supporting the frail, elderly population by supporting them to remain independent and in control.

Place Achievements

The Leading across Boundaries organisational development programme has been completed – relationships across partners have continued to develop through meetings and development sessions. The range of partners involved has increased and will support work around a broader agenda for integrated care.

Places have developed their own plans based on population needs.

Place Alliances have focused on supporting people to stay well for longer through a consistent set of work areas which include frailty, falls, care homes and supporting people to die comfortably:

- Derbyshire-wide frailty model has been launched;
- falls prevention programme for High Peak, South Derbyshire and Chesterfield has been introduced;
- new model of Primary and Community Care Support for Care Homes is being developed;
- focus on non-elective admissions has had a positive impact, reducing the number of admissions.

Community multi-disciplinary teams are held across the District and are proving very successful.

Integrated Care Teams continue to be enhanced through our 'Place' based working approach.

Place has provided the opportunity to network across partner organisations. One such programme is Partners Observing Workplace Roles which has seen partners spending time on observational shifts with EMAS.

Care Planning/Information Sharing – Place Alliances are ensuring that care plans are up to date and current, standardised coding is used across providers where possible. The aim is to continuously improve communication and access to information.

Medicines Management

Derbyshire's Medicines Management Team works with member practices and local providers to improve the safety and cost effectiveness of prescribing and is working to minimise harm from prescribing and maximise health improvement.

Antimicrobial Stewardship

The aim was to ensure that we would meet the national Quality Premium (QP) targets for Antimicrobial Stewardship in Primary Care across Erewash CCG for 2018/19, the targets included:

1. **Target for, total antibiotic items prescribed, of ≤ 1.161 items** (per 'Specific therapeutic group age-sex prescribing unit' (STAR PU)) *(with an additional target of <0.965 items where possible)*;
2. **Target of ≤ 10% of cephalosporins, quinolones and co-amoxiclav prescribed** (out of total number of antibiotic items prescribed);
3. **30% 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 antibiotic prescribing reports 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. Practice pharmacists discussed these results with their GP practices and advised on resources e.g. patient information leaflets 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.

Local GPs had written 'advice and tips' on 'Reducing Unnecessary Antibiotic Prescribing' for other GPs, by explaining how they reduced their antibiotic prescribing; how they overcame problems; and the resultant advantages for their practices. Furthermore, one GP presented to other GPs on this topic at a local education event. Thus, 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.

We presented at a large education event for GPs (in September 2017) outlining the importance of meeting these targets and explaining that reducing the use of trimethoprim prescribing should improve the management of urinary tract infections, which should help to reduce the risk of more serious infections developing e.g. sepsis.

Interim results (12 months, from March 18 to Feb 19) show that the targets have been achieved for NHS Erewash CCG

National Quality Premium Targets	NHS Erewash CCG Results from Mar 18 to Feb 19
Target 1. Total antibiotic items prescribed **≤ 1.161** items / *STAR PU)* Additional new national target of **≤ 0.965** items/STARPU	**0.819** *antibiotic items/STAR PU*
Target 2. **≤ 10%** of cephalosporins, quinolones and co-amoxiclav prescribed (*out of total no. of antibiotic items prescribed*)	**7.9%.** *Note: This national target has now been removed. However, we are continuing to monitor this target locally*
Target 3. Trimethoprim items prescribed to patients aged ≥70 years *Note:* **30% reduction (or greater)** in number of trimethoprim items prescribed to patients aged ≥70 years (*based on data, June 15–May 16).*	**58%** reduction achieved

The Lead Antimicrobial Pharmacist was invited to make a presentation at The Pharmacy Show in Birmingham in October 2018, in order to outline the work that is being done to reduce the risk of Gram negative bacteraemias and reduce unnecessary antimicrobial prescribing. 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.

In order to help achieve the QP for reducing Trimethoprim use and E.coli Bacteraemias, we launched the 'To Dip or Not to Dip' project work across Derbyshire, which aimed to improve the diagnosis and management of urine infections in Care Homes. This involved the production and sharing of resources with both Care Homes and GP practices via education events, newsletters and the CCG Medicines Management team. Relevant resources have been uploaded onto the Derbyshire Medicines Management and Care Home Companion websites.

Derbyshire Medicines Management QIPP Delivery in Primary Care 2018/19

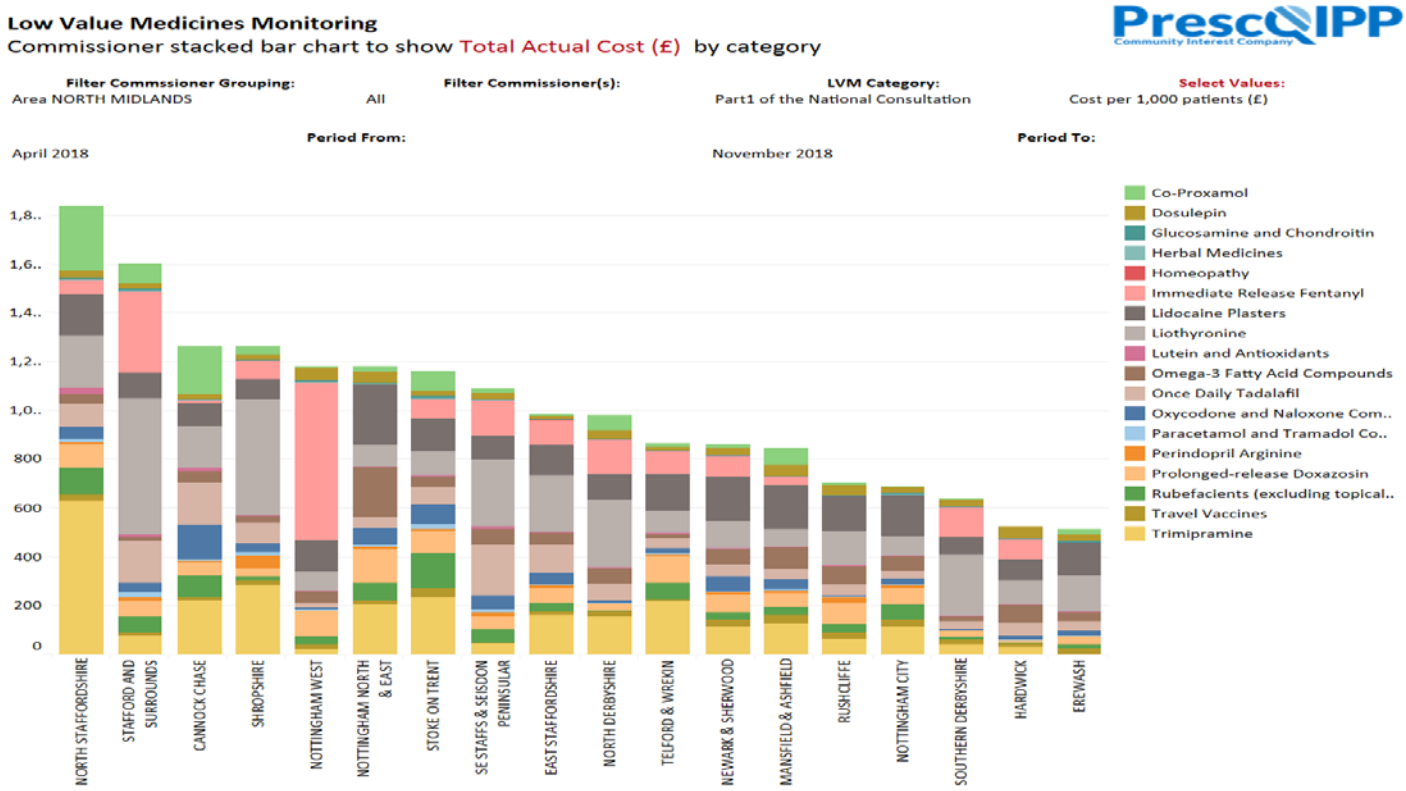
Derbyshire's Medicines Management Team set out to achieve an ambitious QIPP plan of over £13m, which equates to a saving of 9% from the £145m Primary Care prescribing budget. This was made up of a large number of schemes including:

- medication reviews, switches and stopping drugs (including items which should not be routinely prescribed);
- repeat prescribing initiatives;
- nutrition projects;
- gluten free;
- self-care;
- rebates;
- Optimise Rx.

The Medicines Management Team is on track to deliver the QIPP plan. This was achieved through a mixture of clinical engagement, strong leadership, robust decision making, prioritisation of opportunities and a practice-facing team supporting implementation.

An example of how the Medicines Management Team operates can be demonstrated by looking at Low Value Medicines. Guidance was published by NHS England in November 2017 for items which should not be routinely prescribed: https://www.england.nhs.uk/medicines/items-which-should-not-be-routinely-prescribed/

All medicines listed in the guidance were reconsidered at the Joint Area Prescribing Committee (JAPC) and classified according to the traffic light scheme. Guidance was then reviewed at Prescribing Groups, JAPC QIPP Working Group and liaising with providers as needed. Prescribing Leads discussed the guidance at GP forums and our practice-facing team were utilised to review existing prescribing at practice-level. This has resulted in Derbyshire having some of the lowest prescribing in the North Midlands area, as illustrated in the following table:



Derbyshire's prescribing spend prior to April 2018 was already lower than the regional and England average, as detailed in the following table:

	NIC[2]/ASTRO PU[3] (standardised)
	January–March 2018
NHS Erewash CCG	9.175
NHS Hardwick CCG	10.583
NHS North Derbyshire CCG	9.856
NHS Southern Derbyshire CCG	9.176
STP Derbyshire	9.523
Midlands and East of England	10.244
England	10.190

As a result of robust medicines management, Derbyshire's prescribing spend is decreasing at a faster rate than the England average, as detailed in the following table:

Growth Year to Date – April 2018–November 2018

	2017/18	2018/19
Commissioner	**% growth**	**% growth**
NHS Erewash CCG	- 2.98%	- 4.60%
NHS Hardwick CCG	- 4.04%	- 5.58%
NHS North Derbyshire CCG	- 2.06%	- 3.92%
NHS Southern Derbyshire CCG	- 2.00%	- 4.97%
Derbyshire Average	- 2.35%	- 4.69%
England Average	- 0.91%	- 3.67%

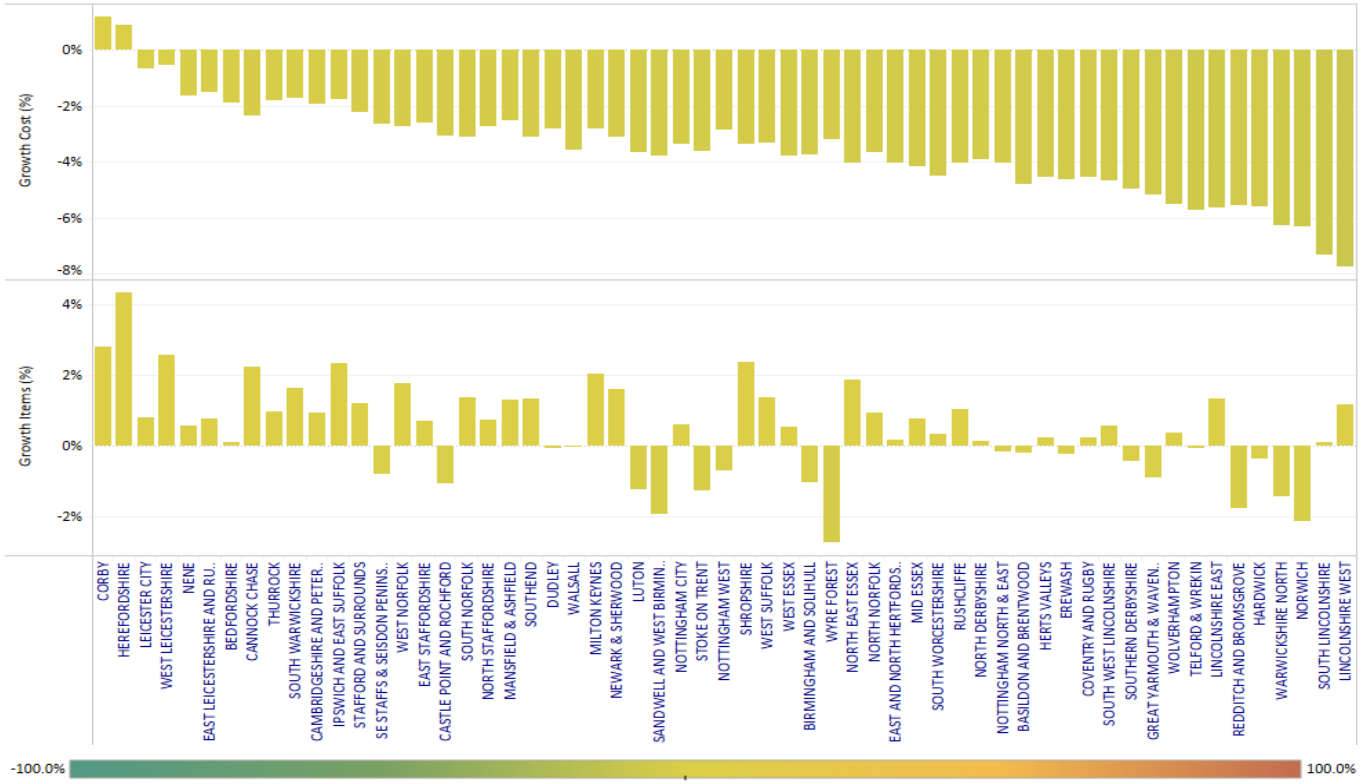
[2] Net Ingredient Cost (NIC)
[3] Age, Sex, and Temporary Resident Originated Prescribing Unit (ASTRO PU) - Weighted population measure

Financial Summary Report Commissioner & Practice

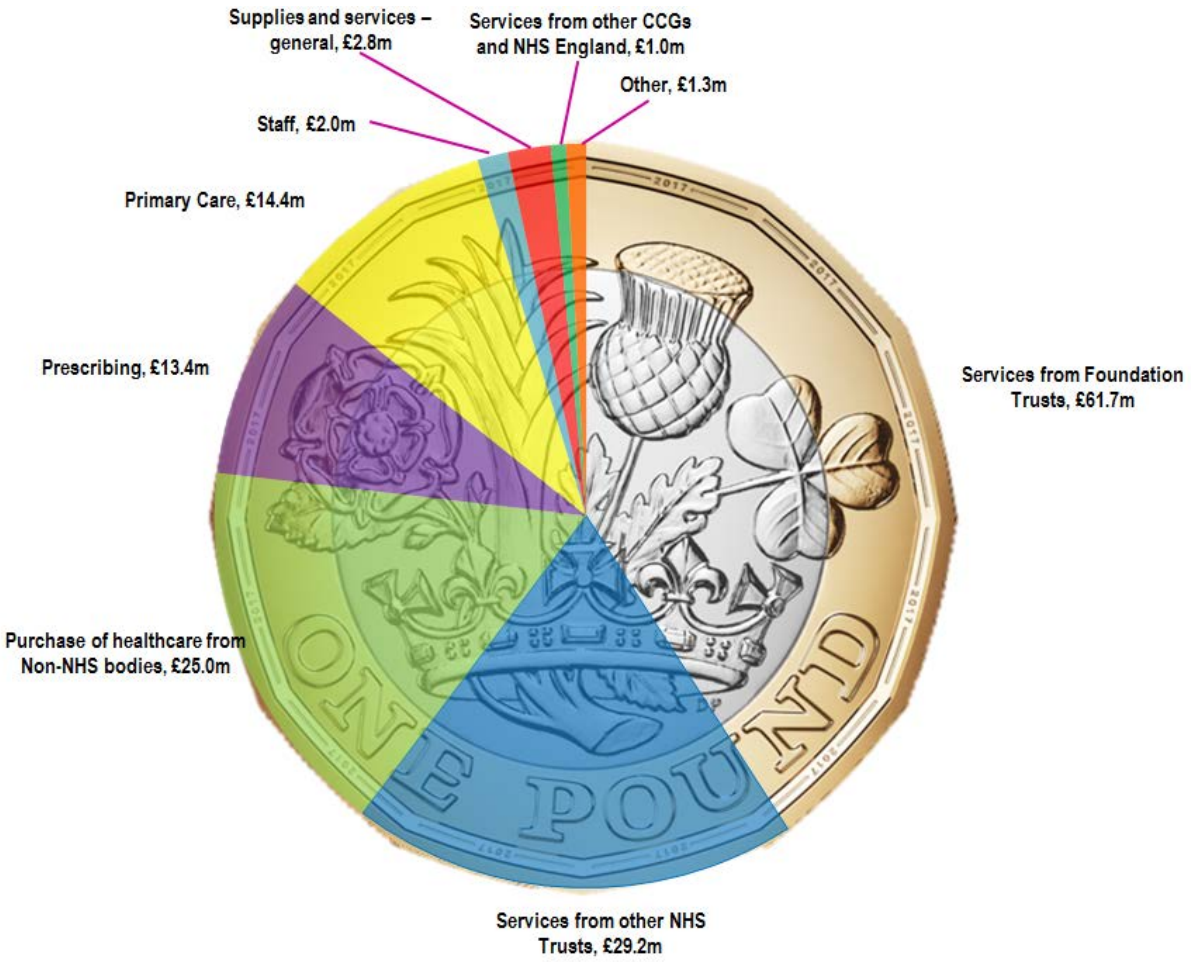
Commissioner growth charts current year to date v previous year to date

Filter Commissioner Grouping: **Select Values:**

Region MIDLANDS AND EAST Totals



Addressing our Financial Challenge during 2018/19



Gross Operating Costs 2018/19 Category of Expenditure	Total Spend £m	Prior Year £m
Services from Foundation Trusts	61.7	61.8
Services from other NHS Trusts	29.2	27.7
Purchase of healthcare from Non-NHS bodies	25.0	23.1
Prescribing	13.4	13.6
Primary Care	14.4	14.4
Staff	2.0	2.5
Supplies and services – general	2.8	2.0
Services from other CCGs and NHS England	1.0	1.2
Other	1.3	1.6
TOTAL	**150.86**	**148.01**

Financial Position

NHS Erewash CCG received two allocations for the financial year 2018/19 – the first for the commissioning of healthcare (programme) and the other for their running costs (administration). These allocations came in the form of Parliamentary Funding from NHS England and by March 2019 totalled £147.8m and £2.1m respectively.

In 2018/2019 any CCG with an agreed deficit control total is eligible to access the Commissioner Sustainability Fund. This is available to CCGs on a quarterly basis if they remain on plan to deliver their deficit control total and by the end of the year the funding received will be equivalent to the deficit control total. The CCG had agreed a £2.5m deficit control total with NHS England for 2018/19 which it has delivered and therefore received £2.5m Commissioner Sustainability Fund allowing the CCG to report an in-year break even position.

NHS Erewash CCG has been able to manage cash effectively during the year, maintaining minimum balances at the end of each month and drawing funds from the treasury on a monthly basis. In doing so we have always been able to pay our staff and creditors on time and have complied with the requirements of the Better Payments Practice Code and Prompt Payment Code.

There have been no instances where circumstances outside the control of the CCG (such as interest rate changes) have impacted on the CCG's ability to deliver our financial obligations. Neither do we foresee circumstances where such events could impact in the future.

The financial outlook for future years is an increasingly challenging one for the Derbyshire CCGs. The efficiency requirement for the 2019/20 year is at 4.3% or £69.5m and is a result of both low growth in funding and also the impact of the shortfall in delivering recurrent efficiencies in 2018/19. Detailed plans for 2019/20 have been submitted to NHS England outlining how the CCG will deliver the financial targets and manage in-year risk.

Allocations for the 2019/20 year have been confirmed, totalling £1,600.0m for programme costs and £22.5m for running costs. Our financial target for the 2019/20 is a £29m deficit but the CCG will be able to report a break-even position after the receipt of £29m Commissioner Sustainability Fund.

Statement as to the Disclosure to Auditors

In the case of each of the persons who are members at the time the report is approved:

- so far as the member is aware, there is no relevant audit information of which the NHS body's auditor is unaware; and
- he has taken all the steps that they ought to have taken as a member in order to make himself aware of any relevant audit information and to establish that the entity's auditor is aware of that information.

Performance Analysis

One of the key areas of focus outlined in the CCG's Operational Plan for 2018/19 was to maintain system resilience and performance whilst meeting all constitutional expectations. The constitutional expectations are those performance standards outlined in the NHS Constitution. These include measures such as Referral to Treatment times, Accident and Emergency waiting times and Cancer waiting time standards.

The CCG Governing Body receives a performance report against these measures on a monthly basis. The Governing Body of the CCG monitors and gains more detailed assurance against the CCG's performance metrics. As part of the development of the Sustainability and Transformation Plan, 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 unvalidated, 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 Sustainability and Transformation Plan 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. The individual projects making up this transformation programme have all 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 seven days a week;
- **prevention** – services are more accessible locally and to patients at risk of their condition worsening without that local support; and
- **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 Accident and Emergency 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.

2018/19 Performance Summary

The overall performance of the CCG in 2018/19 shows that we have delivered 16 of the 24 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 following table shows how we have performed against our targets for the year 2018/19:

Indicator		Standard	CCG	County Wide
Referral to Treatment	18 weeks Referral to Treatment – Elective Surgery	92%	**92.0%**	**90.9%**
	18 weeks Referral to Treatment - 52+ week wait	0	**21**	**167**
Diagnostic waits	Diagnostic test waiting more than 6 weeks from referral	1%	**1.04%**	**2.07%**
A&E waits	A&E <4 hours	95%	**86.5%**	**89.8%**
Cancer waits - <14 days	Urgent GP referral to 1st outpatient appointment	93%	**95.4%**	**92.0%**
	Urgent GP referral to 1st outpatient appointment (breast symptoms)	93%	**94.5%**	**92.3%**
Cancer waits - <31 days	Diagnosis to first definitive treatment for all cancers	96%	**96.3%**	**96.5%**
	Subsequent surgery within 31 days of decision to treat.	94%	**88.6%**	**92.7%**
	Subsequent drugs treatment within 31 days of decision to treat.	98%	**98.2%**	**99.3%**
	Subsequent radiotherapy treatment within 31 days of decision to treat.	94%	**97.2%**	**95.3%**
Cancer waits - <62 days	Urgent GP referral to first definitive treatment for cancer	85%	**79.4%**	**79.4%**
	NHS screening service to first definitive treatment for all cancers	90%	**90.4%**	**88.8%**
	104+ day wait for first treatment	0	**13**	**162**
Mental Health	CPA 7 days follow up	95%	**95.8%**	**96.2%**
	IAPT Access	15%	**28.59%**	**25.2%**
	IAPT Recovery	50%	**55.5%**	**56.1%**
	IAPT Waiting times (6 weeks)	75%	**90.2%**	**86.0%**
	IAPT Waiting times (18 weeks)	95%	**99.9%**	**99.9%**
	Early Intervention in Psychosis – Completed	50%	**75.0%**	**86.3%**
	Early Intervention in Psychosis – wait <2weeks	50%	**73.3%**	**86.3%**
	Dementia Diagnosis	67%	**81.8%**	**71.5%**
Infection control	C. Difficile	15	**14**	**224**
	MRSA	0	**0**	**9**
Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	**4**	**77**

2018/2019 Performance Exceptions

18 weeks Referral to Treatment – 52+ weeks wait

There were 21 patients who waited for more than 52 weeks for their treatment during 2018/19. The first few months of the year saw the effect of a request from NHS England to cancel all non-urgent elective surgery to support the Emergency Department during winter pressures in 2017/18. The CCG is provided with monthly reports for those patients who have waited for more than 40 weeks for their treatment and breach reports are provided to ensure there is no harm to the patients.

Accident and Emergency (A&E) waiting time – proportion with total time in A&E under four hours

The CCG's patients attend both University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and Nottingham University Hospitals NHS Trust (NUH) Emergency Departments.

Attendances have been higher than 2017/18 with a higher level acuity of patient which has been reflected in the high admission rates. The CCG works closely with UHDB, NUH and NHS Improvement (NHSI) to deliver a recovery plan.

Cancer

NHS Erewash CCG achieved six of the nine cancer standards including patients being seen within two weeks of a referral from GP or screening service. The performance was mainly affected by patients attending UHDB and NUH.

Urology and breast cancer referrals have increased significantly from 2017/18 and capacity has been under pressure. At UHDB additional clinics including weekend appointments have been put in place. A weekly performance call takes place between UHDB, the CCG and NHS Improvement with an aim to achieve the 62-day standard. UHDB is expected to deliver this standard in Quarter 2 of 2019/20. The CCG receives case notes for all breaches of the standard and works with UHDB to identify any improvements.

Mixed Sex Accommodation

The NHS has a zero target for mixed sex accommodation breaches. The CCG reported four mixed sex accommodation breaches – these breaches took place at UHDB.

All reported breaches at UHDB 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 award UHDB work to a four 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 NHS England and the CCG's Chief Nursing Officer in 2017/18 to establish the reason for these breaches and to understand the actions undertaken by the Trust to prevent them. In 2018/19 the Trust has been completing its own survey to review the impact upon the person affected and is due to publish the findings. There is no harm to the patient from these breaches.

12 hour Trolley Breaches

The NHS has a zero tolerance of 12 hour trolley waits (12 hours from decision to admission to being moved to a bed). The CCG reported 30 breaches up to the end of Q4 at UHDB.

All reported breaches at the Derby site were as a result of waiting for a Mental Health bed. There were three breaches reported at the Burton site due to extraordinary bed pressures resulting from infection control issues.

All reported breaches are subject to a root cause analysis. The CCG are assured that no harm has been caused by these delays. At Derby these patients are cared for in a bedded area away from the Emergency Department (ED) even though they are still kept on A&E systems. The breaches that occurred at the Burton site were caused when the available bed capacity was reduced due to infection control issues and the decision was made to keep people in ED rather than access beds in closed areas with confirmed norovirus.

Ambulance Response Times

Regional Level

During 2018/19, two of the six national performance standards were met consistently at a total provider level; Category 1 90th centile and Category 4 90th centile. There has been improvement in performance against the Category 1 mean, Category 2 mean and Category 2 90th centile standards during 2018/19, however Category 3 90th centile performance has fluctuated and response times remain longer than the national standard.

The number of operational hours lost due to total hospital handover delays during 2018/19 was an improvement compared to 2017/18; this is made up of a combination of hours lost due to pre hospital handover delays seeing a significant improvement and the hours lost due to post hospital handover delays seeing deterioration. Incident activity during 2018/19 was -0.8% below commissioned plan and on scene response activity was -0.7% below commissioned plan.

Performance EMAS Total	National Standard	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
C1 mean	00:07:00	00:08:38	00:08:06	00:07:15	00:07:41	00:07:34	00:07:26	00:07:37	00:07:51	00:07:43	00:07:40	00:07:39	00:07:29
C1 90th centile	00:15:00	00:15:42	00:14:36	00:12:58	00:13:53	00:13:48	00:13:20	00:13:31	00:13:57	00:13:47	00:13:30	00:13:42	00:13:29
C2 mean	00:18:00	00:31:57	00:30:45	00:31:10	00:33:17	00:31:29	00:32:42	00:29:46	00:31:01	00:31:19	00:30:52	00:30:27	00:26:31
C2 90th centile	00:40:00	01:08:06	01:04:35	01:05:49	01:10:26	01:06:53	01:08:48	01:01:52	01:04:42	01:06:32	01:05:40	01:04:47	00:54:33
C3 90th centile	02:00:00	02:41:18	02:53:55	02:51:48	03:13:58	03:02:22	03:11:45	02:45:50	02:55:19	03:39:17	03:29:50	03:06:17	02:44:40
C4 90th centile	03:00:00	02:01:15	02:42:50	02:09:08	02:29:24	02:47:18	02:27:50	02:16:13	02:45:58	02:50:27	02:21:50	02:50:32	02:53:37

Lost hours to handovers EMAS Total	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19
2017/18 Pre handovers	5,133	5,582	4,678	5,137	4,757	4,905	5,425	5,352	8,251	8,701	7,639	8,431	73,991
2018/19 Pre handovers	5,652	4,237	3,979	5,182	4,366	4,390	4,659	5,495	6,267	7,722	6,345	5,667	63,961
2017/18 Post handovers	1,983	2,097	1,996	1,934	1,977	2,083	2,286	2,259	2,300	2,524	2,375	2,799	26,613
2018/19 Post handovers	2,817	2,900	2,761	2,751	2,565	2,606	2,523	2,465	2,523	2,349	2,510	3,503	32,273
2017/18 Total handovers	5,298	5,788	4,906	5,238	5,008	5,213	5,859	5,713	8,274	8,957	8,045	9,142	77,441
2018/19 Total handovers	6,629	5,364	5,049	6,093	5,200	5,250	5,349	6,057	6,769	7,951	7,033	7,341	74,085

Activity EMAS Total	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19
Incidents Plan	63,654	68,866	67,211	70,619	67,407	65,316	71,490	70,995	74,693	75,144	70,393	77,026	842,814
Incidents Actual	64,476	69,052	66,311	71,435	67,203	67,249	70,135	71,249	76,345	74,666	66,025	72,086	836,232
Variance	*1.3%*	*0.3%*	*-1.3%*	*1.2%*	*-0.3%*	*3.0%*	*-1.9%*	*0.4%*	*2.2%*	*-0.6%*	*-6.2%*	*-6.4%*	*-0.8%*
On Scene Responses Plan	53,982	56,857	54,543	55,923	54,565	53,298	57,065	56,177	59,758	59,984	56,424	60,590	679,166
On Scene Responses Actual	52,772	55,880	53,670	56,778	54,131	53,929	56,559	56,944	60,390	59,888	53,958	59,561	674,460
Variance	*-2.2%*	*-1.7%*	*-1.6%*	*1.5%*	*-0.8%*	*1.2%*	*-0.9%*	*1.4%*	*1.1%*	*-0.2%*	*-4.4%*	*-1.7%*	*-0.7%*

Derbyshire Level

The contractual agreement in place for 2018/19 was that there would be quarterly, county level, performance trajectories from Quarter 2 onwards. Performance for 2018/19 was measured against achievement of these performance trajectories. The Derbyshire division achieved four of the six performance trajectories during Quarter 2, and all six of the performance trajectories during Quarters 3 and 4.

A baseline average pre hospital handover time and an assumed level of on scene activity was used by Operational Health Research (ORH) Ltd to model the performance trajectories. Pre hospital handovers within Derbyshire remained below this baseline and on scene activity was in line with the levels modelled throughout 2018/19.

Performance Derbyshire Division		Category 1		Category 2		Category 3	Category 4
		Average	90th centile	Average	90th centile	90th centile	90th centile
Quarter 2	*Trajectory*	***00:07:43***	***00:15:00***	***00:26:10***	***00:54:36***	***02:50:03***	***04:06:20***
	Actual	00:07:32	00:13:36	00:28:23	00:59:02	02:26:18	02:49:49
Quarter 3	*Trajectory*	***00:07:46***	***00:15:00***	***00:27:04***	***00:55:46***	***02:51:10***	***04:07:56***
	Actual	00:07:42	00:13:29	00:26:57	00:55:28	02:33:45	02:27:27
Quarter 4	*Trajectory*	***00:07:43***	***00:15:00***	***00:25:41***	***00:54:08***	***02:49:41***	***04:05:48***
	Actual	00:07:26	00:13:03	00:25:27	00:51:53	02:37:42	02:34:06

Pre Hospital Handover Time	Derbyshire Baseline	Derbyshire	*Burton Queens Hosp*	*Chesterfield Royal Hosp*	*Macclesfield District General Hospital*	*Royal Derby Hosp*	*Sheffield Northern General Hospital*	*Stepping Hill Hosp*
Quarter Two	00:20:27	00:17:31	*00:19:57*	*00:17:59*	*00:23:16*	*00:16:29*	*00:28:39*	*00:25:41*
Quarter Three	00:21:16	00:18:20	*00:21:17*	*00:19:16*	*00:24:01*	*00:16:27*	*00:26:21*	*00:27:04*
Quarter Four	00:20:35	00:19:06	*00:22:58*	*00:19:10*	*00:23:11*	*00:17:55*	*00:25:24*	*00:25:30*

On Scene Responses - Average per Day	Actuals	Commissioned plan	ORH modelled	Actuals vs Plan (%)	Actuals vs ORH modelled (%)
Quarter Two	364	359	366	1.6%	-0.3%
Quarter Three	385	387	384	-0.6%	0.1%
Quarter Four	389	413	388	-5.7%	0.3%

NHS 111 Performance

During the first half of 2018/19 Derbyshire Health United (DHU) 111 underachieved against a number of the contractual Key Performance Indicators, following a significant increase in demand as a result of the media campaign. This increase in demand was reflected within the Year 3 Indicative Activity Plan, which enabled DHU 111 to increase their staffing levels and in turn deliver improved performance.

		Year Two						Year Three					
Contractual KPIs	Standard	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
1. Calls Abdandoned after 30 seconds	≤ 5%	4.2%	5.0%	7.6%	11.8%	6.3%	4.0%	1.1%	2.6%	2.5%	2.1%	2.0%	1.0%
2. Mean Average Answer Time	≤ 27 seconds	00:00:38	00:00:46	00:00:52	00:00:55	00:00:43	00:00:16	00:00:11	00:00:22	00:00:16	00:00:17	00:00:16	00:00:08
3. Proportion of Calls transferred to a Clinician	≥ 50%	44.6%	62.1%	58.2%	36.1%	61.4%	65.2%	59.1%	59.4%	61.7%	61.8%	61.9%	62.0%
4. Proportion of Calls not Recommended to Attend other Service (Self Care)	≥ 17%	15.1%	15.1%	15.0%	15.1%	17.8%	18.2%	19.6%	19.5%	18.4%	18.5%	18.9%	18.8%
5. Proportion of callers satisifed with their experience of NHS111	≥ 85%	Not available at the time of reporting											
1. Proportion of calls with an initial category 3 and 4 ambulance disposition that are revalidated	50%	91.5%	86.4%	85.2%	59.5%	61.6%	67.5%	62.2%	70.4%	71.1%	73.9%	73.8%	72.4%

National KPI	Standard	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
1. Calls answered within 60 seconds	≥ 95%	85.8%	77.8%	79.1%	63.1%	72.6%	89.3%	94.2%	86.7%	90.5%	91.0%	90.3%	96.2%

The NHS 111 service across Derbyshire is provided by DHU 111 (East Midlands) CIC.

The contract was procured to deliver average speed of answer and not calls answered in 60 seconds and this has been achieved. It has been recognised that to achieve the standard of answering calls in 60 seconds is an expensive model and further funding has been provided to achieve this for 2019/20.

CCGs required the provider to produce a Recovery Action Plan to increase performance and this was completed in January 2019.

DHU, EMAS and the CCGs continually work together to understand the best way to provide a 111 service.

CCG Improvement and Assessment Framework (IAF)

During 2018/19 the CCG continued to be monitored through the IAF which was introduced in 2016/17 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 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 2018/19 the IAF was split into four domains. These are: Well-Led, Sustainability, Better Care and Better Health. Each CCG is assessed as either 'Inadequate', 'Requires Improvement', 'Good' or 'Exceptional'.

The IAF also contains six clinical priority areas which are assessed separately by a panel.

In July 2018 the final assessment for 2017/18 was published which measured Erewash CCG as 'good'.

The Executive Team monitor the actions being taken for each indicator and a quarterly report is discussed with NHSE.

Healthcare Acquired Infections

Methicillin-resistant Staphylococcus aureus (MRSA)

There continues to be a zero tolerance to MRSA. Nine Derbyshire CCG patients have developed an MRSA since April 2018.

Number of cases by CCG	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total
NHS Erewash CCG	0	0	0	0	0	0	0	0	0	0	0	0	**0**
NHS Hardwick CCG	0	0	0	0	0	0	0	0	1	0	0	0	**1**
NHS North Derbyshire CCG	0	1	0	0	0	0	0	1	0	0	0	0	**2**
NHS Southern Derbyshire CCG	1	1	1	1	0	0	0	0	0	1	1	0	**6**
Total	**1**	**2**	**1**	**1**	**0**	**0**	**0**	**1**	**1**	**1**	**1**	**0**	**9**

NHS Southern Derbyshire CCG has had the highest incidence of MRSA, all of which were assigned as community onset. Post infection review has been carried out on all cases with no indication of lapses in care. One case reported within North Derbyshire identified as *hospital onset* noted lapses in care during review – actions required have been addressed.

Clostridium Difficile (CDI) Infection

Annual objectives for CDI are set by NHS England for each CCG, with the combined Derbyshire objective being 279 cases for 2018/19. The table below demonstrates each CCGs performance and individual threshold to year-end 2018/19. The total of 224 cases to date across the four CCGs puts Derbyshire under its threshold by 55 cases.

Number of cases by CCG	Annual Threshold Cases(rate per Population)	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total cases (rate per population)
NHS Erewash CCG	18(18.6)	1	0	0	4	1	1	2	2	0	0	0	3	**14 (14.47)**
NHS Hardwick CCG	42(37.7)	3	4	3	4	4	2	2	3	3	3	0	3	**34 (30.52)**
NHS North Derbyshire CCG	106(38.8)	4	10	7	9	9	8	8	7	3	7	9	4	**85 (31.11)**
NHS Southern Derbyshire CCG	113(21.4)	5	4	14	10	8	7	8	8	10	4	6	7	**91 (17.25)**
Total	**279**	**13**	**18**	**24**	**27**	**22**	**18**	**20**	**20**	**16**	**14**	**15**	**17**	**224**

The CCG objectives were reviewed for this financial year and all organisations had their objectives reduced by one case. Previous objectives were calculated on the 2013 incidence rate per population, with an expected reduction target of 5.6% for each CCG explaining why the objectives across the four CCGs are very different. All Derbyshire CCGs are below their individual objectives in 2018/9.

Cases of CDI are apportioned as either hospital onset or community onset. Patients that develop the infection on or after day four of admission (admission date is day 'one') are categorised as hospital onset (previously known as trust apportioned). University Hospitals of Derby and Burton NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Nottingham University Hospitals NHS Foundation Trust and Sherwood Forest Hospitals NHS Foundation Trust have all remained under objective during 2018/19.

Escherichia coli (E.coli) blood stream infections

The incidence of E.coli blood stream infections has risen annually since the introduction of mandatory reporting in 2011, resulting in guidance being issued to address the high incidence of cases. Hospital onset of E.coli has remained relatively stable according to PHE data while community onset cases continue to rise. NHS England implemented the *Quality Premium Guidance 2017/19: Reducing Gram Negative Blood Stream Infections* and inappropriate antibiotic prescribing in at risk groups. Along with a 10% reduction ambition, Quality Premium requirements include collection and reporting of a core Primary Care data set for all E.coli cases, which is well established. At the end of March 2019, a total of 1,018 cases have been reported across the four Derbyshire CCGs against an ambition of 801 cases. Data collection and submission in line with guidance supports identification of themes and trends contributing to the incidence of this infection and the CCG continues to work in collaboration with colleagues across the health economy to support the E.coli reduction ambition, with an initial focus on reduction of infection related to urinary infection, which data indicates is the primary focus of infection leading to E.coli bloodstream infections. Nationally the incidence rate of E.coli bloodstream infections have increased for all reported cases from the same period last year, with a 6% increase in community onset cases.

The following table demonstrates each CCG's performance and individual 10% target to March 2019.

Number of cases by CCG	Annual target cases(rate per 100,000 population)	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Total cases (rate per 100,000 population)
NHS Erewash CCG	74(77.0)	3	6	8	9	10	10	5	5	5	11	4	4	**80 (82.71)**
NHS Hardwick CCG	112(109.8)	9	16	9	9	8	10	12	12	16	8	10	13	**132 (118.49)**
NHS North Derbyshire CCG	212(73.0)	11	22	16	27	29	28	20	21	14	27	21	34	**270 (98.83)**
NHS Southern Derbyshire CCG	403(76.7)	39	31	37	38	46	56	50	46	45	48	50	50	**536 (101.62)**
Total	**801**	**62**	**75**	**70**	**83**	**93**	**104**	**87**	**84**	**80**	**94**	**85**	**101**	**1018**

Serious Incident reporting

Over the past year there has been successful work to form a single patient safety function for Derbyshire which includes one process for reporting Serious Incidents by our NHS providers within Derbyshire. This has ensured a consistent and streamlined approach for our providers with a single point of contact and all reporting to the correct standard.

Since forming this single process we have found that the team have developed a much stronger relationship and openness with the providers which has contributed to more comprehensive reporting, higher standard of investigation reports and shared learning across the local health economy. This ultimately improves the care that patients receive.

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 11 never events reported within 2018/19, all of which have been thoroughly investigated by the Providers, and signed off by the relevant CCG Chair and Chief Nurse Officer.

Organisation	Type	Total
University Hospitals of Derby and Burton NHS Foundation Trust	Wrong site surgery	4
	Wrong route administration of medication	1
	Retained foreign object post-procedure	1
	Unintentional connection of a patient requiring oxygen to an air flowmeter	3
Chesterfield Royal Hospital NHS Foundation Trust	Retained foreign object post-procedure	1
	Wrong site surgery	1
Derbyshire Community Health Services Foundation Trust	None reported	0

Better Care Fund metrics

As in previous years the CCG has pooled resources with Derbyshire County Council and Derby City Council, along with all other Derbyshire CCGs, 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 Better Care Fund dashboard shows performance against the mandated standards and can be found in Appendix One.

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 identify 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 2018 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 '	71%	38%	54%	35%	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	3.5	3.5	2.5	3.5	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%	95%	98%	83%	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	78%	83%	99%	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 it 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 improve 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 Sustainable Travel Plans; and
- **Procurement:** by taking account of the Procurement for Carbon Reduction Sustainable Procurement tool.

We also worked closely with the University of Derby to identify suitable placements for students who are looking to experience the delivery of care within a care home setting. The aim of this project was to develop the future and present workforce through the relationships that are established during the placement and which will then continue once students become qualified and work within the local health economy. Understanding the environments where our Derbyshire residents are cared for helps to break down barriers between health and social care staff and improve the communication and care planning for people.

Improving Quality

Quality Impact Assessment Panel and Process

The four Derbyshire CCGs historically had individual policies and procedures in place for undertaking and reviewing Quality Impact Assessments (QIA) for proposed disinvestment/ decommissioning decisions and plans for change. The four CCGs were also using different QIA assessment tools.

Following the success of the process implemented in 2016 in one of the CCGs, a single QIA policy and single QIA tool was developed in 2017 and a Derbyshire-wide QIA panel was introduced.

The objectives of the Policy are to:

- ensure that there is a robust analytical approach to Quality, Innovation, Productivity and Prevention (QIPP) and other business decisions for change that considers the impact on quality;
- provide assurance to the Governing Bodies that the Quality Impacts of QIPP, disinvestment/decommissioning decisions and plans for change have been assessed and considered and mitigating actions identified where potential negative quality impacts have been recognised; and
- provide a framework for the QIA of CCG QIPP and other change projects.

The QIA Panel aims to ensure effective mechanisms are in place to consider, monitor and review the impact on quality of all:

- commissioning/decommissioning decisions;
- service redesign and pathway development;
- business case refusal;
- QIPP and cost improvement plans;
- changes to the infrastructure of the organisation; and
- workforce redesign.

The QIA tool was co-produced with project managers, transformation team members and the Quality team to ensure ease of use and capture of all relevant domains:

- patient safety;
- patient experience;
- clinical effectiveness;
- productivity and innovation;
- prevention; and
- operational impact.

More recently the QIA panel has been expanded to include review of Equality Impact Assessments to ensure we understand how proposed changes might directly, indirectly, intentionally or unintentionally discriminate against the users of our services or our staff.

Maternity Quality Review Group

Prior to the establishment of the Local Maternity System (LMS) Steering Group (now Maternity Transformation Board), specific meetings were held at both University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) focussing upon quality and safety in Maternity Services. Quality highlights and concerns were then fed into the respective provider Quality Assurance Group (QAG) meetings. When the LMS was established both of these were dissolved with the general perception being that the ongoing monitoring of Quality and Safety in Maternity Services would become the remit of the LMS Steering Group.

Following review of these arrangements it was agreed that ongoing Quality and Safety Monitoring of Maternity Services should sit separate to but feed into the Maternity Transformation Programme Board and the provider QAGs. The Maternity Quality Review Group was established. By holding joint Maternity Quality Review Group meetings that include both the main providers of Maternity Services in Derbyshire and lead commissioners of Maternity Service providers in our bordering areas it was anticipated that there would be greater opportunity for shared learning, reflection and improvement.

The principal duties of the Maternity Quality Review Group are to:

- undertake scrutiny and provide objective assurance to the QAGs and Maternity Transformation Programme Board that UHDB and CRHFT provide Maternity Services that are safe, effective and provide a good experience for mothers and their families;
- routinely review performance against the dashboard Clinical Quality Performance Indicators – this will include themes and trends for complaint and incident data, all Never Events and Serious Incidents, clinical audit programme and in depth monitoring of any non-compliance or area at risk of being non-compliant and development of action plans and work programmes. A Derbyshire-wide Maternity dashboard has been developed; and
- monitor progress in the implementation of all nationally available guidance (including NICE and National Confidential Enquires) to ensure a systematic approach to clinical effectiveness and that clinical interventions are based upon best available evidence.

The Maternity Quality Review Group has ensured that any identified actions required to improve the quality and safety of Maternity Services are fed into the wider Maternity Transformation Programme action plan. Equally**,** it has ensured that the impact of any actions taken or changes made through the Maternity Transformation Programme only impact positively upon the safety and quality of care. The Maternity Quality Review Group has enabled rich and positive shared learning across the local maternity system with providers now regularly meeting, sharing training and education and sharing policies and procedures to improve safety, quality and experience of Maternity Care in Derbyshire.

Healthcare associated Infections

Clostridium difficile infection (CDI) is caused by a bacteria which is found in people's intestines. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies), but can cause disease for some people who may be more at risk due to taking antibiotics or due to other ongoing illness increasing the susceptibility to developing other infection. The CDI can then grow to unusually high levels allowing the toxin produced to reach levels where it attacks the intestines and causes mild to severe diarrhoea. In line with Public Health England,

requirements for CDI is subject to mandatory reporting and has been subject to enhanced surveillance since April 2007.

Each CCG is set an objective for CDI set by NHS England which is reviewed on an annual basis to support an ongoing reduction in number of CDI cases. Data received to date indicates a reduction in the total number of CDI cases affecting the population of the Derbyshire CCGs with a total of 224 cases during 2018/19 compared to 270 cases in 2017/18. All CCGs are on track to meet the objectives set by NHS England.

All CDI cases are subject to review by the infection prevention and control teams with an aim to identify any factors contributing to development of the disease, and to ensure best practice in the treatment and management of the patients. Any lessons learnt are shared with clinicians involved in the care of the patient and the wider healthcare teams to promote the quality and safety of our population.

Patient Safety success

Over the past year there has been successful work to form a single patient safety function for Derbyshire which includes one process for reporting Serious Incidents by our NHS providers within Derbyshire. This has ensured a consistent and streamlined approach for our providers with a single point of contact and all reporting to the correct standard.

Since forming this single process we have found that the team have developed a much stronger relationship and openness with the providers which has contributed to more comprehensive reporting, higher standard of investigation reports and shared learning across the local health economy. This ultimately improves the care that patients receive.

Engaging People and Communities

Public Engagement and Consultation

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

- the planning of services;
- the development and consideration of proposals for changes which, if implemented, would have an impact on services; and
- decisions which, when implemented, would have an impact on services.

These include:

Equality 2018/2019

The financial challenge has meant that there has had to be an unprecedented rate of review of services to optimise the opportunity to contribute to the financial turnaround but also to ensure that the impact of any changes take into account the impact on all nine protected characteristics. Therefore, time has been invested into setting up robust processes and ensuring the completion and understanding of Equality Analysis and linking this to the Quality Analysis of any potential change through the development of a joint Quality Impact Assessment Equality Impact Assessment Panel where the implications of any proposed change are challenged and confirmed. This is in addition to the ongoing engagement and equality considerations through engagement or consultation on service changes.

Community engagement

During the summer a series of engagement events were undertaken across Derbyshire to engage and inform people about the Derbyshire Health System financial challenge and how the CCGs make decisions on what service to commission. These events were an opportunity to share some of the plans to meet the financial challenge.

Wheel Chair Service

During 2017/18, the four Derbyshire CCGs completed a review of the Derbyshire Wheelchair Service. We were concerned that waiting times were too long, there was a backlog of patients that had built up and there was not enough clarity 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 four CCGs, managers from Derbyshire Community Health Services NHS Foundation Trust, who provide the Wheelchair Service and Lay Representatives.

The review led to the procurement of a new provider. Lay Representatives (who were wheelchair users) were involved at every stage of the review. An engagement exercise to gain a wider range of views was run when the specification for the new service was being developed. Over 100 patients completed an online survey and there were also workshops at a range of groups, including Parkinson's Disease Support Group, Fibromyalgia Group, Stakeholder Forums, Community Connectors, Care Homes and Children's Support Forums. Children and young people made up 20% of the responses overall, and men and women were equally represented.

The following feedback directly informed the specification:

- the requirement to provide a 'chair in a day' model, but not setting any targets for this as users were concerned that people should not be put on a scheme just to meet a performance metric;
- opening hours during evenings and weekends – each hub will be open for a three hour session, one evening per week and every Saturday morning;
- users were happy to return their own equipment when no longer needed – so the new provider was asked to facilitate this rather than automatically collecting; and
- there was support for personal wheelchair budgets but users had lots of queries and will need access to support – this was included in the specification.

Two Lay Representatives were supported to play a full role in the procurement process, scoring bidders' submissions and attending the moderation meetings. The CCG's Head of Patient Experience was also involved in the process, providing support and challenge to the procurement panel to really take on board the Lay Representative's views. The Lay Representatives are now working with the new provider to develop a range of ways that users can inform the development of the new service.

Red Bag scheme – Derbyshire-wide

The Red Bag Scheme has been ongoing in Derbyshire for a number of years. It is helping to provide a better care experience for care home residents by improving communication between care homes and hospitals. When a resident becomes unwell and is assessed as needing hospital care, care home staff pack a dedicated red bag that includes the resident's standardised paperwork and their medication, as well as day-of-discharge clothes and other personal items such as hearing aids, teeth and glasses; that often get separated from the resident. Each care home has been given an appropriate quantity of red bags. Smaller homes may only have one with the prediction that no more than one resident at a time needs admission, whereas larger homes are issued with two or three bags due to being statistically more likely to have multiple admissions. Each red bag has a personalised serial number, meaning if the patient's belongings/information should be removed or the patient passes away whilst an impatient, then the care home has a better chance of tracking their bag back to the home.

Discharge to Assess – Derbyshire-wide

The four Derbyshire CCGs have worked collaboratively with providers to develop a robust process to support the most vulnerable patients being discharged from hospital. The process is broken down into pathways, with Pathway One being the first option wherever possible.

<u>Pathway One</u>

This is the most commonly used and always the first option considered. Pathway One aims to discharge the patient home, with either therapy and a package of care, therapy only, or care input only. This enables ongoing assessments to be done out of hospital in the right place at the right time, and makes assessments more meaningful for the patient.

<u>Pathway Two</u>

This pathway involves patients being discharged short term to a residential setting to have a period of assessment and support to get them back to their own homes. Patients are often given this pathway as an option if they have developed nighttime needs in hospital and would therefore struggle between care calls at home. Pathway Two is a re-enablement and should be a

combination of support and therapy to encourage improvement so that the patient can get home independently or work towards being appropriate for Pathway One.

Pathway Three

Beds in this pathway are there to assist discharging people with complex or nursing needs. The reasons a patient may require Pathway Three could be for rehabilitation (e.g. physiotherapy or occupational therapy), further assessment (through Social Care) or complex discharge planning (e.g. social issues or engagement issues). Pathway Three beds include community hospital beds, specialist rehab units and nursing home interim beds.This pathway is specifically for patients with significant nursing needs that cannot be managed by Pathway One or Pathway Two.

Principles of Discharge to Assess

- Supporting people to go home should be the default pathway.
- Support services should be time-limited and should aim to return people to their previous levels of independence.
- Assessing longer-term care needs when the actual level of care required can be more accurately assessed.
- Ensuring that people do not have to make decisions about long term residential or nursing care while they are in crisis.
- Free at the point of delivery, regardless of ongoing funding arrangements.
- Non selective, a service that tries to always say ‘yes’.
- Putting people and their families at the centre of decisions, respecting their choices and not being prescriptive about their future care options.
- Taking steps to ensure there is no duplication in assessments throughout the patient’s journey from hospital to home.
- Building networks of service that place more emphasis on the person’s needs rather than on organisational boundaries. This encompasses multi/cross-disciplinary learning and planning.
- Finding ways to use money, resources and skills across organisational boundaries.

The impact of the Discharge to Assess model

- It reduces the time people spend in hospital, at the point that they no longer need acute care, therefore preventing deterioration in patients who become institutionalised in the hospital environment.
- Wherever possible, it supports people to return to their home for assessment. Having a model where going home is the default pathway, with alternative pathways for people who cannot go straight home, is more than good practice, it is the right thing to do.
- People often function differently in their own home than in the hospital environment. The hospital environment is recognised as an institutional and alien setting that can disable people, limiting their opportunity to manage core activities of daily living independently. People are more relaxed in their own home, they know the environment well, are comfortable and the balance of power is more equal.

The Discharge to Assess model supports people while they are at their most vulnerable. This is sometimes related to a protected characteristic or just through a temporary health condition. The model is designed to put the patient’s preferred discharge destination at the core of discharge planning and ensuring we do everything possible to get them back to baseline.

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:

- reducing mortality rates from preventable diseases;
- working with practices to tackle practice and clinical variation;
- focusing on evidence-based and effective delivery;
- improving the integration of health and social care;
- improving integration of Primary Care and Secondary Care to improve care for the frail, elderly and those with one or more long term conditions; and
- working with partners to improve lifestyle choices of the Derbyshire population in relation to smoking, alcohol, diet and exercise.

Place-based care strives to reduce health 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. 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 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 ensures that patients have access to the organisations that are the most appropriate to help and support them. The clinicians involved are 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. Collaborative working across 'places' means that there will be a pooled workforce which should create flexibility in clinicians' roles.

This year has seen a great improvement in how the different organisations work together which has led to us being able to develop various 'pilot schemes' around the patch that will help us identify what works best. This in turn will ensure that we can make the services match the need of the population, share the learning and provide services which meet local needs.

Primary Care Plus

This scheme involves a group of 16 practices in Derby City who are working with their community matrons to carry out acute home visits in a different way. In this scheme, a Community Matron will make a home visit after a request has been triaged by a GP. The GP is available by phone should the Community Matron need additional clinical support. Findings so far have been that patients prefer the Community Matron to visit because they can take more time to talk to them and it frees up GP time to see more patients in the practice.

Social Connectors

All GP healthcare assistants, frontline staff and Care Co-ordinators are included in the Erewash Social Connectors Network. Social drop-ins at surgeries have been set up across the locality.

Self-Care South Derbyshire

This is a project partly funded by Health and Wellbeing Group Locality Funding and led by the Voluntary Sector. It supports people via a multi-disciplinary team approach to better help themselves with regard to their health and wellbeing.

Falls and Falls Prevention

Amber Valley is focusing on locally implementing a Derbyshire pathway and maximising local assets. DCHS has looked at their involvement with falls and self-care literature has been sourced and distributed to all providers so that they can ensure patients are aware of what is available.

Community Multidisciplinary Team

All local providers in Derbyshire Dales are attending the meeting and sharing complex cases to better meet the needs of the patients in the Derbyshire Dales. “If we can’t solve it who can?” is the question asked.

Care Homes

Chesterfield has developed an approach to identifying people from care homes that are taken to hospital frequently. They have developed an aligned approach to routine care and escalation planning in care homes in conjunction with adult care colleagues.

The four Derbyshire CCGs have been working closely to review the current engagement processes and to understand how it could look in the future moving towards a CCG merger or joint management structure. Work so far has centred around developing lay representative confirm and challenge sessions at project initiation stage, working with Joined up Care Derbyshire to develop a proposed joint engagement structure and working with Joined up Care Derbyshire and the existing current CCG engagement structures and groups in a co-producing the final engagement structure.

In addition, the Engagement Team has set out to further develop 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. Examples of how this has been achieved is provided in the Annual Engagement Report 2018/19 http://www.derbyandderbyshireccg.nhs.uk/publications/ and includes Learning Disability carers, children and young people and parents of babies/young children.

One of our Engagement Managers is a regular member of the Chesterfield Equality and Diversity Forum which provides a setting to consider local equalities issues. Through this forum, staff have participated in Disabilities Equalities specialist training as well as in a programme of Celebrating Diversity “lunch and mingle” events organised by the local Links: the Chesterfield and North East Derbyshire Council for Voluntary Service and Action Limited. These events have proven such a valuable forum for the Engagement Team to make links with diverse groups in our community that the Manager, who won a Staff Pride Award, donated her £50 charitable donation to support these. Several contacts made there have this year participated in an Equality Focus Group for the South Yorkshire and Bassetlaw Hospital Services Review. Staff also joined in with Derbyshire County

Council's Diversity Day in October which celebrated Black History Month with the Derbyshire Black and Minority Ethnic (BME) Forum and other BME community groups and associations.

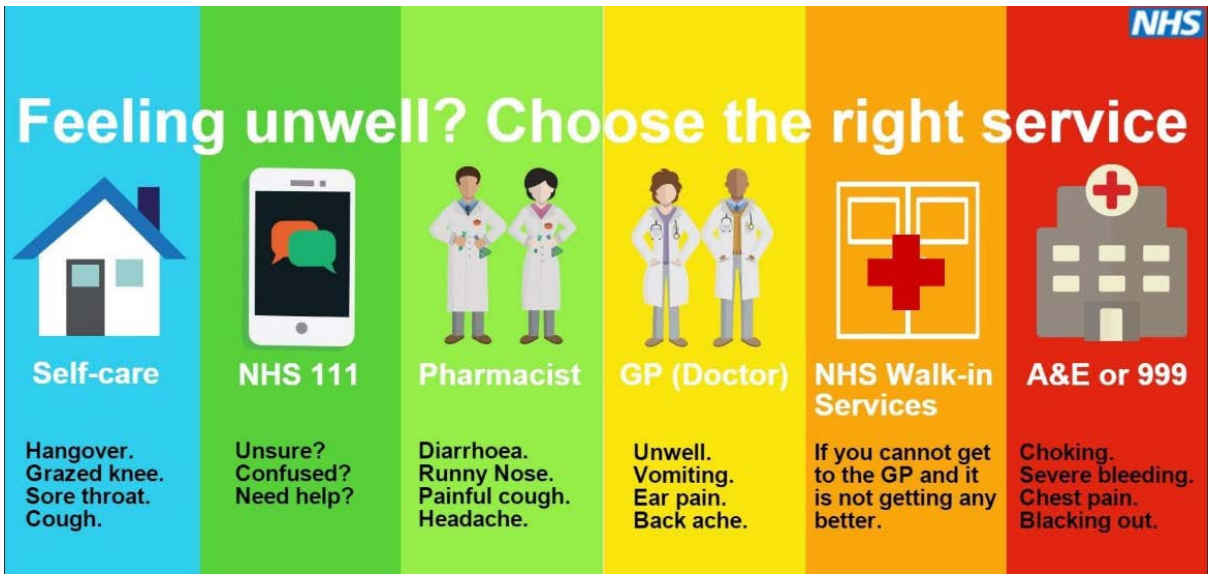
In order to access a wider range of participants we have continued to develop our engagement with patients via social media. We have Facebook, Twitter and YouTube pages where we have: Twitter 1466, Facebook 595 and 33 subscribers on YouTube.

Throughout the year the campaigns that have featured on these channels have varied to engage followers, friends and subscribers. Campaigns have included:

<u>Winter – Help Us Help You</u>

This is a campaign to promote positive messages along with clear signposting to other services across Derbyshire. From early September the aim was to highlight to local people the importance of the flu jab and dispelling any myths. During the same time we promoted our local services including pharmacy, how to self-care and NHS 111. These were strategically scheduled to be posted during the weekend and evenings when people might think of using Accident and Emergency.

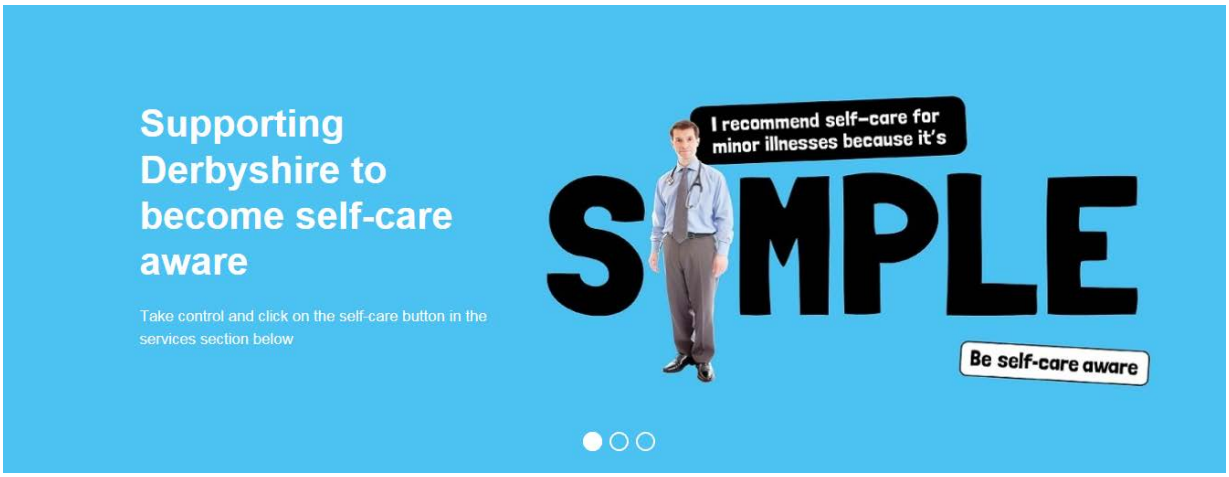
To support the signposting, clear and engaging images were used for followers to like, share, retweet and comment. A good example is as follows:



Over the winter months when services are busier than normal, to support our partners and providers, we ensured that any relevant content was shared accordingly. Examples include University Hospitals of Derby and Burton Hospital NHS Foundation Trust who ran a 'What's Your Emergency' campaign where different healthcare professionals promoted key messages relevant over the winter.

Throughout the year, we encouraged parents and carers to download the free HANDi App for minor conditions, rather than using children's Accident and Emergency. This was promoted on Twitter and Facebook to encourage people to download it in preparation for when it might be needed. An example is as follows:

From August, the CCG launched a ‘Be self-care aware’ campaign, which was aimed at Derbyshire residents who could live life well, with individuals best placed to look after themselves but with the support of services when required. A social media calendar was created to promote Self-care Week and World Antibiotic Week. Resources were shared with local hospitals to ensure consistent messages were delivered. The cost comparison poster went viral with more than 2,800 likes and 52,000 shares. The poster was also shared via other local Trusts and channels such as LinkedIn, which sparked much conversation and debate.



Other relevant messages that have been cascaded have been supporting Joined Up Care Derbyshire with encouraging recruitment into the health industry.

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 ill 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[4], which represents 1,391 deaths per year.

The wider determinants of health underpin lifestyle risk factors. In Derbyshire about 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 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[5], 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.

Health and Wellbeing Boards 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 city and county Health and Wellbeing Boards since early in 2011. The Accountable Officer sits on the Core Group on behalf of the Derbyshire CCGs. 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.

In addition, representatives from the Derbyshire CCGs' Governing Bodies regularly attend the Derbyshire Health Improvement and Scrutiny Committee and the Derby City Protecting Vulnerable Adults Committee to update, present reports and to develop a dialogue and partnership with Derby City and Derbyshire County Council councillors.

Joint Working with the Local Authority

The CCG is a key partner of the Joined Up Care Derbyshire Sustainability and Transformation Partnership (STP), which involves working closely with colleagues in Derbyshire's provider organisations and the two unitary authorities to develop health and care priorities for our local people. This has strengthened links between the local Health and Wellbeing Board strategies and

[4] Rate per 100,000 population.
[5] Rate per 100,000 population

the priorities emerging from the NHS Long Term Plan will be a key part of the refresh of the STP in 2019/20.

Health and Wellbeing Strategy

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

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; and
- 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.

Derbyshire County Council Health and Wellbeing Board web link:

www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-andwellbeing-board/health-and-wellbeing-board.aspx

Derby City Council Health and Wellbeing Board web link:

www.derby.gov.uk/health-and-social-care/health-medical-advice/hwb/

Equality Delivery System

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 taken 'due regard' to them in its own 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 its 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

The CCG has 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 2019

Corporate Governance Report

Members Report

Member practices

The CCG is comprised of 12 member practices and a further seven branch surgeries:

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

Composition of Governing Body

The Governing Body members for the CCG are:

Governing Body Member	Position
Dr Avi Bhatia	GP Clinical Chair & Leader of NHS Erewash CCG
Dr Chris Clayton	Chief and Accountable Officer
Deborah Hayman	Interim Chief Finance Officer (from 2 January 2019)
Louise Bainbridge	Chief Finance Officer (to 2 March 2019)
Brigid Stacey	Chief Nursing Officer (from 25 June 2018)
Jayne Stringfellow	Interim Chief Nurse Officer (to 31 August 2018)
Dr Markus Henn	GP Member & Clinical Vice Chair
Dr Arvind Mistry	GP Member/Clinical Lead
Dr Duncan Gooch	GP Member/Clinical Lead
Dr Katherine Bagshaw	GP Member/Clinical Lead
Andrew Booth	Lay Member, Audit and Conflicts of Interest Guardian
Professor Ian Shaw	Lay Member, Governance
Pam Watson	Lay Member, Patient and Public Involvement (and Equality Champion/Freedom to Speak Up Guardian)
Post vacant	Secondary Care Doctor
Simon Stevens	Derbyshire County Council Representative
Sharon Mellors	Engagement Officer, Healthwatch Representative
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Zara Jones	Executive Director of Commissioning Operations
Steve Lloyd	Medical Director
Sandy Hogg	Executive Turnaround Director
Falu Bharmal	Interim Director Corporate Governance (Board Secretary) (to the 31st July 2018)

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.

Full details of other sub-committees can be found in the Annual Governance Statement.

Audit Committee Membership

The membership of the Audit Committee of the CCG is as follows:

Audit Committee Member	Position
Margaret Amos	Chair – Governing Body Lay Member, Audit and Conflicts of Interest Guardian
Professor Ian Shaw	Deputy Chair – Governing Body Lay Member, Governance
Pam Watson	Lay Representative, Patient and Public Involvement and Freedom to Speak Up Guardian

Register of Interests

The CCG holds a register of interests for all individuals who are engaged by the CCG. The register is viewable on the CCG's website via http://www.derbyandderbyshireccg.nhs.uk and is available on request at the CCG Headquarters.

Personal data related incidents

There have been no serious information governance incidents during 2018/2019 that have met the criteria for reporting through the Data Protection and Security 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 the 31st March 2019 is published on our website at http://www.derbyandderbyshireccg.nhs.uk.

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) states that each CCG shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Erewash CCG.

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

- the 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);
- safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- the relevant responsibilities of accounting officers under Managing Public Money;
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended));
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts 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 income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual 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 Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

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

I also confirm that:

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

Dr Chris Clayton
Accountable Officer
NHS Erewash CCG
23 May 2019

Governance Statement

Introduction and Context

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

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1st April 2018, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The 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.

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.

Following the appointment of the Derbyshire Accountable Officer in October 2017, the four Derbyshire CCGs have been working collaboratively to joint working across Derbyshire. As a result of this, the Governing Bodies of the four CCGs agreed to establish formal governance arrangements to Committees in Common in respect of statutory duties (Governing Body, Audit, Remuneration and Primary Care Commissioning) and Committees in Common to support joint working (Finance, Governance, Quality and Performance and Clinical and Lay Commissioning). The Committees in Common were established from April 2018.

In July 2018, the Derbyshire CCGs' Governing Body Meetings in Common gave approval for the Derbyshire CCGs to make an application to NHS England to formally merge the four Derbyshire CCGs into a single CCG from the 1st April 2019.

NHS Erewash CCG has a revenue income of £150m for 2018/2019 and has a workforce of around 23 employees.

Scope of Responsibility

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

I am responsible for ensuring that the CCG 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 CCG 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 was last amended in May 2018, and has been under review to bring consistency across the four Derbyshire CCGs' constitutions. As a result of the Derbyshire CCGs making an application to merge in to a single CCG, a new constitution has been developed using the revised model Constitution template which was published by NHS England in August 2018.

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 and 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 Appendix 3 (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 unless detailed otherwise below:

Governing Body Member	Position
Dr Avi Bhatia	GP Clinical Chair & Leader of NHS Erewash CCG
Dr Chris Clayton	Chief and Accountable Officer
Deborah Hayman	Interim Chief Finance Officer (from 2 January 2019)
Louise Bainbridge	Chief Finance Officer (to 2 March 2019)
Brigid Stacey	Chief Nursing Officer (from 25 June 2018)
Jayne Stringfellow	Interim Chief Nurse Officer (to 31 August 2018)
Dr Markus Henn	GP Member & Clinical Vice Chair
Dr Arvind Mistry	GP Member/Clinical Lead
Dr Duncan Gooch	GP Member/Clinical Lead
Dr Katherine Bagshaw	GP Member/Clinical Lead
Andrew Booth	Lay Member, Audit and Conflicts of Interest Guardian
Professor Ian Shaw	Lay Member, Governance

Pam Watson	Lay Member, Patient and Public Involvement (and Equality Champion/Freedom to Speak Up Guardian)
Post vacant	Secondary Care Doctor
Simon Stevens	Derbyshire County Council Representative
Sharon Mellors	Engagement Officer, Healthwatch Representative
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Zara Jones	Executive Director of Commissioning Operations
Steve Lloyd	Medical Director
Sandy Hogg	Executive Turnaround Director
Falu Bharmal	Interim Director Corporate Governance (Board Secretary) (to 31July 2018)

The Governing Body met a total of nine times in public during 2018/19, seven of which were held as Meetings in Common with NHS Hardwick CCG, NHS North Derbyshire CCG and NHS Southern Derbyshire CCG. If the meeting was not fully quorate, members present agreed in principle to any decisions, with a caveat that agreement be sought from the missing members outside of the meeting. Confirmation that these items were agreed with the missing members were included as a post-meeting note within the minutes of the meeting and then ratified at the next meeting.

The membership and attendance record for the Governing Body and sub-committees can be found in Appendix two.

Governing Body Performance

In the last quarter of 2017/18, the Derbyshire Accountable Officer worked closely with NHS England to develop a Derbyshire Financial Recovery Plan across the four CCGs and a Derbyshire Improvement plan. This represented a significant part of the CCG Governing Body effort and they have been heavily involved in the development and delivery of these plans. The Derbyshire CCGs have continued to meet in monthly Escalation Meetings with NHS England.

At the December 2018 Derbyshire CCGs' Governing Body Meetings in Common, the Medium Term Financial Plan was provisionally approved. The Medium Term Financial Plan was updated to reflect the NHS Long Term Plan and the Operating and Planning guidance issued in January 2019. The final Medium Term Financial Plan was approved by the Derbyshire CCGs' Governing Body Meetings in Common in February 2019.

At the end of 2017/18 the Derbyshire CCGs' Governing Body Meetings in Common approved the single Executive/Director structure and the consultation and appointment process took place during March and April 2018. The single Executive/Director structure was finalised in May 2018 and the Derbyshire CCGs are now operating under a single Executive Management Team.

At the end of June 2018, the Derbyshire CCGs' Governing Body Meetings in Common approved the commencement of phase two of the restructuring process. A 30 day staff consultation period took place from the 4th July 2018 to the 3rd August 2018. A second 30 day staff consultation period commenced on the 10th September 2018 and closed on the 9th October 2018. At the Governing Body Meetings in Common on the 1st November 2018, approval was given for implementation of the new Derbyshire-wide organisational structures and the transition to the new structures commenced in December 2018 in accordance with the CCG's Organisational Change policies.

In December 2017, the Derbyshire CCGs' Governing Body Meetings in Common approved the establishment of a decision making structure across the CCGs. The Governing Bodies agreed to establish a Transitional Working Group with representation across the four CCGs to oversee the development of the proposals.

The following governance arrangements were agreed and 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);
- a Strategic Programme Board to develop and inform the Sustainability and Transformation Plan and Strategic Commissioning.

Terms of Reference were approved by Governing Bodies in March 2018 and the first Audit Committee in Common took place in March 2018. The remaining Committees in Common commenced as follows:

- Quality and Performance Committee – April 2018
- Governance Committee – April 2018
- Clinical and Lay Commissioning Committee – May 2018
- Finance Committee – June 2018
- Primary Care Commissioning Committee – July 2018

Increased scrutiny has been imposed on the Governing Body by its regulator during 2018/2019 for the CCG's position; however Governing Body members continue to fully discharge their duties and responsibilities as Governing Body members.

From April 2018, the CCGs undertook the process to combine the four Governing Body Assurance Frameworks (GBAF) and Corporate Risk Registers into a single Derbyshire CCGs' GBAF and Corporate Risk Register. The CCGs held a workshop in August 2018 with non-executive Directors and Lay Members to determine the strategic objectives of the Derbyshire CCGs and established nine strategic risks in September 2018 which were considered by the Derbyshire CCGs' Governing Bodies' Committees in Common. The Derbyshire CCGs' Governing Body Meetings in Common approved the 2018/19 GBAF in November 2018. The GBAF is reviewed by responsible officers on a monthly basis and reported to the Governing Body Meetings in Common in January 2018 and March 2018.

In July 2018, the Derbyshire CCGs' Governing Body Meetings in Common agreed for the Derbyshire CCGs to make an application to NHS England to formally merge the four Derbyshire CCGs into a single CCG from the 1st April 2019. An application to merge the CCGs was made to NHS England in August 2018 to create a single unified strategic commissioner co-terminous with both Derby and Derbyshire Local Authorities. This application was fully supported by all partners of Derbyshire Joined Up Care.

The draft Constitution development started in November 2018 and was developed by the CCG together with advice and recommendations being provided by the Transition Working Group (comprising of CCG Chairs, clinicians and governance representatives). Drafts of the Constitution were submitted informally to NHS England for review and feedback. Engagement with the CCG membership took place over a three week period between the 16th December 2018 and the 9th January 2019. The draft Constitution was approved by the four Derbyshire CCGs' Governing Body Meetings in Common on the 24th January 2019 and this was formally submitted to NHS England on the 28th January 2019 for approval.

The Constitution was approved by NHS England on the 19th February 2019.

Authorisation of NHS Derby and Derbyshire Clinical Commissioning Group and the dissolution of NHS Erewash Clinical Commissioning Group, NHS Hardwick Clinical Commissioning Group, NHS

North Derbyshire Clinical Commissioning Group and NHS Southern Derbyshire Clinical Commissioning Group were approved by NHS England on the 11th March 2019.

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
    - Clinical and Lay Commissioning Committee
    - Finance Committee
    - Governance Committee
    - Primary Care Commissioning Committee
    - Quality and Performance 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 in Common

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:

Audit Committee Member	Position
Margaret Amos	Chair – Governing Body Lay Member, Audit and Conflicts of Interest Guardian
Professor Ian Shaw	Deputy Chair – Governing Body Lay Member, Governance
Pam Watson	Lay Representative, Patient and Public Involvement and Freedom to Speak Up Guardian

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 2018/19 were:

Significant items approved/discussed by Audit Committee 2018/19
Governance, Risk Management and Internal Control
Annual Report and Accounts
Board Assurance Framework/Risk Register 2018/19
Financial Control Governance and Self-Assessment
Financial Systems – CCG Merger
Losses and Special Payments
QIPP Programme
Scheme of Delegation
Service Auditor Reports
Staff Property and Asset Transfer
Standards of Business Conduct and Conflicts of Interest
Waivers
Internal Audit
Internal Audit Progress Reports
Head of Internal Audit Opinion
Internal Audit Plan 2018/19
Survey Report 2018
External Audit
Annual Audit Letter
External Audit Plan 2018/19
Counter Fraud
Counter Fraud, Bribery and Corruption Risk Assessment and Work Plan 2018/19
Self-Assessment against Counter Fraud Commissioner Standards

A benchmark of one meeting per quarter at appropriate times in the reporting and audit cycle is suggested. The Committee met seven times in 2018/19 as a 'committee in common' with the three other CCGs in Derbyshire.
The quorum necessary for the transaction of business is two of the four members of the Audit Committee. If the meeting was not fully quorate, members present agreed in principle to any decisions, with a caveat that agreement be sought from the missing members outside of the meeting. Confirmation that these items were agreed with the missing members were included as a post-meeting note within the minutes of the meeting and then ratified at the next 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.

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. The Lay Members who are conflicted are not part of the decision making.

The Committee meets as required but as a minimum annually. The Committee met six times during 2018/19. The meeting was quorate and in accordance with its terms of reference.

The composition of the Remuneration Committee is as follows:

Remuneration Committee Member	Position
Andrew Booth	Lay Member (Audit)
Margaret Amos	Lay Member (Audit)
Ian Shaw	Lay Member (Governance)
Pam Watson	Lay Member (Patient & Public Involvement)

Significant items that were discussed and approved during 2018/19 were:

Significant items approved/discussed by Remuneration Committee 2018/19
Accountable Officer Remuneration
Approval of new Derby and Derbyshire CCG Governing Body Member Remuneration
Long Service Awards
Redundancy Payments
Very Senior Manager Remuneration

The quorum necessary for the transaction of business is two of the three members of the Remuneration Committee. If the meeting was not fully quorate, members present agreed in principle to any decisions, with a caveat that agreement be sought from the missing members outside of the meeting. Confirmation that these items were agreed with the missing members were included as a post-meeting note within the minutes of the meeting and then ratified at the next meeting.

Finance Committee in Common

The purpose of the Finance Committee is to review both the financial and service performance of the CCG against 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 Committee met 11 times during 2018/19.
The composition of the Finance Committee is as follows:

Finance Committee Membership
3 x Governing Body GPs
4 x Governing Body Lay Members (including Audit, Governance and Patient and Public Involvement)
Chief Finance Officer
Turnaround Director

Finance Committee Membership
Clinical Representative (Chief Nurse Officer/Medical Director)

Significant items that were discussed and approved during 2018/19 were:

Significant items approved/discussed by Finance Committee 2018/19
Acute Expenditure – Action Plan
Annual Budget/Plan 2019/20
Budget Setting Principles
Continuing Healthcare Market Management Proposal
Contract and Activity Reports
Contract Financial Envelopes 2019/2020
Financial Plan 2018/2019
Financial Recovery Plan
Integrated Finance, Performance and Quality Report
Primary Care Prescribing
QIPP Reports/Planning 2018/2019 and 2019/20
Risk Register
Scheme of Delegation
Turnaround Improvement Plan

The quorum necessary for the transaction of business is five members, to include one executive lead (Chief Finance Officer or Turnaround Director), one clinical representative and two Governing Body Lay Members. If the meeting was not fully quorate, members present agreed in principle to any decisions, with a caveat that agreement be sought from the missing members outside of the meeting. Confirmation that these items were agreed with the missing members were included as a post-meeting note within the minutes of the meeting and then ratified at the next meeting.

Clinical and Lay Commissioning Committee in Common

The purpose of the Clinical and Lay Commissioning Committee is to provide a clinical forum within which discussions can take place, and recommendations to be made, on the clinical direction of the CCG and to help secure the continuous improvement of the quality of services. The committee has delegated authority to make financial recommendations as set out in the Standing Financial Instructions on disinvestment/de-commissioning decisions.

The Committee met 10 times during 2018/19. The composition of the Clinical and Lay Commissioning Committee is as follows:

Clinical and Lay Commissioning Committee Membership
4 x GPs (preferably Governing Body members providing appropriate geographical coverage)
Clinical Representative
Secondary Care Doctor
2 x Lay Members (Patient & Public Involvement)
Lay Member (Audit or Governance)
Chief Nurse Officer or Deputy
Medical Director or Deputy
Chief Finance Officer or Deputy
Public Health Representative

Executive Director of Commissioning Operations

Significant items that were discussed and approved during 2018/19 were:

Significant items approved/discussed by Clinical and Lay Commissioning Committee 2018/19
Better Value Prescribing Policy
Commissioning Prioritisation Framework
Community Paediatric Continence Service
Community Phlebotomy – Southern Derbyshire
Decommissioned Services
Decommissioning and Disinvestment Policy
Derby Urgent Care
Derbyshire Commissioning Strategy
EMAS Clinical Navigators
Enhanced Observation, One to One Care Policy
Excess Treatment Cost Applications
Fast Track – New Model of Care for End of Life Patients
Financial Recovery Plan
Frailty Unit
Gastroenterology HCD Pathways and sequential use
Improving Access to Psychological Therapies
NHS 111
Non-Emergency Patient Transport
Orthotic Services
Physiotherapy and Occupational Therapy
Planned and Urgent Care
Procurements
Psychodynamic Psychotherapy
Quality, Innovation, Productivity and Prevention
RightCare
Self-Care Policy
Specialist Fertility Treatments
Specialist Respiratory Services
Targeted Intervention Service
Type 2 Diabetes structured education

The quorum necessary for the transaction of business is eight members, to include four clinicians (can include the Chair), one Lay Member and one Executive. If the meeting was not fully quorate, members present agreed in principle to any decisions, with a caveat that agreement be sought from the missing members outside of the meeting. Confirmation that these items were agreed with the missing members were included as a post-meeting note within the minutes of the meeting and then ratified at the next meeting.

Governance Committee in Common

The purpose of the Governance Committee is to ensure that the CCG complies with the principles of good governance whilst effectively delivering the statutory functions of the CCGs.

The Committee has delegated authority to make decisions as set out in the CCG's Prime Financial Policies and the Scheme of Reservation and Delegation.

The Committee met six times during 2018/19. The composition of the Governance Committee is as follows:

Governance Committee Membership
3 x Governing Body Lay Members
2 x GP Governing Body Members
Executive Director (Corporate) or Deputy

Significant items that were discussed and approved during 2018/19 were:

Significant items approved/discussed by Governance Committee 2018/19
Business Continuity
Conflicts of Interest
Derbyshire CCGs' Improvement Plan
Emergency Planning
Equality Delivery System 2
Equality Objectives
Estates and Facilities
European Union Exit
Freedom of Information Requests
Health and Safety
Human Resources
Information Governance
Organisational Development
Procurement
Research Governance
Risk Management
Serious Incidents (non-clinical)
Workforce Race Equality Standard

The quorum necessary for the transaction of business is four members, to include either two Governing Body Lay Members, one clinical representative and one executive lead; or two clinical representatives, one Governing Body Lay Member and one executive lead. If the meeting was not fully quorate, members present agreed in principle to any decisions, with a caveat that agreement be sought from the missing members outside of the meeting. Confirmation that these items were agreed with the missing members were included as a post-meeting note within the minutes of the meeting and then ratified at the next meeting.

Primary Care Commissioning Committee in Common

The Primary Care Commissioning Committee was established in April 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 wellbeing 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 Derbyshire 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. 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 CCG therefore has limited GP input into this Committee.

The Primary Care Commissioning Committee met nine times during 2018/2019.

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

Primary Care Commissioning Committee Membership
2 x Governing Body Lay Members
Accountable Officer or nominated Deputy
Chief Finance Officer or nominated Deputy
Chief Nurse Officer or nominated Deputy
Medical Director or nominated Deputy

Significant items that were discussed and approved during 2018/19 were:

Significant items approved/discussed by Primary Care Commissioning Committee 2018/19
Anticoagulation Management Enhanced Service
Applications for Discretionary Payments: Sickness Reimbursement
Care Home Programme Updates
Delegation Agreements
Financial Position Updates
Joined-Up Care Derbyshire
NHS England Position Statement and Returns
Practice Contract Merger Application
Practice Request for Change to Practice Boundary
Primary Care Governance
Primary Care Quality and Performance Assurance Report
Quality, Innovation, Productivity and Prevention
Strategy for General Practice
Wound Care

The quorum necessary for the transaction of business is four voting members from each of the Derbyshire CCGs, two of whom shall be Lay Members, and either the appointed Chair or Deputy covering the meeting must be present. If the meeting was not fully quorate, members present agreed in principle to any decisions, with a caveat that agreement be sought from the missing members outside of the meeting. Confirmation that these items were agreed with the missing members were included as a post-meeting note within the minutes of the meeting and then ratified at the next meeting.

Quality and Performance Committee in Common

The Quality and Performance Committee provides assurance to the CCG's Governing Body in relation to the quality, performance, safety, experience and outcomes of services commissioned by the CCG. It shall also ensure that the CCG discharges its statutory duties in relation to the achievement of continuous quality improvement and safeguarding of vulnerable children and adults.

The Quality and Performance Committee met 12 times during 2018/2019.

The composition of the Quality and Performance Committee is as follows:

Quality and Performance Committee Membership
3 x GP Governing Body Members
4 x Lay Members
Chief Nurse Officer or Deputy
Medical Director
Director of Contracting, Performance and Assurance
2 x Senior Healthwatch Representative (Derby City and Derby County)

Significant items that were discussed and approved during 2018/19 were:

Significant items approved/discussed by Quality and Performance Committee 2018/19
Acute Provider Performance Reports
Adult Deprivation of Liberty Policy
Better Care Fund
Cancer
Care Homes
Continuing Healthcare
Contract Performance Notices
Derbyshire Healthcare NHS Foundation Trust Performance
NHS 111
East Midlands Ambulance Service
End of Life
Healthcare Associated Infections
Improvement and Assessment Framework
Learning Disability Mortality Review
Looked After Children
Maternity
Medicines Safety
National/Regional Guidance
Patient experience and safety

Significant items approved/discussed by Quality and Performance Committee 2018/19
Quality Impact Assessment Policy
Risk Management
Safeguarding Adults
Safeguarding Children's and Looked After Children

The quorum necessary for the transaction of business is four members, to include one clinical representative, one Lay member and one executive lead (Chief Nurse Officer or Deputy). If the meeting was not fully quorate, members present agreed in principle to any decisions, with a caveat that agreement be sought from the missing members outside of the meeting. Confirmation that these items were agreed with the missing members were included as a post-meeting note within the minutes of the meeting and then ratified at the next meeting.

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 the 31st March 2019.

For the financial year ended the 31st March 2019, 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 2013 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk Management arrangements and effectiveness

The CCG's Risk Management Strategy was reviewed and approved in July 2018. 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 the Governing Body and its Committees in Common. The Committees in Common are provided with the Risk Register report and the risks that the committee is responsible for at every meeting. The Governing Body receive an exception report with details of all 'very high' 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. The Executive Team also receive a monthly high level risk report.

The Derbyshire CCGs established a Risk Group in November 2018. The Risk Group is established to review the risks on the Derbyshire CCG risk register and provide assurance to the CCG Governing Body and subcommittees that the risks on the risk register are being monitored and managed, and that the risk management process is firmly embedded within the organisation.

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 and Governance, and Public and Patient Engagement; other Governing Body members include Public Health and Local Authority representation.

Public events including Stakeholder 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 detection of 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, and 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. 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.

NHS Erewash CCG continues to work closely with neighbouring 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 *Substantial Compliance* for the 2018/19 EPRR Core Standards Assessment from NHS England together with NHS Hardwick CCG, NHS North Derbyshire CCG and NHS Southern Derbyshire CCG.

Capacity to Handle Risk

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

- Governing Body – oversight and holding management to account;
- Finance 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;
- Executive Director of Corporate Strategy and Delivery;

- Head of Governance – responsible for the development, implementation and maintenance of the risk management arrangements for the CCG; and
- All Staff – responsible for identifying, reporting and managing risks within their areas.

The Board Assurance Framework has been presented to the Audit Committee and Governing Body during 2018/19 for scrutiny. Following consultation with Audit Committee and the Executive Team, the Board Assurance Framework was reviewed by Governing Body members as the CCG moved towards a more joined up approach across the Derbyshire CCGs and with a view to a merged organisation from the 1st April 2019.

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 Finance Committee and Quality and Performance 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/ Executive Director of Corporate Strategy and Delivery.

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's 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's Executive Director of Corporate Strategy and Delivery coordinates 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.

Risk Assessment

2018/2019 has continued to be challenging in a number of areas for the CCG, particularly in relation to the deteriorating financial position of the CCG, in turn this has had a major impact on the risk profile of the CCG and its reputation. Increased scrutiny and oversight has been imposed on the Governing Body to understand the reasons for the CCG's position.

In context, the following details the most significant risks we have faced during 2018/2019 and how we are managing them.

Significant risks identified during 2018/2019

Failure to meet statutory financial duties in 2018/19

A Turnaround Director was appointed in June 2018 to manage delivery of the financial turnaround required to support the CCGs in achieving the agreed control totals and delivering their statutory financial duties. A weekly Executive-led Financial Recovery Group has been convened to oversee progress on delivery and instigate actions where necessary. The CCG's budgets are aligned to Executive Directors ensuring senior oversight and management of budgets. There is a budget escalation process in place which is overseen by the Financial Recovery Group and the Derbyshire CCGs' Finance Committees in Common and has been strengthened for 2019/20.

A 2018/19 control total action plan is in place to manage and monitor key actions, which is overseen by the Financial Recovery Group. The Derbyshire CCGs' Finance Committees in Common receives a standardised Derbyshire-wide report and individual CCGs' financial positions, QIPP delivery and actions being taken. The Finance Committee receives action plans on areas where forecast overspends are greater than 0.5% of the budget. The 2019/20 savings programme is supported by detailed individual plans and was approved by Derbyshire CCGs' Governing Body Meetings in Common on the 29th March 2019. Many of these schemes have been included in Trust contracts and a system-wide approach has been agreed for appropriate schemes with a risk share under development for approval by all parties.

Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care Services resulting in negative impact on patient care.

The CCGs have developed and implemented a Derbyshire-wide Primary Care Strategy to support the implementation of a Derbyshire plan to deliver General Practice Forward View (GPFV) and 10 point plan for nursing. This includes supporting practices with practice resilience through GP provider networks via the NHS England GP Resilience Programme allocations. It also includes implementing the Sustainability and Transformation Plan/Derbyshire-wide plans to invest in and develop practices at scale and continuing to work with Local Medical Committee, Federations and emerging groups to support the sustainability of general practice. The Primary Care Team continues to work closely with practices to understand and respond to early warning signs including identification of support/resources available including practice support in discussions around workload transfer from other providers.

The Derbyshire CCGs' Primary Care Commissioning Committees in Common oversee the commissioning, quality and GPFV workstreams. Assurance is provided to NHS England/ Joined Up Care Derbyshire through monthly returns and assurance meetings.

Accident and Emergency – failure to meet the Derbyshire-Wide CCGs' constitutional standards and quality statutory duties

Derbyshire-wide performance to the end of February 2019 was 83.1%, the same as January's performance. The Year to Date (YTD) performance is 89.6%. Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) reported 90.2% (YTD 90.9%) and University Hospital of Derby and Burton (UHDB) reporting 80.1% (YTD 87.1%).This is system-level performance not individual trust four hour performance, and reporting is agreed at the Accident and Emergency Board.

CRHFT have recruited to five middle-grade vacancies and staff in post from January 2019 although they will be supernumery until trained. Locums are in place for the vacancies and the department is fully staffed. A recovery action plan has been received by the CCG with a recovery date of March 2019.

There is now consultant cover in UHDB's Emergency Department (ED) each day until 2am. All discharges are progressed and delays are escalated in the Trust to alleviate flow issues. The Trust have recruited a Community Psychiatric Nurse on the 10th October 2018 to understand the issues impacting on ED service delivery and to ensure the correct actions are being taken to mitigate and ensure delivery against the 95% standard.

National shortage of Psychiatric Intensive Care Unit (PICU) beds

This has resulted in delayed transfers (12 hour breaches) in ED for Royal Derby Hospital, CRHFT and in police custody. It is also a concern for prison release where there is a significant Mental Health problem and community risk. This has resulted in an increased use of PICU over the last three years locally, which is impacting on CCG and Derbyshire Healthcare NHS Foundation Trust budget overspend.

The CCGs have appointed a coordinator for PICU to help bring length of stay down, build relationships with providers and bring data together. The CCG provides challenge in the system and more robust control of gateway. Escalated performance management from NHS England/NHS Improvement and an agreed action plan is in place. The budget is to be reset utilising Mental Health Minimum Investment Standard and it may take a year to see if demand is reduced. A date is set for target change in numbers for March 2020.

Organisation Change

The CCG experienced challenges due to the complexity and scale of organisational change. However the CCG completed a full staffing restructure, appointed the Governing Body for the newly formed NHS Derby and Derbyshire CCG and met all requirements to enable the four CCGs to merge successfully on the 1st April 2019.

European Union (EU) Exit Assurance

The CCG has in place an agreed EU Exit Plan which has been used for our planning and preparation work in a 'no deal' scenario. In addition, the CCG has in place a System Wide EU Exit Plan which has been shared with our provider colleagues. This document details the route for escalation of issues relating to EU exit preparedness. In line with the EU exit operational readiness guidance, the CCG has received full assurance from the national EPRR team for compliance with the standards. The CCG can report minimal impact compared to other parts of the NHS in terms of its business continuity.

The CCG has identified a risk which relates to the supply of medicines and vaccines and this is regularly monitored through our corporate risk register and the Governing Body on a monthly basis.

Anticipated risks for 2019/20

Failure to meet statutory financial duties in 2019/20

The CCG enters 2019/20 with a considerable financial challenge. The CCG's Operational Plan agreed with NHS England has been produced within the business rules they set out in the NHS Long Term Plan issued in January 2019. This Operational Plan identifies that the CCG has allocations totalling £1,622m with planned expenditure of £1,651m, which leaves the CCG with an agreed in-year position of a deficit of £29m. The CCG is again able to access Commissioner Sustainability Funds (CSF) and provided the Operational Plan is being delivered throughout the year, £29m of CSF will be available to the CCG, which will allow the CCG to deliver an in-year break-even position.

The delivery of the CCG's Operational Plan is dependent on delivering a QIPP savings of £69.5m and ensuring that the CCG manages any over-performance of planned activity with the healthcare contracts it has agreed. A prudent level of risk mitigation has been establish to manage the risk within the CCG's Operational Plan and is confident that it will deliver the agreed financial position in 2019/20.

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, it is also 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 process for equality impact assessments and quality impact assessments has been strengthened and a robust system has been developed to support the Programme Management Office in the production of Project Initiation Documents which are thoroughly scrutinised by the

Finance Committee in Common, Financial Recovery Group and the Clinical and Lay Commissioning Committee.

The CCG is committed to maximising public involvement through the use of the Patient Reference Group, Stakeholder Groups and Public Events. 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 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The 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. A quarterly return to NHS England is produced and approved by the Accountable Officer and Conflicts of Interest Guardian.

During 2018/19 all CCG staff were required to complete Managing Conflicts of Interest training, made up of three modules. By the 31st January 2019 all staff will have completed module one. This training was been launched through NHS England and NHS Clinical Commissioners.

360 Assurance carried out an internal audit of the CCG management of conflicts of interest in February 2019; the assurance opinion for this audit is '*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 the 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 and Greater East Midlands Commissioning Support Unit. During 2017/18 the Derbyshire CCGs re-procured this service and we have commissioned from North of England Commissioning Support (NECS) since October 2017. During 2018/19, CCG Leads have worked with the team at 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 and Performance 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 CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust Information Governance systems and processes in place to help protect patient and corporate information. The Derbyshire CCGs have a developed and established an Information Governance Group across Derbyshire, with membership from each of the CCG Senior Information Risk Owners, Caldicott Guardians and Information Governance Leads. This group report to the Governance Committee in Common who provides the assurance to the Governing Body.

Staff and Governing Body members have undertaken annual Information Governance training relevant to their role with more comprehensive training for the Senior Information Responsible Officer (SIRO), Deputy SIRO, Caldicott Guardian and Information Asset Owners.

The CCG have implemented a staff Information Governance 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 Information Governance roles and responsibilities and how they can access further information and support.

The CCG appoints a Caldicott Guardian who plays a key role in ensuring that the organisation satisfies the highest practical standards for handling patient identifiable information. The Chief Nurse Officer 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, 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 or security breaches during 2018/19 which has required reporting to the Information Commissioners Office.

The CCG's internal auditors, 360 Assurance, reviewed the Data Security and Protection Toolkit evidence in February 2019 giving '*limited'* assurance opinion due to the CCGs failure to achieve 95% of staff to have completed their annual Data Security training. However, 21 of the 22 standards examined were satisfactory. The CCG has received *full* compliance for the previous five years with the standards of the Information Governance Assurance Framework.

For 2018/19 the CCG submitted to NHS Digital its self-assessment to comply with the Data Security and Protection Toolkit.

Data Security

The new General Data Protection Regulation took effect during May 2018 and is supported by The Data Protection Act 2018. It places new obligations on organisations which process data and the CCG has ensured it complies by updating its policies, processes and procedures. As part of the changes the CCG have also appointed 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/ Midlands and Lancashire CSU	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

In the Month 9 Governance Statement return the following control issues were identified:

Finance, Governance and Control – Finance and Procurement

The four Derbyshire CCGs have agreed a £44m deficit control total for 2018/19 with NHS England. Achievement of the £44m deficit will enable the CCGs to access £44m non-recurrent commissioner sustainability funding/prior year draw down to allow them to report an in year breakeven position. As at month 9 the CCGs are forecasting delivery of the £44m deficit and are therefore in receipt of the equivalent non-recurrent funding, allowing them to forecast a breakeven position. In order to ensure the control total is met:

- a Turnaround Director has been appointed to manage delivery of the financial turnaround required to support the CCGs in achieving the agreed control totals and delivering its statutory financial duties;
- a weekly Executive led Finance Recovery Group has been convened to oversee progress on delivery and instigate actions where necessary;
- the Derbyshire CCGs' Finance Committees meet in common, receiving a standardised Derbyshire-wide report to provide information and assurance on the CCGs' financial positions, QIPP delivery and actions being taken;
- the CCGs' budgets are aligned to Executive Directors ensuring senior oversight and management of budgets;
- there is a budget escalation process in place overseen by the Financial Recovery Group and the Derbyshire Finance Committees in Common; and at planning stage all CCGs are holding a 0.5% uncommitted risk contingency.

Quality and Performance – Accident and Emergency

Derbyshire failed to deliver against the national 95% standard during November (87.8%). Underperformance has been attributed predominantly to underperformance at University Hospitals of Derby and Burton NHS Foundation Trust and Chesterfield Royal Hospital NHS Foundation Trust.

University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)

Emergency Department

The Emergency Department on the Derby Hospital site has failed to deliver against the national standard for 39 consecutive months, with current type 1 performance for December 2018 at 75.58%, as opposed to 73.62% in December 2017. The Emergency Department site performance for December (including Derby Urgent Care Centre) was 83.15%, compared to 83.15% in December 2017. There is a Recovery Action Plan in place and new trajectory is to be agreed. Average attendance during the month was 421 (compared to 401 in 2017) and the admission rate during December 2018 was 38.92% (average admission rate is 20% from Emergency Department attendances). The acuity of patients attending has been cited as the reason for non-compliance. Actions being taken include an update to the current Recovery Action Plan and new trajectory is to be agreed. UHDB are currently not meeting their NHS Improvement trajectory of 91.2%.

12-hour Trolley Breaches

Since April 2018, the number of 12 hour trolley breaches at the Derby Hospital site totaled 24. Of these, 23 were attributable to the unavailability of a mental health bed. A stakeholder meeting was held on 7 September 2018, which was attended by all providers, commissioners and regulators; an action plan has been prepared and is being monitored on a regular basis.

Chesterfield Royal Hospital NHS Foundation Trust (CRHFT)

CRHFT has failed to deliver against the national standard for seven consecutive months, with current performance for December 2018 at 87.7%. A Recovery Action Plan is in place with recovery planned for March 2019 and CRHFT has delivered against the 91.7% NHS Improvement trajectory in December 2018. CRHFT has identified workforce issues and has recently recruited seven new Consultants, two to start in December 2018 and five will commence in post during January 2019. Activity has risen slightly but acuity of patients is higher and the admission rate has increased causing flow issues.

Quality and Performance

Diagnostics

Derbyshire failed to deliver against the national 1.0% standard for Diagnostics during October 2018 (2.05%), with underperformance mainly being attributed to underperformance at CRHFT who were reporting 4.14%. Other trusts treating Derbyshire patients who have failed are East Cheshire NHS Trust and Nottingham University Hospitals NHS Trust (NUH). The two main providers in Derbyshire have particular issues with Echocardiographs (CRHFT) and Dexa Scans (UHDB) – although UHDB are meeting the standards. Diagnostic referrals have risen, averaging 1000 more per month at CRHFT. Staffing and Capacity issues have been highlighted as the contributing factors for non-delivery at CRHFT. Recovery plans are in place with improvement expected in Quarter 4.

Cancer

Derbyshire failed to deliver against three of the eight national targets during October 2018. Two week breast symptoms were 92.6% due to non-compliance at CRHFT, who missed the standard by 0.1%.

Subsequent surgery was non-compliant at 93%, which was due to breaches at NUH and Sheffield Teaching Hospitals NHS Foundation Trust. Both UHDB and CRHFT achieved this standard.

62-day performance continues to be non-compliant at a Derbyshire level (69.7%) which is a significant reduction on the September 2018 figure (75.5%). CRHFT met the standard during the month (86.1%) although UHDB performance reduced again (76.4%).

At a Derbyshire level there was 62-day screening compliance for the standard relating to first treatment; however CRHFT failed this standard at 87.2%.

The number of patients waiting over 104 days for treatment during October 2018 was 19, which is an increase on the September 2018 figure of 12. 11 of the patients were treated at UHDB and three at CRHFT (some shared breaches).

62-day Standard

UHDB has failed this standard for the last six months and performance for October 2018 was 76.41%. Two week wait referrals increased by 12% during the first two quarters of the year compared to the same period during 2017/2018. The increase in referrals to the urology specialty was 22.52%. Actions being taken include weekly Cancer escalation meetings, where any difficulties can be escalated to divisional directors; and extra clinics when possible for Breast, Urology and Gynaecology. Oncology capacity has been an issue in Urology and Upper Gastrointestinal and there are currently two locums employed by the UHDB until they are able to recruit on a substantive basis.

CRHFT achieved this standard during October (86.13%) and year to date (84.4%), although they are not expected to achieve in November 2018 and December 2018. The current shared pathway continues to result in delays in treatment but this will transfer to Sherwood Forest Hospitals NHS Foundation Trust during January 2019. An updated referral form has been introduced but only 30% of forms received are using the new template causing a delay from CRHFT having to ring to ask for more details. There have also been a number of very complex cases which have caused patients to breach.

Referral to Treatment/52-week wait

18-week Referral to Treatment for incomplete pathways continues to be non-compliant for Derbyshire at 90.3%, which is a slight increase on the September 2018 figure of 90.0%. Both main providers in Derbyshire (UHDB and CRHFT) failed to meet the 92% standard (91.0% and 88.2%, respectively). Contract Performance Notices are currently in place for both UHDB and CRHFT. Actions within the recovery plan form part of the Referral to Treatment recovery plan which aims to reduce the total waiting list size back to the March 2018 position.

There was an increase of 52+ week waiters in October 2018 to 29. Of the 16 reported for Derbyshire CCGs, 12 of them were for our two main acute providers UHDB (five) and CRHFT (seven), there were five for providers out of the Derbyshire area.

Discharge to Access

The data below shows the Derbyshire-wide position of Discharge to Access (D2A) for November 2018. Work is ongoing to ensure patients are discharged to the most appropriate pathway first time. CRHFT discharges are close to the aspirational target and work with UHDB is continuing to reach the target.

% People discharged from D2A pathway			
Location	**P1**	**P2**	**P3**
Target	60%	30%	10%
Total	44.3%	15.9%	39.8%
Derby	39.2%	10.2%	50.6%
Chesterfield	55.6%	28.1%	16.3%

Review of Economy, Efficiency and 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 complies with the NHS Pension Scheme regulations.

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 Quality, Innovation, Productivity and Prevention 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's 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 responsible Committees in Common 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.

The CCG's rating for the Improvement and Assessment Framework (IAF) for 2018/19 will be confirmed in July 2019.

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 – 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 under the authority of the Health and Wellbeing Board.

Although the CCG has taken on delegated powers for the commissioning of Primary Medical Care, the detailed financial transactions are processed by NHS England into the CCG's ledger from the Exeter/National Health Application and Infrastructure Services system. Capita was responsible for Primary Care support services at all NHS sites and the CCG were aware that the Capita Service Auditor Report did not give the required assurance over Primary Care services for 2018/19. As a result the CCG worked 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 Better Care Fund Finance and Performance Sub-Group and the Better Care Fund Programme Board. Through attendance at these monthly meetings the CCG is fully aware of the performance of the Better Care Fund and any associated risks.

Counter Fraud Arrangements

The CCG's Chief Executive 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 in relation to these Standards which is submitted annually to NHS Protect.

During 2018/19 the CCG's Fraud, Corruption and Bribery Policy was reviewed by the CCG's Accredited Counter Fraud Specialist and made available to all staff. Counter fraud awareness has also taken place and regular updates including distribution of the publication 'Fraudulent Times' are made available.

The 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:

> My overall opinion for the four CCG's is **Moderate Assurance** in that there is now a generally sound framework of governance, risk management and control, however, inconsistent application of controls puts the achievement of the organisation's objectives at risk. The CCG's did not have a fully operational Governing Body Assurance Framework or sufficiently robust risk management processes in place for the entire year. Whilst the CCG has faced an extremely challenging year and my opinion is moderate, recent reviews of the Governing Body Assurance Framework and a positive response to our Risk Management review recommendations, shows a more positive direction of travel at the CCG over the latter part of the financial year to improve the overall opinion.

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

Area of Audit	Level of Assurance Given
Financial Management Budget Monitoring and Key Financial Systems	Significant
Risk Management	Limited
Information Governance and Data Protection	Limited
Primary Medical Care Delegated Commissioning Functions	Not Applicable
Conflicts of Interest Stage Two	Significant

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the 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 CCG 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 and Quality and Performance Committee, and have addressed weaknesses during the year and ensure continuous improvement of the system is 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. A log 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:

- Governing Body;
- Audit Committee;
- NHS England – Improvement and Assessment Framework (IAF), MyNHS (MyNHS is a website which reports on all elements of the CCG's IAF and allows users to compare the CCG's position against other CCGs);
- 360 Assurance – Internal Audit reviews and Head of Internal Audit Opinion;
- KPMG – External Audit;
- North of England Commissioning Support Unit – monthly contract monitoring meetings;
- Sub-Committees of the Governing Body; and
- Executive Team.

Conclusion

No significant internal control weaknesses have been identified during the year.

Remuneration and Staff Report

Remuneration 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:

Remuneration Committee Member	Position
Andrew Booth	Lay Member for Audit
Margaret Amos	Lay Member for Audit
Pam Watson	Lay Member for Patient and Public Involvement
Ian Shaw	Lay Member for Governance

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 funds 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 salary for 2018/19 and 2017/18 are shown in the following tables:

Salaries and Allowances 2018/2019

2018-19								
Name	Title	Notes	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e)
			£000	£	£000	£000	£000	£000
Katherine Bagshaw	Governing Body GP	Ended 31 March 2019	15-20	0	0	0	0	15-20
Louise Bainbridge	Chief Finance Officer	Ended 2 March 2019	10-15	0	0	0	37.5-40	45-50
Falu Bharmal	Assistant Chief Officer and Corporate Director	Ended 31 July 2018	25-30	0	0	0	0-2.5	25-30
Avneesh Bhatia	Clinical Chair	Ended 31 March 2019	40-45	0	0	0	0	40-45
Andrew Booth	Lay Member, Audit	Ended 8 August 2018	0-5	0	0	0	0	0-5
Christopher Clayton	Chief Executive Officer		10-15	0	0	0	17.5-20	30-35
Helen Dillistone	Executive Director of Corporate Strategy & Delivery		10-15	0	0	0	52.5-55	60-65
Duncan Gooch	GP Member	Ended 31 March 2019	15-20	0	0	0	0	15-20
Deborah Hayman	Chief Finance Officer	Since 2 January 2019	0-5	0	0	0	0-2.5	0-5
Markus Henn	GP Member (Vice Clinical Chair)	Ended 31 March 2019	30-35	0	0	0	0	30-35
Sandra Hogg	Executive Turnaround Director	Since 1 July 2018	5-10	0	0	0	17.5-20	25-30
Zara Jones	Executive Director of Commissioning Operations	Since 20 August 2018	5-10	0	0	0	22.5-25	25-30
Steven Lloyd	Medical Director	Since 1 July 2018	5-10	0	0	0	280-282.5	285-290
Arvind Mistry	GP Member	Ended 31 December 2018	10-15	0	0	0	0	10-15
Prof Ian Shaw	Lay Member, Governance	Ended 31 March 2019	5-10	0	0	0	0	5-10
Brigid Stacey	Chief Nurse	Since 25 June 2018	5-10	0	0	0	0-2.5	5-10
Jayne Stringfellow	Chief Nurse	Ended 31 August 2018	0-5	0	0	0	0-2.5	0-5
Pamela Watson	Lay Member, Public & Patient Involvement	Ended 31 March 2019	5-10	0	0	0	0	5-10
Karen Ritchie	Healthwatch Representative		0	0	0	0	0	0
Julie Vollor	Local Authority Representative		0	0	0	0	0	0

Notes to Salaries and Allowance - 2018/19

1. Louise Bainbridge, Chris Clayton, Helen Dillistone, Deborah Hayman, Sandra Hogg, Zara Jones, Steven Lloyd, Brigid Stacey and Jayne Stringfellow are Executives shared between the 4 Derbyshire CCGs. The salaries represented in the table above represent Erewash CCG's share. The total salaries received from all four CCGs during 2018/19, in salary bands of £5,000, were: Louise Bainbridge £110,000-£115,000, Chris Clayton £145,000-£150,000, Helen Dillistone £110,000-£115,000, Deborah Hayman £40,000-£45,000, Sandra Hogg £80,000-£85,000, Zara Jones £65,000-£70,000, Steven Lloyd £80,000-£85,000, Brigid Stacey £85,000-£90,000 and Jayne Stringfellow £205,000-£210,000 (includes £160,000 redundancy costs picked up North Derbyshire CCG).
2. 'All Pension related benefits' shows the increase in 'lifetime' pension which has arisen in 2018/19. The sum reported reflects the amount by which the annual pension received on retirement age has increased in 2018/19, 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 Louise Bainbridge, Chris Clayton, Helen Dillistone, Deborah Hayman, Sandra Hogg, Zara Jones, Steven Lloyd, Brigid Stacey and Jayne Stringfellow, represent the total benefits across all four Derbyshire CCGs.

4. Where relevant the payments made to Senior Manager GP's include the pension contributions for them to pay directly to the Pensions Agency.
5. No payments were made to the Healthwatch or Local Authority Representatives nor were recharges made by their employers.
6. The GP and Lay members contracts all ended on 31 March 2019 which co-incides with the end of the 4 individual Derbyshire CCGs. New fixed term contracts have been agreed between Derby and Derbyshire CCG with some of the former members.

7. Falu Bharmal attended the Erewash CCG Governing Body until July 2018. From August 2018 the Derbyshire CCG's moved to holding joint Governing Body in Common meetings with a different structure.

Salaries and Allowances 2017/2018

			2017/18					
Name and Title		**Note**	**Salary (bands of £5,000) £000**	**Expense payments (taxable) (to nearest £100) £00**	**Performance pay and bonuses (bands of £5,000) £000**	**Long-term performance pay and bonuses (bands of £5,000) £000**	**All pension related benefits (bands of £2,500) £000**	**TOTAL (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	0	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 & Director of Quality	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

Notes to Salaries and Allowance - 2017/18

1. Chris Clayton, Louise Bainbridge and Jayne Stringfellow are Executives shared between Erewash CCG, Hardwick CCG, North Derbyshire CCG and Southern Derbyshire CCG. The salaries reported in the table above represent 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 2017-31 March 2018; started with Erewash CCG from 3 July 2018).

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. 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 nor 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 & Director of Quality	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

Pension benefits as at 31 March 2019

Name	Title	Real Increase in Pension at pension age (bands of £2,500)	Real Increase in Pension Lump Sum at pension age (bands of £2,500)	Total Accrued Pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Louise Bainbridge	Chief Finance Officer	2.5-5	0-2.5	20-25	40-45	278	58	367	0
Falu Bharmal	Assistant Chief Officer and Corporate Director	0-2.5	0-2.5	30-35	80-85	540	22	634	0
Christopher Clayton	Chief Executive Officer	0-2.5	0-2.5	20-25	30-35	239	33	301	0
Helen Dillistone	Executive Director of Corporate Strategy & Delivery	2.5-5	2.5-5	25-30	55-60	323	78	427	0
Deborah Hayman	Chief Finance Officer	0-2.5	0-2.5	35-40	110-115	712	16	823	0
Sandra Hogg	Executive Turnaround Director	0-2.5	0-2.5	35-40	100-105	665	66	788	0
Zara Jones	Executive Director of Commissioning Operations	0-2.5	0-2.5	20-25	45-50	228	35	309	0
Steven Lloyd	Governing Body Chair & GP and Medical Director (2 posts)	12.5-15	37.5-40	15-20	55-60	39	290	440	0
Brigid Stacey	Chief Nurse	0-2.5	0-2.5	40-45	125-130	777	21	845	0
Jayne Stringfellow	Chief Nurse	0-2.5	0-2.5	45-50	145-150	1023	0	0	0

Notes

1. Pensions figures included in the above table are for Senior Managers that have pensions paid directly by the CCG and include all of their NHS Service not just pension payments that relate to 2018/2019.

2. Louise Bainbridge, Chris Clayton, Helen Dillistone, Deborah Hayman, Sandra Hogg, Zara Jones, Steven Lloyd, Brigid Stacey and Jayne Stringfellow are Executives shared between 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 which are borne across the 4 Derbyshire CCGs.

3. The CETVs shown in the table above, and prior year comparator values have been provided by the NHS Business Services Authority (BSA) and have been used to calculate the real movement in CETV value.

Cash equivalent transfer values

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

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

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

Real increase in CETV

This reflects the increase in CETV 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

No 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.

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 CCG 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 executive leads, that are shared across the Derbyshire CCGs and NHS Erewash CCG receives a share of the costs. However for the purpose of pay multiple calculations the full-time equivalent salary of these shared staff has been included (rather than just a share).

The banded remuneration of the highest paid director/member in NHS Erewash CCG for the financial year 2018/19 was £145,000–£150,000 (2017/18, £140,000-£145,000). This was 2.95 times (2017/18, 3.67) the median remuneration of the workforce, which was £49,969 (2017/18, £38,845).

In 2018/19, nil (2017/18, zero) employees received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £19,122 to £150,000 (2017/18, £16,902 to £142,500).

Total remuneration includes salary, non-consolidated performance-related pay and 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 decreased by 0.72 (19.5%) since 2017/18. This decrease is due to the increase in median, which is a result of the agenda for change pay increased the lower bands more significantly than the higher paid individuals and the four Derbyshire CCGs' restructuring process which has seen a shared executive structure across the four Derbyshire CCGs where an increased number are on higher salaries.

Staff Report

Number of Senior Managers and Staff Composition

The table below shows the gender and pay band of the Very Senior Managers and gender of the other CCG Employees for 2018/19.

	Male	Female	Total
Executive Members	1	1	2
Band 8c	1	2	3
Band 8b	0	0	0
Band 8a	1	3	4
Other banded CCG employees	2	12	14
Total CCG employees	5	18	23
Other non-permanent engagements including non-executive directors and lay members	3	4	7
Total	**8**	**22**	**30**

Staff numbers and costs

The staff costs are shown in the following tables:

Employee benefits: 2018-19

	2018-19								
	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	514	74	**588**	811	65	**876**	1,325	139	**1,464**
Social security costs	56	0	**56**	89	5	**94**	145	5	**150**
Employer contributions to the NHS Pension Scheme	73	0	**73**	131	6	**137**	204	6	**210**
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	187	0	**187**	0	0	**0**	187	0	**187**
Gross employee benefits expenditure	**830**	**74**	**904**	**1,031**	**76**	**1,107**	**1,861**	**150**	**2,011**
Less recoveries in respect of employee benefits (note 4.1.2)	(2)	0	**(2)**	(166)	0	**(166)**	(168)	0	**(168)**
Total - Net admin employee benefits including capitalised costs	**828**	**74**	**902**	**865**	**76**	**941**	**1,693**	**150**	**1,843**
Less: Employee costs capitalised	0	0	**0**	0	0	**0**	0	0	**0**
Net employee benefits excluding capitalised costs	**828**	**74**	**902**	**865**	**76**	**941**	**1,693**	**150**	**1,843**

Employee benefits: 2017-18

	2017-18								
	Admin			Programme			Total		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	540	62	**602**	971	202	**1,173**	1,511	264	**1,775**
Social security costs	67	0	**67**	108	0	**108**	175	0	**175**
Employer contributions to the NHS Pension Scheme	79	0	**79**	118	0	**118**	197	0	**197**
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	0	**320**	0	0	**0**	320	0	**320**
Gross employee benefits expenditure	**1,006**	**62**	**1,068**	**1,197**	**202**	**1,399**	**2,203**	**264**	**2,467**
Less recoveries in respect of employee benefits (note 4.1.2)	(250)	0	**(250)**	(298)	0	**(298)**	(548)	0	**(548)**
Total - Net admin employee benefits including capitalised costs	**756**	**62**	**818**	**899**	**202**	**1,101**	**1,655**	**264**	**1,919**
Less: Employee costs capitalised	0	0	**0**	0	0	**0**	0	0	**0**
Net employee benefits excluding capitalised costs	**756**	**62**	**818**	**899**	**202**	**1,101**	**1,655**	**264**	**1,919**

Average number of people employed

The average number of staff employed by the CCG, excluding non-executive members and lay members, is:

	2018/19			2017/18		
	Permanently employed	**Other**	**Total**	Permanently employed	Other	Total
	Number	**Number**	**Number**	Number	Number	Number
Total	**26**	**2**	**28**	34	4	38

Sickness absence data

The average number of working days lost during the two years 2017 to 2018 is shown below:

	2018	2017
Total days lost	60	127
Average FTE	28	33
Average working days lost	2	4

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

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 2016/19 outlines our strategic direction in Equality, Inclusion and Human Rights, including how this relates to workforce.

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

Derbyshire and Nottinghamshire CCGs 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. The CCG has a Trade Union Official. The CCG is required to publish the relevant information on their website by 31st July 2019.

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 Peninsula, 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 2018/19 for the Clinical Commissioning Group was £1,000.

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 tables:

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at the 31st March 2019, for more than £245 per day and that last for longer than six months:

	Number
Number of existing engagements as of 31 March 2019	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 2: New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between the 1st April 2018 and the 31st March 2019, for more than £245 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between the 1 April 2018 and 31 March 2019	1
Of which:	
Number assessed as caught by IR35	1
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll member/senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between the 1st April 2018 and the 31st March 2019.

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements. (2)	20

Exit packages, including special (non-contractual) payments

During the year, two exit packages totalling £229,617 were agreed and paid. These packages were subject to approval by the Remuneration Committee and under the NHS redundancy terms and conditions. The 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

2018/2019

Dr Chris Clayton

Accountable Officer

NHS Erewash CCG

23 May 2019

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	(944)	(2,403)
Other operating income	2	0	(31)
Total operating income		**(944)**	**(2,434)**
Staff costs	4	2,011	2,467
Purchase of goods and services	5	148,393	145,382
Depreciation and impairment charges	5	0	0
Provision expense	5	300	41
Other Operating Expenditure	5	155	118
Total operating expenditure		**150,859**	**148,008**
Net Operating Expenditure		**149,915**	**145,574**
Finance income		0	0
Finance expense		(3)	(3)
Net expenditure for the year		**149,912**	**145,571**
Net (Gain)/Loss on Transfer by Absorption		0	0
Total Net Expenditure for the Financial Year		**149,912**	**145,571**
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			
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		**149,912**	**145,571**

The notes on pages 116 to 138 form part of this statement.

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'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	1,741	1,282
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	72	43
Total current assets		**1,813**	1,325
Non-current assets held for sale	21	0	0
Total current assets		**1,813**	1,325
Total assets		**1,813**	1,325
Current liabilities			
Trade and other payables	23	(10,607)	(10,484)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(374)	(115)
Total current liabilities		**(10,981)**	(10,599)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(9,168)**	(9,274)
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	(146)	(157)
Total non-current liabilities		**(146)**	(157)
Assets less Liabilities		**(9,314)**	(9,431)
Financed by Taxpayers' Equity			
General fund		(9,314)	(9,431)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(9,314)**	(9,431)

The notes on pages 116 to 138 form part of this statement.

The financial statements on pages 112 to 138 were approved by the Audit Committee (as delegated by the Governing Body), on 23 May 2019 and signed on its behalf by:

Dr Chris Clayton
Chief Executive Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(9,431)	0	0	**(9,431)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Impact of applying IFRS 9 to Opening Balances	(3)			**(3)**
Impact of applying IFRS 15 to Opening Balances	0			**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(9,434)**	**0**	**0**	**(9,434)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating expenditure for the financial year	(149,912)			**(149,912)**
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**
Net gain (loss) on available for sale financial assets	0	0	0	**0**
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			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	**(149,912)**	**0**	**0**	**(149,912)**
Net funding	150,032	0	0	**150,032**
Balance at 31 March 2019	**(9,314)**	**0**	**0**	**(9,314)**

	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 of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(9,787)**	**0**	**0**	**(9,787)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating costs 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**
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)**

The notes on pages 116 to 138 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(149,912)	(145,571)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		(3)	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		(9)	(2)
Unwinding of Discounts		(3)	(3)
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(459)	(344)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	123	(88)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(49)	0
Increase/(decrease) in provisions	30	309	43
Net Cash Inflow (Outflow) from Operating Activities		**(150,003)**	(145,965)
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
Non-cash movements arising on application of new accounting standards		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		**(150,003)**	(145,965)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		150,032	145,927
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
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**150,032**	145,927
Net Increase (Decrease) in Cash & Cash Equivalents	20	**29**	(38)
Cash & Cash Equivalents at the Beginning of the Financial Year		**43**	81
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		**72**	43

The notes on pages 116 to 138 form part of this statement.

Notes to the Financial Statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the Department of Health and Social Care. 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 a 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 **Movement of Assets within the Department of Health and Social Care 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 and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Subsidiaries**

Entities over which the Clinical Commissioning Group has the power to exercise control are classified as subsidiaries and are consolidated. The Clinical Commissioning Group has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. 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 coterminous.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.5 **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.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.6 **Joint Arrangements**

Arrangements over which the Clinical Commissioning Group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.
A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Clinical Commissioning Group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.7 **Pooled Budgets**

The Clinical Commissioning Group has entered into a pooled budget arrangement with NHS Hardwick, NHS North Derbyshire, NHS Southern Derbyshire and NHS Tameside & Glossop, Clinical Commissioning Groups, along with Derbyshire County Council (in accordance with section 75 of the NHS Act 2006). Under the arrangement, funds are pooled for the Derbyshire County "Better Care Fund". Additionally the Clinical Commissioning Group is a partner of the "Children and Young People with Complex Needs" pooled budget along with NHS Hardwick, NHS North Derbyshire and NHS Southern Derbyshire, Clinical Commissioning Groups and Derbyshire County Council. Note 35 to the accounts provides details of the income and expenditure.

The Derbyshire County "Better Care Fund" and "Children and Young People with Complex Needs" pools are both hosted by Derbyshire County Council. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget agreements.

1.8 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Clinical Commissioning Group.

1.9 **Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.
In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application.
The main sources of income relate to services and recharges made to other Department of Health and Social Care bodies and from local authorities reflecting local commissioning arrangements.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles. Significant terms include: None.
The value of the benefit received when the Clinical Commissioning Group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.10 **Employee Benefits**

1.10.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, 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.

1.10.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in a 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.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.11 **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.

1.12 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Clinical Commissioning Group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.13 **Property, Plant & Equipment**

1.13.1 **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.

1.13.2 **Measurement**

All property, plant and equipment is 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.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
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. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

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.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.13.3 **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.

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

1.15 **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 property, plant and equipment assets 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.

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

1.17 **Government Grant Funded Assets**
The Clinical Commissioning Group has no Government grant funded assets.

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

1.19 **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.

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

1.19.2 **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.

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

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

1.22 **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.

1.23 **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:
Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cash flows from the Statement of Financial Position date:
• A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

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.

1.24 **Clinical Negligence Costs**
NHS Resolution 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.

1.25 **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.

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

1.27 **Contingent Liabilities and Contingent Assets**
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, contingent liabilities and contingent assets are disclosed at their present value.

1.28 **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 amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.28.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.28.2 **Financial Assets at Fair Value through Other Comprehensive Income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.28.3 **Financial Assets at Fair Value through Profit and Loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.28.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

The Clinical Commissioning Group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Clinical Commissioning Group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.29 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.29.1 **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.

1.29.2 **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.

1.29.3 **Other Financial Liabilities**

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

1.30 **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.

1.31 **Foreign Currencies**

The Clinical Commissioning Group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. 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.

1.32 **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.

1.33 **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).

1.34 **Critical Accounting Judgements and Key Sources of Estimation Uncertainty**

In the application of the Clinical Commissioning Group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.34.1 **Critical Accounting Judgements in Applying Accounting Policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the Clinical Commissioning Group's accounting policies and 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.

1.34.2 **Sources of Estimation Uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.
· None

1.35 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.36 **Accounting Standards That Have Been Issued but Have Not Yet Been Adopted**

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2020-21, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.
Further guidance is expected from DHSC regarding IFRS 16 Leases. Additionally information from NHS Property Services and Community Health Partnerships regarding existing property leases is yet to be confirmed. Therefore the impact remains to be quantified. The other two standards are expected to have little or no impact.

2. Other Operating Revenue

	2018-19 Admin	2018-19 Programme	2018-19 Total	2017-18 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Education, training and research	0	2	**2**	63
Non-patient care services to other bodies	18	756	**774**	1,792
Patient transport services	0	0	**0**	0
Prescription fees and charges	0	0	**0**	0
Dental fees and charges	0	0	**0**	0
Income generation	0	0	**0**	0
Other Contract income	0	0	**0**	0
Recoveries in respect of employee benefits	2	166	**168**	548
Total Income from sale of goods and services	**20**	**924**	**944**	**2,403**
Other operating income				
Rental revenue from finance leases	0	0	**0**	0
Rental revenue from operating leases	0	0	**0**	0
Charitable and other contributions to revenue expenditure: NHS	0	0	**0**	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	**0**	27
Receipt of donations (capital/cash)	0	0	**0**	0
Receipt of Government grants for capital acquisitions	0	0	**0**	0
Continuing Health Care risk pool contributions	0	0	**0**	0
Non cash apprenticeship training grants revenue	0	0	**0**	0
Other non contract revenue	0	0	**0**	4
Total Other operating income	**0**	**0**	**0**	**31**
Total Operating Income	**20**	**924**	**944**	**2,434**

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	2	761	0	0	0	0	0	156
Non NHS	0	13	0	0	0	0	0	12
Total	**2**	**774**	**0**	**0**	**0**	**0**	**0**	**168**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	0	0	0	0	0	0	0	0
Over time	2	774	0	0	0	0	0	168
Total	**2**	**774**	**0**	**0**	**0**	**0**	**0**	**168**

3.2 Transaction price to remaining contract performance obligations

NHS Erewash Clinical Commissioning Group had no future income relating to contracts that commenced prior to the year end, where the performance obligations had not been fulfilled (i.e. income was not recognised in-year).

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2018-19		
	Permanent Employees	**Other**	**Total**
	£'000	**£'000**	**£'000**
Employee Benefits			
Salaries and wages	1,325	139	**1,464**
Social security costs	145	5	**150**
Employer Contributions to NHS Pension scheme	204	6	**210**
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	187	0	**187**
Gross employee benefits expenditure	**1,861**	**150**	**2,011**
Less recoveries in respect of employee benefits (note 4.1.2)	(168)	0	**(168)**
Total - Net admin employee benefits including capitalised costs	**1,693**	**150**	**1,843**
Less: Employee costs capitalised	0	0	**0**
Net employee benefits excluding capitalised costs	**1,693**	**150**	**1,843**

Termination benefits are net of a £42k provision raised in 2017-18 relating to the restructure of the Chief Nursing function, released in 2018/19 (see also note 30 Provisions, for details of the provision released in 2018/19).

4.1.1 Employee benefits

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

4.1.2 Recoveries in respect of employee benefits

	2018-19			2017-18
	Permanent Employees	**Other**	**Total**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Employee Benefits - Revenue				
Salaries and wages	(138)	0	**(138)**	(244)
Social security costs	(16)	0	**(16)**	(29)
Employer contributions to the NHS Pension Scheme	(14)	0	**(14)**	(35)
Other pension costs	0	0	**0**	0
Other post-employment benefits	0	0	**0**	0
Other employment benefits	0	0	**0**	0
Termination benefits	0	0	**0**	(240)
Total recoveries in respect of employee benefits	**(168)**	**0**	**(168)**	(548)

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed	**Other**	**Total**	Permanently employed	Other	Total
	Number	**Number**	**Number**	Number	Number	Number
Total	**26**	**2**	**28**	34	4	38
Of the above:						
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0	0	0

4.3 Staff sickness absence and ill health retirements

Details of sickness are included in the Annual report, page 107. NHS Erewash Clinical Commissioning Group had no ill health retirements (2017/18 - nil).

4.4 Exit packages agreed in the financial year

	2018-19 Compulsory redundancies		**2018-19 Other agreed departures**		**2018-19 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	1	100,000	0	0	**1**	**100,000**
£100,001 to £150,000	1	129,617	0	0	**1**	**129,617**
£150,001 to £200,000	0	0	0	0	**0**	**0**
Over £200,001	0	0	0	0	**0**	**0**
Total	**2**	**229,617**	**0**	**0**	**2**	**229,617**

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

	2018-19 Departures where special payments have been made		**2017-18** 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

	2018-19 Other agreed departures		2017-18 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	1	41,494
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval *	0	0	0	0
Total	**0**	**0**	**1**	**41,494**

* Includes any non-contractual severance payments made following judicial mediation, and nil settlements valued at £nil relating to non-contractual payments in lieu of notice.

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

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

Redundancy and other departure costs have been paid in accordance with the provisions of the 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. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables. NHS Erewash Clinical Commissioning Group did not have any early 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 for Health 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.
For 2018-19, employers' contributions of £165k were payable to the NHS Pensions Scheme (2017-18: £193k) at the rate of 14.38% of pensionable pay. These costs are included in the NHS pension line of note 4.1.1. (Note 4.1.1 reports a higher employer's contribution. This is because it includes pension contributions for staff shared by the Clinical Commissioning Group 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 Clinical Commissioning Group).

5. Operating expenses

	2018-19 Admin £'000	2018-19 Programme £'000	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services				
Services from other CCGs and NHS England	202	791	**993**	1,193
Services from foundation trusts	0	61,695	**61,695**	61,807
Services from other NHS trusts	0	29,233	**29,233**	27,781
Provider Sustainability Fund (Sustainability Transformation Fund 1718)	0	0	**0**	0
Services from Other WGA bodies	0	0	**0**	0
Purchase of healthcare from non-NHS bodies	0	24,991	**24,991**	23,138
Purchase of social care	0	15	**15**	15
General Dental services and personal dental services	0	0	**0**	0
Prescribing costs	0	13,376	**13,376**	13,604
Pharmaceutical services	0	49	**49**	63
General Ophthalmic services	0	30	**30**	26
GPMS/APMS and PCTMS	0	14,413	**14,413**	14,379
Supplies and services – clinical	0	0	**0**	0
Supplies and services – general	236	2,584	**2,820**	2,011
Consultancy services	0	1	**1**	0
Establishment	35	58	**93**	169
Transport	1	0	**1**	6
Premises	81	397	**478**	948
Audit fees	42	0	**42**	45
Other non statutory audit expenditure				
· Internal audit services	0	0	**0**	0
· Other services	14	0	**14**	0
Other professional fees	131	0	**131**	44
Legal fees	4	(33)	**(29)**	59
Education, training and conferences	0	47	**47**	94
Funding to group bodies	0	0	**0**	0
CHC Risk Pool contributions	0	0	**0**	0
Total Purchase of goods and services	**746**	**147,647**	**148,393**	**145,382**
Depreciation and impairment charges				
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
Total Depreciation and impairment charges	**0**	**0**	**0**	**0**
Provision expense				
Change in discount rate	(9)	0	**(9)**	(2)
Provisions	(65)	374	**309**	43
Total Provision expense	**(74)**	**374**	**300**	**41**
Other Operating Expenditure				
Chair and Non Executive Members	126	29	**155**	115
Grants to Other bodies	0	0	**0**	0
Clinical negligence	1	0	**1**	1
Research and development (excluding staff costs)	0	2	**2**	2
Expected credit loss on receivables	0	(3)	**(3)**	0
Expected credit loss on other financial assets (stage 1 and 2 only)	0	0	**0**	0
Inventories written down	0	0	**0**	0
Inventories consumed	0	0	**0**	0
Non cash apprenticeship training grants	0	0	**0**	0
Other expenditure	0	0	**0**	0
Total Other Operating Expenditure	**127**	**28**	**155**	**118**
Total operating expenditure	**799**	**148,049**	**148,848**	**145,541**

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

The audit fees relating to the statutory external audit include VAT.

The Clinical Commissioning Group has yet to commission the non-statutory audit of Mental Health Investment in 2018/19. As the audit relates to 2018/19, the estimated expenditure has been accrued in-year, and is disclosed as "Other non-statutory audit expenditure - other services".

6.1 Better Payment Practice Code

Measure of compliance	2018-19 Number	2018-19 £'000	2017-18 Number	2017-18 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	1,489	19,147	1,884	18,447
Total Non-NHS Trade Invoices paid within target	1,444	18,979	1,866	18,373
Percentage of Non-NHS Trade invoices paid within target	**96.98%**	**99.12%**	99.04%	99.60%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,860	103,191	2,055	99,435
Total NHS Trade Invoices Paid within target	1,841	103,077	2,048	99,424
Percentage of NHS Trade Invoices paid within target	**98.98%**	**99.89%**	99.66%	99.99%

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	2018-19 £'000	2017-18 £'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 (2017/18 £nil).

8. Investment revenue
NHS Erewash Clinical Commissioning Group received £nil investment revenue in the year (2017/18 £nil).

9. Other gains and losses
NHS Erewash Clinical Commissioning Group had £nil gains or losses in the year (2017/18 £nil).

10.1 Finance costs

	2018-19 £'000	2017-18 £'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)	(3)
Total finance costs	**(3)**	**(3)**

10.2 Finance income
NHS Erewash Clinical Commissioning Group received £nil finance income during the year (2017/18 £nil).

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 (2017/18 £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 property portfolio covering NHS Erewash Clinical Commissioning Group. 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 to NHS Erewash Clinical Commissioning Group and the General Practitioners to use the properties.

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

	2018-19				2017-18			
	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	336	4	**340**	0	881	8	**889**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**336**	**4**	**340**	**0**	**881**	**8**	**889**

While property arrangements with Community Health Partnerships Limited and NHS Property Services Limited fall within the definition of operating leases, rental charges for future years has not yet been agreed . Consequently note 12.1.2 does not include future minimum lease payments for these arrangements only.

12.1.2 Future minimum lease payments

				2018-19				2017-18
	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	0	**0**	0	0	4	**4**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**44**	**4**	**48**	**0**	**44**	**8**	**52**

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 2018/19 has been calculated as 6 months from the date following the accounting period reported (31 March 2019).

12.2 As lessor
NHS Erewash Clinical Commissioning Group was not a lessor during the year (2017/18 £nil).

13. Property, plant and equipment
NHS Erewash Clinical Commissioning Group had £nil property, plant and equipment in the year (2017/18 £nil).

14. Intangible non-current assets
NHS Erewash Clinical Commissioning Group did not have any non-current assets (2017/18 nil).

15. Investment property
NHS Erewash Clinical Commissioning Group had £nil investment property in the year (2017/18 £nil).

16. Inventories
NHS Erewash Clinical Commissioning Group had £nil inventories in the year (2017/18 £nil).

17.1 Trade and other receivables

	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
NHS receivables: Revenue	220	0	383	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	778	0	409	0
NHS accrued income	18	0	23	0
NHS Contract Receivable not yet invoiced/non-invoice	405	0	0	0
NHS Non Contract trade receivable (i.e. pass through funding)	0	0	0	0
NHS Contract Assets	0	0	0	0
Non-NHS and Other WGA receivables: Revenue	20	0	252	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	260	0	195	0
Non-NHS and Other WGA accrued income	0	0	1	0
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	0	0	0	0
Non-NHS and Other WGA Non Contract trade receivable (i.e. pass through funding)	0	0	0	0
Non-NHS Contract Assets	0	0	0	0
Expected credit loss allowance-receivables	0	0	0	0
VAT	39	0	19	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	1	0	0	0
Total Trade & other receivables	**1,741**	**0**	**1,282**	**0**
Total current and non current	**1,741**		**1,282**	

There were no prepaid pension contributions in 2018/19 (2017/18 £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.

17.2 Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	4	3	89	231
By three to six months	7	0	66	1
By more than six months	60	0	37	0
Total	**71**	**3**	**192**	**232**

NHS Erewash Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2019 (31 March 2018 £nil).

17.3 Impact of Application of IFRS 9 on financial assets at 1 April 2018

	Cash and cash equivalents	Trade and other receivables - NHSE bodies	Trade and other receivables - other DHSC group bodies	Trade and other receivables - external	Other financial assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at FVTPL	0	0	0	0	0	**0**
Financial Assets held at Amortised cost	43	24	381	253	1	**702**
Financial assets held at FVOCI	0	0	0	0	0	**0**
Total at 31st March 2018	**43**	**24**	**381**	**253**	**1**	**702**
Classification under IFRS 9 as at 1st April 2018						
Financial Assets designated to FVTPL	0	0	0	0	0	**0**
Financial Assets mandated to FVTPL	0	0	0	0	0	**0**
Financial Assets measured at amortised cost	43	24	381	250	1	**699**
Financial Assets measured at FVOCI	0	0	0	0	0	**0**
Total at 1st April 2018	43	24	381	250	1	**699**
Changes due to change in measurement attribute	0	0	0	3	0	**3**
Other changes	0	0	0	0	0	**0**
Change in carrying amount	0	0	0	3	0	**3**

17.4 Movement in loss allowances due to application of IFRS 9

	Trade and other receivables - NHSE bodies	Trade and other receivables - other DHSC group bodies	Trade and other receivables - external	Other financial assets	Total
	£000s	£000s	£000s	£000s	£000s
Impairment and provisions allowances under IAS 39 as at 31st March 2018					
Financial Assets held at Amortised cost (i.e. the 17-18 Closing Provision)	0	0	0	0	**0**
Financial assets held at FVOCI	0	0	0	0	**0**
Total at 31st March 2018	**0**	**0**	**0**	**0**	**0**
Loss allowance under IFRS 9 as at 1st April 2018					
Financial Assets measured at amortised cost	0	0	(3)	0	**(3)**
Financial Assets measured at FVOCI	0	0	0	0	**0**
Total at 1st April 2018	**0**	**0**	**(3)**	**0**	**(3)**
Change in loss allowance arising from application of IFRS 9	**0**	**0**	**(3)**	**0**	**(3)**

18. Other financial assets
NHS Erewash Clinical Commissioning Group had £nil other financial assets in the year (2017/18 nil).

19. Other current assets
NHS Erewash Clinical Commissioning Group had £nil other current assets in the year (2017/18 £nil).

20. Cash and cash equivalents

	2018-19 £'000	2017-18 £'000
Balance at 01 April 2018	43	81
Net change in year	29	(38)
Balance at 31 March 2019	**72**	**43**
Made up of:		
Cash with the Government Banking Service	72	43
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	**72**	**43**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2019	**72**	**43**

NHS Erewash Clinical Commissioning Group held no patients monies (2017/18 £nil).

21. Non-current assets held for sale
NHS Erewash Clinical Commissioning Group held £nil non-current assets for sale in the year (2017/18 £nil).

22. Analysis of impairments and reversals
NHS Erewash Clinical Commissioning Group had £nil impairments or reversals in the year (2017/18 £nil).

23. Trade and other payables	**Current 2018-19 £'000**	**Non-current 2018-19 £'000**	Current 2017-18 £'000	Non-current 2017-18 £'000
Interest payable	0	0	0	0
NHS payables: Revenue	181	0	836	0
NHS payables: Capital	0	0	0	0
NHS accruals	3,170	0	3,798	0
NHS deferred income	0	0	0	0
NHS Contract Liabilities	0	0	0	0
Non-NHS and Other WGA payables: Revenue	47	0	0	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	5,738	0	3,975	0
Non-NHS and Other WGA deferred income	0	0	0	0
Non-NHS Contract Liabilities	0	0	0	0
Social security costs	19	0	22	0
VAT	0	0	0	0
Tax	16	0	53	0
Payments received on account	0	0	0	0
Other payables and accruals	1,436	0	1,800	0
Total Trade & Other Payables	**10,607**	**0**	10,484	0
Total current and non-current	**10,607**		10,484	

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 (2017/18 £nil).

Other payables include £108,203 outstanding pension contributions at 31 March 2019 (£117,951 at 31 March 2018). Other payables include GP pensions.

23.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

	Trade and other payables - NHSE bodies	**Trade and other payables - other DHSC group bodies**	**Trade and other payables - external**	**Other borrowings (including finance lease obligations)**	**Other financial liabilities**	**Total**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Classification under IAS 39 as at 31st March 2018						
Financial Liabilities held at FVTPL	0	0	0	0	0	**0**
Financial Liabilities held at Amortised cost	2,904	1,730	5,775	0	0	**10,409**
Total at 31st March 2018	**2,904**	**1,730**	**5,775**	**0**	**0**	**10,409**
Classification under IFRS 9 as at 1st April 2018						
Financial Liabilities designated to FVTPL	0	0	0	0	0	**0**
Financial Liabilities mandated to FVTPL	0	0	0	0	0	**0**
Financial Liabilities measured at amortised cost	2,904	1,730	5,775	0	0	**10,409**
Financial Liabilities measured at FVOCI	0	0	0	0	0	**0**
Total at 1st April 2018	**2,904**	**1,730**	**5,775**	**0**	**0**	**10,409**
Changes due to change in measurement attribute	0	0	0	0	0	**0**
Other changes	0	0	0	0	0	**0**
Change in carrying amount	**0**	**0**	**0**	**0**	**0**	**0**

24. Other financial liabilities
NHS Erewash Clinical Commissioning Group had £nil other financial liabilities in the year (2017/18 £nil).

25. Other liabilities
NHS Erewash Clinical Commissioning Group had £nil other liabilities in the year (2017/18 £nil).

26. Borrowings
NHS Erewash Clinical Commissioning Group had £nil borrowings (2017/18 £nil).

27. Private finance initiative, LIFT and other service concession arrangements
NHS Erewash Clinical Commissioning Group had £nil LIFT or PFI schemes (2017/18 £nil).

28. Finance lease obligations
NHS Erewash Clinical Commissioning Group had £nil finance lease obligations as a lessee (2017/18 £nil).

29. Finance lease receivables
NHS Erewash Clinical Commissioning Group had £nil finance lease obligations as a lessor (2017/18 £nil).

30. Provisions

	Current 2018-19 £'000	**Non-current 2018-19 £'000**	Current 2017-18 £'000	Non-current 2017-18 £'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	42	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	1	0
Continuing care	237	0	0	0
Other	137	146	72	157
Total	**374**	**146**	**115**	**157**
Total current and non-current	**520**		**272**	

	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 2018	**0**	**0**	**42**	**0**	**0**	**0**	**1**	**0**	**229**	**272**
Arising during the year	0	0	0	0	0	0	0	237	137	**374**
Utilised during the year	0	0	(42)	0	0	0	0	0	(7)	**(49)**
Reversed unused	0	0	0	0	0	0	(1)	0	(64)	**(65)**
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	(9)	**(9)**
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 2019	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**237**	**283**	**520**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	237	137	**374**
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	146	**146**
Balance at 31 March 2019	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**237**	**283**	**520**

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.

An additional provision of £72k was created in 2015/16, for settlement of HMRC liabilities with respect to taxation treatment of off-payroll engagements. The on-going HMRC review was concluded in 2018/19 and after settlement, £64k of unused provision was released to operating expenditure.

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 was established in 2017/18 for NHS Erewash Clinical Commissioning Group's share of the associated costs. This was used in the early part of 2018/19 to offset the costs associated with restructuring the Chief Nursing function and associated exit costs. The other Derbyshire Clinical Commissioning Groups likewise set up provisions in 2017/18 and these were used to offset the restructuring costs incurred in 2018/19.

Two new provisions have been recognised in year: £237k relating to continuing healthcare retrospective claims and disputes; and £137k relating to the estates and technology transformation fund revenue costs.

Pension payments are made quarterly and amounts are known. The pension provision is based on life expectancy.

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them. In 2017/18 NHS Resolution disclosed one claim lodged for NHS Erewash Clinical Commissioning Group and the likely financial impact of £1k, to the Clinical Commissioning Group. The legal claim has since been cancelled and the provision reversed as unused in 2018/19. As at 31 March 2019, there were no legal claims provided by NHS Resolution on behalf of the Clinical Commissioning Group.

31. Contingencies

NHS Erewash Clinical Commissioning Group had £nil contingent liabilities; and £nil contingent assets (one contingent liability of £87k, relating to the re-organisation of the executive management structure; and £nil contingent assets, in 2017/18).

32. Commitments

NHS Erewash Clinical Commissioning Group had £nil capital commitments or other financial commitments (2017/18 £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.

Because NHS Erewash 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 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

NHS Erewash 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. The Clinical Commissioning Group therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

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

33.1.3 Credit risk

Because the majority of NHS Erewash Clinical Commissioning Group's revenue comes from 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

NHS Erewash 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.

33.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Equity investment in group bodies		0	**0**
Equity investment in external bodies		0	**0**
Loans receivable with group bodies	0		**0**
Loans receivable with external bodies	0		**0**
Trade and other receivables with NHSE bodies	37		**37**
Trade and other receivables with other DHSC group bodies	601		**601**
Trade and other receivables with external bodies	26		**26**
Other financial assets	1		**1**
Cash and cash equivalents	72		**72**
Total at 31 March 2019	**737**	**0**	**737**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
Loans with group bodies	0		**0**
Loans with external bodies	0		**0**
Trade and other payables with NHSE bodies	1,336		**1,336**
Trade and other payables with other DHSC group bodies	4,541		**4,541**
Trade and other payables with external bodies	3,259		**3,259**
Other financial liabilities	1,435		**1,435**
Private Finance Initiative and finance lease obligations	0		**0**
Total at 31 March 2019	**10,571**	**0**	**10,571**

34 Operating segments

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

35 Joint arrangements - interests in joint operations

35.1 Interests in joint operations

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 £95,557,542 including iBCF funding (£70,651,376 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 £24,906,166 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 £7,317,265 (7.66%). In 2017-18 it was £7,199,000 (8.11%).

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

	2018-19 £000	2017-18 £000
Income	7,600	7,460
Expenditure	(7,600)	(7,460)
Net position for pooled budgets	**0**	0

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

	2018-19 £'000	**Pool Share %**	2017-18 £'000	Pool Share %
Income				
NHS Erewash CCG	7,317	7.66	7,199	8.11
NHS Hardwick CCG	12,526	13.11	12,447	14.02
NHS North Derbyshire CCG	21,492	22.49	21,289	23.98
NHS Southern Derbyshire CCG	19,070	19.96	19,170	21.59
NHS Tameside and Glossop CCG	2,295	2.40	2,252	2.54
Derbyshire County Council	32,858	34.38	26,419	29.76
Total Income	**95,558**	**100.00**	88,776	100.00

Expenditure	**£'000**	£'000
CCG schemes aimed at reducing non elective activity	31,255	31,870
CCG schemes - wheelchairs	0	0
Derbyshire County Council schemes	6,451	5,966
ICES (Integrated Community Equipment Service)	5,487	6,123
Reablement	8,487	8,046
7 Day working	1,294	1,346
Administration, Performance and Information Sharing	490	490
Care Bill	2,058	2,058
Delayed Transfer of Care	6,409	5,481
Carers	1,962	1,962
Integrated Care	1,500	1,500
Workforce Development	2,570	2,570
Dementia Support	1,239	981
Autism and Mental Health	1,450	2,165
iBCF	24,906	18,218
Total Expenditure	**95,558**	88,776
Net position for Pool	**0**	0

35.1 Interests in joint operations cont'd

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

	2018-19 £'000	**Pool Share %**	2017-18 £'000	Pool Share %
Income				
NHS Erewash CCG	283	4.57	261	4.57
NHS Hardwick CCG	331	5.35	305	5.35
NHS North Derbyshire CCG	818	13.22	755	13.22
NHS Southern Derbyshire CCG	610	9.86	563	9.86
Derbyshire County Council	4,145	67.00	3,824	67.00
Total Income	**6,187**	**100.00**	5,708	100.00
Expenditure	**£'000**		£'000	
Purchase of Equipment and Healthcare Services	6,187		5,708	
Total Expenditure	**6,187**		5,708	
Net position for Pool	**0**		0	

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11
NHS Erewash Clinical Commissioning Group does not have any interests in entities not accounted for under IFRS 10 or IFRS 11.

36. NHS Lift investments
NHS Erewash Clinical Commissioning Group had £nil NHS LIFT investments (2017/18 £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):

		2018-19			
Governing Body Member	Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£000	£000	£000	£000
Louise Bainbridge, Dr Chris Clayton, Helen Dillistone, Deborah Hayman, Sandy Hogg, Zara Jones, Dr Steven Lloyd, Brigid Stacey, Jayne Stringfellow	NHS North Derbyshire CCG	167	(159)	602	(165)
Louise Bainbridge, Dr Chris Clayton, Helen Dillistone, Deborah Hayman, Sandy Hogg, Zara Jones, Dr Steven Lloyd, Brigid Stacey, Jayne Stringfellow	NHS Hardwick CCG	88	(8)	390	(11)
Louise Bainbridge, Dr Chris Clayton, Helen Dillistone, Deborah Hayman, Sandy Hogg, Zara Jones, Dr Steven Lloyd, Brigid Stacey, Jayne Stringfellow	NHS Southern Derbyshire CCG	587	(172)	283	(91)
Dr Katherine Bagshaw, Dr Markus Henn	Derbyshire Community Health Services NHS Foundation Trust	17,494	(40)	69	(20)
Andrew Booth	University Hospitals of Derby and Burton NHS Foundation Trust (formerly Derby Teaching Hospitals NHS Foundation Trust)	32,548	(51)	779	(839)
Jayne Stringfellow	Chesterfield Royal Hospital NHS Foundation Trust	142	(12)	4	(1)
Falu Bharmal, Dr Avi Bhatia	Nottingham University Hospitals NHS Trust	24,498	0	498	(2)
Julie Vollor	Derbyshire County Council	7,112	(5)	340	(4)
Dr Katherine Bagshaw, Dr Markus Henn	Littlewick Medical Centre	2,520	0	0	0
Dr Avi Bhatia, Dr Duncan Gooch, Dr Markus Henn, Dr Arvind Mistry	Erewash Health Ltd	278	0	0	0
Dr Avi Bhatia	GP Contractor at Moir Medical Centre	1,640	0	0	0
Karen Ritchie	Healthwatch Derbyshire	7	0	0	0

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

Shared management and working arrangements have been developed between NHS Erewash; NHS Hardwick; NHS North Derbyshire; and NHS Southern Derbyshire Clinical Commissioning Groups, This includes the appointment of shared executive directors. Although the four organisations were separate statutory organisations, they were 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

- NHS England including: NHS England North Midlands; NHS Arden & GEM Commissioning Support Unit; NHS Midlands and Lancashire Commissioning Support Unit; North of England Commissioning Support Unit
- NHS Foundation Trusts including: Derbyshire Community Healthcare Services NHS Foundation Trust; Derbyshire Healthcare NHS Foundation Trust; and University Hospitals of Derby and Burton 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 2017/18 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):

		2017-18			
Governing Body Member	Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£000	£000	£000	£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

38. Events after the end of the reporting period
NHS Erewash Clinical Commissioning Group was dissolved on 31 March 2019, having merged with the Clinical Commissioning Groups of: NHS Hardwick; NHS North Derbyshire; and NHS Southern Derbyshire, to establish NHS Derby and Derbyshire Clinical Commissioning Group, with effect from 1 April 2019. This followed approval by NHS England in March 2019.The Department of Health and Social Care Group Accounting Manual directs that such changes should be accounted for as a 'transfer by absorption'. The new NHS Derby and Derbyshire Clinical Commissioning Group will recognise all of the assets and liabilities received as at the date of transfer (1 April 2019).

39. Losses and special payments
NHS Erewash Clinical Commissioning Group had no losses or special payments in the year, £nil (2017/18, no cases, £nil).

40. Third party assets
NHS Erewash Clinical Commissioning Group had no third party assets in the year, £nil (2017/18 £nil).

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

	2018-19			2017-18		
	Target £'000	**Performance £'000**	**Duty Achieved?**	Target £'000	Performance £'000	Duty Achieved?
Expenditure not to exceed income	150,869	150,856	Yes	148,018	148,005	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	149,925	149,912	Yes	145,584	145,571	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	12,874	12,321	Information only	12,693	12,844	Information only
Revenue administration resource use does not exceed the amount specified in Directions	2,124	1,680	Yes	2,119	1,881	Yes

NHS Erewash Clinical Commissioning Group reported a surplus of £13k after accounting for a £2.5m Commissioner Sustainability Funding adjustment which reduces the historical surplus.

The expenditure performance of £150.856m (£148.005m in 2017/18) and revenue administration resource performance of £1.680m (£1.881m in 2017/18), are both net of the £3k finance cost credit (£3k finance cost credit in 2017/18). 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. Analysis of charitable reserves
NHS Erewash Clinical Commissioning Group had £nil charitable funds (2017/18 £nil).

43. Impact of IFRS
There were no material impacts on NHS Erewash Clinical Commissioning Group as the result of application of IFRS 9 and IFRS 15 in year (2017/18 £nil).

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 2019 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 2019 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 and Social Care Group Accounting Manual 2018/19.

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 Trust 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

The Accountable Officer has prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

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 a year from the date of approval of the financial statements. In our evaluation of the Accountable Officer's conclusions we considered the inherent risks to the CCG's operations, including the impact of Brexit, and analysed how these risks might affect the CCG's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

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 and Social Care Group Accounting Manual 2018/19.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 69, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal controls as they determine are 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 69, 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
28 May 2019

APPENDICES

Better Care Fund metrics

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	7695	7668	8410	7871	8030	7955	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	Quarterly	22111			22066			23346			23228			
					Plan	22075			22235			21974			21648			
				2018/19	Monthly	7450	7650	7415	7783	7655	7426	8098	8023	7921	8229			
					Quarterly	22515			22864			24043						
					Plan	22212			21432			22213			21892			

		Exception Report	Data Source	Period	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
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	170.85	174.1			185.3			175.3			173.5			
				2018/19		66.25	62.64	53.61	53.00	65.05	56.62	60.23	69.87	46.38	42.76			
					161.775	182.5			174.7			176.5						
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%			86.6%			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%			76.5%			
				2018/19		74.1%	71.7%	79.3%	80.3%	80.0%	83.7%	82.8%	85.2%	77.5%	82.8%			
					86.1%	75.2%			79.6%			82.0%						

		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	Actual	191.4	267.5	244.2	256.8	221.9	177.2	199.6	134.9	170.0	214.9	178.4	195.2	
					BCF Plan				268.8	265.7	254.3	262.8	252.9	261.4	261.4	236.1	261.4	
				2018/19	NHS	125.3	119.5	121.5	135.2	138.9	152.8	108.4	131.6	104.9	152.9			
					Social Care	45.1	33.1	21.9	52.2	30.8	36.8	36.3	44.2	38.5	45.0			
					Both	3.5	3.9	7.7	14.8	3.0	0.9	0.8	1.7	0.9	2.5			
					Total	173.9	156.5	151.2	202.3	172.6	190.5	145.5	177.5	144.4	200.4			
					BCF Plan	183.1	185.8	176.5	179.0	172.8	165.1	170.6	165.1	170.6	170.6	154.1	170.6	

Appendix two

Governing Body Attendance Record 2018/19

Governing Body Member	3 May 2018	5 July 2018	2 Aug 2018	17 Aug 2018	27 Sep 2018	1 Nov 2018	13 Dec 2018	24 Jan 2019	28 Feb 2019	28 Mar 2019
Dr Avi Bhatia *Chair, Clinical Chair*	✓	✓	✓	x	✓	x	✓	✓	✓	✓
Dr Markus Henn *Vice Chair, GP Member*	✓	✓	✓	x	✓	✓	✓	✓	x	x
Dr Katherine Bagshaw *GP Member*	✓	✓	x	x	✓	x	✓	✓	✓	x
Dr Duncan Gooch *GP Member*	✓	x	x	x	x	x	x	✓	x	x
Dr Arvind Mistry *GP Member*	✓	x	✓	✓	✓	✓	x	x	x	x
Dr Chris Clayton *Chief Executive Officer*	✓	x	x	✓	✓	✓	✓	✓	✓	x
Louise Bainbridge *Chief Finance Officer*	x	✓	✓	✓	✓	x	x	x	x	
Deborah Hayman *Chief Finance Officer*								✓	✓	✓
Jayne Stringfellow *Chief Nurse Officer*	✓	✓								
Brigid Stacey *Chief Nurse Officer*			✓	✓	✓	x	✓	✓	x	✓
Andrew Booth Lay Member *(Audit)*	x	✓	x	x	x	x	x			
Margaret Amos *Lay Member (Audit)*								✓	✓	✓
Professor Ian Shaw *Lay Member (Governance)*	✓	✓	x	x	✓	✓	✓	✓	x	✓
Pam Watson *Lay Member (Patient & Public Involvement)*	✓	✓	✓	x	x	✓	✓	✓	✓	✓
Officer Derbyshire County Council Representative	x	x	x	x	x	✓	x	✓	x	✓
Healthwatch Representative	x	x	x	✓	✓	x	✓	✓	x	x
Post Vacant *Secondary Care Doctor*	x	x	x	x	x	x	x	x	x	x
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	x	x	✓	✓	✓	✓	✓	✓	✓	✓

Governing Body Member	3 May 2018	5 July 2018	2 Aug 2018	17 Aug 2018	27 Sep 2018	1 Nov 2018	13 Dec 2018	24 Jan 2019	28 Feb 2019	28 Mar 2019
Zara Jones *Executive Director of Commissioning Operations*	x	x	x	x	✓	x	✓	✓	✓	x
Sandy Hogg *Executive Turnaround Director*	x	x	✓	✓	✓	✓	✓	✓	✓	✓
Falu Bharmal Director of Corporate Delivery	✓	✓								

Audit Committees in Common Attendance Record 2018/19

Governing Body Member	30 Apr 2018	23 May 2018	19 Sep 2018	15 Nov 2018	18 Dec 2018	17 Jan 2019	21 Mar 2019
Margaret Amos, *Chair,* *Lay Member (Audit)*	x	✓	✓	x	✓	✓	x
Professor Ian Shaw *Lay Member (Governance)*	✓	✓	✓	✓	x	x	x
Pam Watson *Lay Representative (Patient and Public Involvement)*	✓	✓	✓	✓	✓	✓	x

Clinical and Lay Commissioning Committee Attendance Record 2018/19

Clinical & Lay Commissioning Committee Member	18 May 2018	28 June 2018	9 Aug 2018	13 Sep 2018	11 Oct 2018	8 Nov 2018	13 Dec 2018	31 Jan 2019	14 Feb 2019	14 Mar 2019
GP Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical Representative	x	✓	x	x	✓	✓	✓	✓	✓	x
Secondary Care Doctor	x	x	x	x	x	x	x	x	x	x
Lay Member (Patient & Public Involvement)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lay Member (Patient & Public Involvement)	x	x	✓	x	x	x	x	x	x	x
Lay Member (Audit or Governance)	x	x	x	x	x	x	x	✓	✓	✓
Chief Nurse Officer or Deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Director or Deputy	✓	x	x	x	✓	x	✓	✓	✓	✓
Chief Finance Officer or Deputy	✓	✓	x	✓	✓	x	✓	✓	x	✓
Public Health Representative	✓	✓	✓	✓	✓	✓	x	✓	✓	✓
Executive Director of Commissioning Operations	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Finance Committees in Common Attendance Record 2018/19

Finance Committee Member	21 June 2018	20 July 2018	7 Sep 2018	20 Sep 2018	25 Oct 2018	22 Nov 2018	29 Nov 2018	17 Jan 2019	31 Jan 2019	27 Feb 2019	27 Mar 2019
Governing Body GP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governing Body GP	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	x
Governing Body GP	x	x	x	x	✓	✓	✓	✓	✓	x	x
Governing Body Lay Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governing Body Lay Member	x	✓	✓	✓	✓	x	✓	✓	✓	✓	x
Governing Body Lay Member	x	x	✓	x	✓	x	x	x	x	x	x
Governing Body Lay Member	x	x	x	x	x	x	x	x	x	x	x
Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Turnaround Director	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical Representative (Chief Nurse Officer/Medical Director)	x	✓	x	✓	✓	✓	x	✓	✓	✓	✓

Governance Committees in Common Attendance Record 2018/19

Governance Committee Member	12 April 2018	12 July 2018	13 Sep 2018	8 Nov 2018	10 Jan 2019	14 Mar 2019
Governing Body Lay Member	✓	✓	✓	✓	✓	✓
Governing Body Lay Member	✓	x	x	✓	✓	✓
Governing Body Lay Member	✓	x	x	x	x	x
Governing Body GP	x	x	✓	✓	✓	✓
Governing Body GP	x	x	✓	✓	✓	x
Executive Director (Corporate) or Deputy	✓	✓	✓	✓	✓	✓

Quality and Performance Committees in Common Attendance Record 2018/19

Quality and Performance Committee Member	5 April 2018	3 May 2018	7 Jun 2018	5 Jul 2018	2 Aug 2018	6 Sep 2018	4 Oct 2018	8 Nov 2018	6 Dec 2018	3 Jan 2019	7 Feb 2019	7 Mar 2019
Governing Body GP	✓	✓	✓	✓	✓	x	✓	x	✓	✓	✓	✓
Governing Body GP	x	x	x	✓	✓	x	✓	x	x	x	✓	x
Governing Body GP	x	x	x	x	x	x	✓	x	x	x	x	x
Governing Body Lay Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governing Body Lay Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governing Body Lay Member	✓	✓	✓	✓	✓	x	✓	✓	✓	x	✓	x
Governing Body Lay Member	✓	x	x	x	✓	x	✓	✓	x	x	x	x
Chief Nurse Officer or Deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medical Director	x	x	x	x	x	x	x	x	x	x	x	x
Director of Contracting, Performance and Assurance	✓	✓	✓	✓	✓	✓	✓	x	✓	x	✓	✓
Senior Healthwatch Representative (Derby City)	x	✓	x	x	x	x	x	x	x	x	x	x
Senior Healthwatch Representative (Derbyshire)	✓	✓	x	✓	x	✓	✓	✓	x	✓	✓	x

Primary Care Commissioning Committees in Common Attendance Record 2018/19

Primary Care Commissioning Committee Member	18 July 2018	15 Aug 2018	19 Sep 2018	17 Oct 2018	21 Nov 2018	18 Dec 2018	16 Jan 2019	20 Feb 2019	20 Mar 2019
Governing Body Lay Member	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governing Body Lay Member	✓	✓	✓	✓	✓	✓	✓	✓	✓
Accountable Officer or nominated Deputy	x	x	x	x	x	x	x	x	x
Chief Finance Officer or nominated Deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Nurse Officer or nominated Deputy	✓	✓	✓	✓	x	✓	✓	✓	✓
Medical Director or nominated Deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓

Remuneration Committees in Common Attendance Record 2018/19

Remuneration Committee Member	15 May 2018	15 June 2018	11 Oct 2018	6 Nov 2018	19 Nov 2018	21 Dec 2018	24 Jan 2019
Lay Member (Audit)	✓	✓	x	x	x		
Lay Member (Audit)						✓	✓
Lay Member (Governance)	✓	x	✓	✓	✓	✓	x
Lay Member (Patient & Public Involvement)	✓	x	✓	✓	✓	✓	✓

Glossary

A&E	Accident and Emergency
AfC	Agenda for Change
ASTRO PU	Age, Sex, and Temporary Resident Originated Prescribing Unit
BCF	Better Care Fund
BME	Black Minority Ethnic
BMI	Body Mass Index
bn	Billion
CDI	Clostridium difficile
CATS	Clinical Assessment and Treatment Service
CCG	Clinical Commissioning Group
CETV	Cash Equivalent Transfer Value
CHC	Continuing Healthcare
CQC	Care Quality Commission
CSU	Commissioning Support Unit
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
D2A	Discharge to Assess
DCHS	Derbyshire Community Healthcare Services NHS Foundation Trust
DHU	Derbyshire Health United
E.coli	Escherichia coli
ED	Emergency Department
EIP	Early Intervention in Psychosis
EMAS	East Midlands Ambulance Service NHS Trust
EPRR	Emergency Preparedness Resilience and Response

FCP	First Contact Practitioner
FFT	Friends and Family Test
GBAF	Governing Body Assurance Framework
GPFV	General Practice Forward View
HbA1c	HbA1c is the average blood glucose (sugar) levels for the last two to three months
HSJ	Health Service Journal
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICO	Information Commissioner's Office
IT	Information Technology
JAPC	Joint Area Prescribing Committee
k	Thousand
LMS	Local Maternity System
m	Million
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
NECS	North of England Commissioning Support
NHSE	NHS England
NHS e-RS	NHS e-Referral Service
NIC	Net Ingredient Cost
NICE	National Institute for Health and Care Excellence
NUH	Nottingham University Hospitals NHS Trust
PCD	Patient Confidential Information

PCNs	Primary Care Networks
PICU	Psychiatric Intensive Care Unit
PSED	Public Sector Equality Duty
PSO	Paper Switch Off
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
QAG	Quality Assurance Group
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QP	Quality Premium
SBS	Shared Business Services
SQI	Supporting Quality Improvement
SIRO	Senior Information Risk Owner
STAR PU	Specific therapeutic group age-sex prescribing unit
STHFT	Sheffield Teaching Hospital NHS Foundation Trust
STP	Sustainability and Transformation Partnership
UHDB	University Hospitals of Derby and Burton NHS Foundation Trust
VCS	Voluntary Care Sector
WRES	Workforce Race Equality Standard
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

About NHS Erewash Clinical Commissioning Group (CCG)

NHS Erewash Clinical Commissioning Group brings together the combined expertise of 12 local GP practices to commission health services on behalf of over 98,977 patients in Erewash.

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