NHS
Hardwick
Clinical Commissioning Group

Annual Report & Accounts 2017 - 2018

NHS Hardwick
Clinical Commissioning Group



Contents

FOREWORD

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

Our collective Governing Bodies instigated and supported this change to help create efficiencies and enhanced decision making processes for Derbyshire. The drive to establish closer working relationships is also a key factor in our move towards place-based commissioning and the delivery of enhanced, high quality services to our patients.
The transition to joint working relationships has inevitably resulted in changes to the way we operate. We appointed Dr Chris Clayton as our Chief Executive Officer for our four Derbyshire CCGs from 1 October 2017 and have also appointed Louise Bainbridge as our Chief Finance Officer from 1 November 2017. Our interim, single executive team for the four CCGs was also established at that point. Following a consultation process we are now finalising our substantive executive team.

As part of this process, our four previous Chief Executive Officers and Chief Finance Officers left their respective CCGs during the second half of the year to take up new opportunities. In Hardwick we said farewell to Andy Gregory and Miles Scott along with our sincere thanks for their contributions to the success of Hardwick CCG, and for their support for the transition process to joint functional working.

Locally, our absolute priority is to ensure that we respond to the needs of our local population in Hardwick. I am delighted to say that alongside a year of significant change Hardwick CCG has delivered another strong performance across all areas this year leading on some innovative and forward thinking approaches.

Our Better Care Closer To Home consultation and mobilisation delivered in conjunction with North Derbyshire CCG, providers and other partners is the most significant piece of work Hardwick CCG has delivered this year. The roll out of clinically proven models of home-based care is part of a national move to provide more care at the right time and in the right place. Better Care Closer to Home introduces enhanced and more joined up and integrated community-based services to better support for specific patient groups. These are generally people receiving inpatient care in a community hospital, usually following a spell in an acute hospital because of an illness or accident, and people with dementia who currently receive services in community hospitals. The mobilisation is progressive and programmed over the coming months and years, and we have included commitments and reassurances around continuity of existing services until the new ones are introduced.

I would like to highlight our House of Care programme which enables GPs to work holistically with people with cardiovascular disease and other co-morbidities. In partnership with the British Heart Foundation, the House of Care adopts a “whole person” approach. This includes additional support around coping strategies and other life challenges and it has proven to be really successful for the over 1500 patients who have been part of the programme.
Other Hardwick led initiatives include the Rotating Paramedic project which is a Health Education England (HEE) pilot to trial a new working model for specialist and advanced

paramedics. This will involve deploying them in rotation across a variety of settings including primary and community-based care, as well as within the ambulance service. The dual benefits of this are that it enables frail older patients to remain at home wherever clinically appropriate, and the variety and opportunity to use other skills encourages paramedics to stay in their substantive paramedic roles rather than leave to take up other roles in the health system.

There are other examples in this report of the exciting and innovative work being delivered to enhance the experience of our patients both in Hardwick and across Derbyshire and I hope you will find these a helpful illustration of the work we do.

I am delighted to continue as Chair of the CCG Governing Body and again look forward to working with all of our partners to make a real difference to the health and wellbeing of the people of Hardwick.

Dr Steve Lloyd, Clinical Chair, NHS Hardwick Clinical Commissioning Group

PERFORMANCE REPORT

Dr Chris Clayton
Accountable Officer
NHS Hardwick CCG
23 May 2018

Performance Overview

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

Chief Officer's statement

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

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

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

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

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

Reflecting on the performance in key areas across the system during 2017/18 the system has performed well. We have seen various levels of achievement against the key national standards, underperforming against the 4 hour Accident & Emergency, 6 week Diagnostic, Cancer 2 week breast and 62 day standards. During 2018/19 we will continue to work with the wider health and care system, regulators and STP colleagues in driving improvements to patient care and delivery of national performance standards for the population of Derbyshire. We have seen mixed outputs with A&E under four hour waits at 90.4% (target 95%) which we know is a direct result of higher levels of acuity and we are working to address this. However, our performance on Referral to Treatment for elective surgery within 18 weeks is strong at 94.2% (target 93.3%) which is very positive but we still want to improve further. Our cancer waits within 62 days are also mixed with urgent GP referral to first treatment at 78.1% (target 85%) but NHS screening to first treatment at 91.2% (target 90%). Our teams are working hard to respond to the ever increasing demands across the health and care system and in conjunction with provider colleagues we are constantly seeking out, testing, and where we can demonstrate improvement, enacting new and innovative approaches.
Our Chair has covered some of the highlights in his foreword and I encourage you to read the full examples in the pages that follow. As we look forward to 2018 to 2019 we have some very

significant challenges but we are making real strides in many of the key areas. I offer you my personal commitment and assurance that I will do everything within my power to ensure that we respond to, and meet the needs of our local population whilst also addressing the challenges we face with innovative and robust solutions.

Dr Chris Clayton
Accountable Officer
NHS Hardwick CCG
23 May 2018

Purpose and activities of the CCG

NHS Hardwick Clinical Commissioning Group (CCG) brings together local general practice and other NHS organisations to plan and help shape local health services for the people of Hardwick. The CCG has representation from 15 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 South Normanton, Bolsover and Clay Cross and serves a population of over 103,000.

NHS Hardwick's CCG's mission is to lift the health of the people of Hardwick.

To achieve this, the CCG is constantly working towards the following strategic aims:

- helping people to look after themselves;
- ensuring care is provided closer to home and in the most appropriate setting;
- guaranteeing great specialist care when needed; and
- living within our means (making best use of available resources).

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

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

- Failure to align cross-system investment and savings plans leads to poor value and insufficient funds to invest in service priorities and delivery of the CCG's strategic objectives
- Failure to lead and partner effectively and get better value from working with other CCGs (Lead/ Associate arrangements) will lead to poor use of resources and an inconsistent commissioner approach
- Failure to deliver QIPP leads to lack of financial balance/ viability and an inability to fund transformation in our communities
- Insufficient capacity and resilience in primary care adversely affects quality and access to service impacting service viability
- Failure to manage activity pressures leads to constitutional failures, financial challenge and reputational damage
- Inability to deliver the Sustainability and Transformation Plan across Derbyshire may lead to failure to address Health and Wellbeing gaps, outcomes and cost effectiveness
- failure to consult effectively on strategic service change may lead to legal challenge and reputational damage with specific reference to the Better Care Closer To Home (21C) programme;

Adoption of the going concern approach

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

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

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

Key Developments during 2017/2018

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

Transformation

Better Care Closer To Home (21c #JoinedUpCare Programme)

Better Care Closer to Home (BCCTH) is part of the 21c #JoinedUpCare transformation work. It is driven by the aim to make better joined-up care closer to home a reality for many older people in northern Derbyshire. The programme is focused on introducing enhanced and more joined up community-based services to support:

- Older people receiving inpatient care in a community hospital, usually following a spell in an acute hospital because of an illness or accident, and
- Older people with dementia who currently receive services in community hospitals.

Public consultation

In 2016 we conducted a large scale public consultation which put forward a number of proposals to help make the objectives outlined above a reality. The proposals put forward were a direct response to feedback from patients, their families, carers and others which consistently said that where possible people would prefer to receive their care in or near to home. On completion of the consultation all the responses were analysed by Dr Steven Wilkinson, an independent academic from the University of East Anglia. All feedback was included in the analysis and was represented in the feedback report which was published in the public domain on 1 February 2017.

Decision making

The Governing Bodies of NHS North Derbyshire Clinical Commissioning Group and NHS Hardwick Clinical Commissioning Group met in public in the evening of Monday 24 July to make their decisions on the proposals that were put forward. Papers that supported the

meeting were made available to the public in advance of the meeting and the meeting itself was streamed live on YouTube to ensure as many people as possible were able to view the meeting. The public were also invited to submit any questions about Better Care Closer to Home prior to the meeting. The meeting was attended by over 150 members of the public and hundreds more viewed via the live stream.

The Governing Bodies agreed the proposals. Their decisions meant that the proposals to provide enhanced and more joined up community-based services could enter an implementation phase which would be guided by a set of agreed implementation principles

Implementation

The immediate priorities as the two Clinical Commissioning Groups moved forward with implementation were to:

- Support staff and families who have been used to us providing care in a particular way for a long period of time
- Set up a governance framework for the project

Maternity Transformation Plan

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

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

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

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

The plan outlines an ambitious vision for Maternity Services in Derbyshire. Achieving this vision is as much about creating a lasting ethos of greater collaboration as it is about system design and it will require a cultural shift in many communities, organisations, and also for

professionals working within the system. The CCGs are committed to this vision and the Chief Nurse is the Senior Responsible Officer for the Maternity Transformation Programme.

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

The plan is structured around seven key priorities as follows:

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

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

Integrating Patient Care

Integrated care means the care someone receives should be:

- **Person-centred** - the priority should be meeting the needs of the person not just delivering a service
- **Co-ordinated** - 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 (21C) work programme is being brought together across the county. The roll-out of clinically proven models of home-based care in Derbyshire is part of a national move to provide more care at the right time and in the right place.

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

Community support beds and integrated community services

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

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

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

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

Dementia Rapid Response Team

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

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

The service is being implemented in two phases subject to successful recruitment, it is anticipated that the service will be fully operational across High Peak and North Dales by

September 2018 and across Chesterfield, Bolsover and North East Derbyshire by November 2018.

Within the North of Derbyshire we continue to work with local service providers and partners in Chesterfield we are working with Derbyshire County Council public health colleagues, Chesterfield Borough Council and local housing and falls service providers to explore ways in which we can better identify people at risk of falling to then offer a falls risk assessment and services and information, targeted to reduce a person's risk of falling, for example strength and balance activities.

Mental Health

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

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

The target for 2020 is for 25% of adults with a common mental disorder are treated in IAPT services. By February 2018, 21.7% of Hardwick patients were treated in IAPT services, this figure exceeded our set target for the year, and furthermore, the CCG has been recognised nationally as a 'high performer'. Derbyshire-wide 24% of patients accessed the service. A further target is for 50% of patients who enter therapy to move into a 'recovery' phase. By March 2018 the CCG had again exceeded the target; 56.5% of Hardwick patients entered the recovery stage, whilst the figure Derbyshire-wide was 54%.

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

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

During 2017, the CCGs, local authorities, and service providers have worked together on a Mental Health Transformational Plan. This focuses on four main programme areas where we wish to make progress on: primary care mental health; responsive community mental health and in–patient services; dementia and delirium; rehabilitation and forensic services. The CCGs have seen continued good performance against national indicators for: early

intervention in psychosis; dementia diagnosis; and access to psychological therapies in primary care. Mental Health Liaison Teams in Chesterfield Royal Hospital have been enhanced with both of our major hospitals providing 24-hour mental health cover to the hospital emergency departments.

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

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

Children's Mental Health

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

The Children's Commissioners are now working as one team across the STP footprint. A Future in Mind Strategic Board across the STP footprint has now been established with all key stakeholders, Chaired by the Director of Children's Services for Derbyshire County Council. The voices of children and young people have underpinned developments during 2017/18 and will continue to do so, including leading events with a wide range of stakeholders.

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

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

Children's Commissioning

The CCG Children's Commissioning team has continued to work with partners in the local authority to embed the Special Educational Needs and Disabilities (SEND) Reforms. This has included a significant amount of joint working including several multi-agency training and awareness events and continued improvements to the pathway and process for Education, Health and Care Plans. There has also been work with partners in social care and education

as part of the Transforming Care Program to enable young people with autism and learning disabilities and with mental health needs to be better supported in their local communities. Transformation funding from NHS England has been used to facilitate increased understanding of this cohort and particularly of children and young people with autism.

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

Transforming Care

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

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

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

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

There are many other positive things that have been happening in Transforming Care but it is important that we recognise how far we have come in a year. Derbyshire already had an

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

Safeguarding

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

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

Primary Care

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

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

General Practice Forward View (GPFV)

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

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

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

- Support of General Practice Transformation

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

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

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

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

Care Quality Commission (CQC) Inspections of Primary Care

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

- For practices that have a 'Good' or Outstanding' report, a fully focused visit will take place up to every five years.
- Practices who are rated 'Requires Improvement' will now have a return visit within 12 months, with the six month time frame being abolished.
- 'Inadequate' practices will still have a revisit within six months
- More emphasis on well-led in future inspections as this filters into all areas. The GP insight report is publically available and is published on the CQC website.

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

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

Erewash CCG		**Hardwick CCG**	
Outstanding	2 practices	Outstanding	1 practices
Good	10 practices	Good	13 practices
Requires Improvement	0 practice	Requires Improvement	1 practice
North Derbyshire CCG		**Southern Derbyshire CCG**	
Outstanding	9 practices	Outstanding	12 practices
Good	25 practices	Good	40 practices
Requires Improvement	1 practice	Requires Improvement	3 practices

Support for Quality Improvement Visits

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

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

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

Educational support to General Practice

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

Primary Care-based Dermatology

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

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

Ophthalmology

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

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

Improving communications for clinicians and patients

NHS e-Referral Service

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

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

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

NHS.Net

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

Enhanced Care Home Service

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

Winter Pressures

Hardwick CCG General Practices have again worked together to provide services to patients over a very busy winter. The CCG invested in additional funding to Derbyshire Health United to provide extra GP and nursing appointments over the Christmas holidays and extra capacity until March 2018. The CCG will continue to work with General Practice on plans to improve access and increase capacity, including over the winter. This year the focus has been on capacity in general practice and an evaluation will be undertaken of the effectiveness will be undertaken in 2018/19.

Planned Care

Preventing the onset of Diabetes

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

Chris Askew, Chief Executive, Diabetes UK

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

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

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

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

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

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

Diabetes Treatment Targets

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

Silhouette Telehealth for Diabetic Footcare

Regular assessment of patients with diabetic foot ulcers is vital to ensure timely care and treatment and minimise risk of complications. The Silhouette® 3D digital imaging cameras give an accurate assessment of foot ulcers at outpatient clinics, by capturing wound data which can then be shared remotely with other healthcare professionals. This helps Diabetes Foot teams to deliver care based on objective data and rapidly refer patients from community to hospital if required. Following a successful roll out in South Derbyshire the use of 3D cameras to more accurately assess foot ulcers was expanded across clinics in North Derbyshire during the year, improving wound care and waiting times for diabetes patients. Providing an additional 15 cameras in the community means more Derbyshire patients are regularly monitored without the need for a hospital outpatient appointment.

Since its launch a year ago, Silhouette® has helped to significantly reduce outpatient waiting times, with 72% of patients at the Royal Derby Hospitals now seen within 30 minutes of their appointment time compared with only 3% previously. In the community, 71% of patients are now seen within five minutes of their appointment time. The project was shortlisted for a Health Service Journal (HSJ) Healthcare Partnership Award for Best Innovation in Medical Technology during the year.

Musculoskeletal (MSK)

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

Integration Agenda

Personal Health Budgets

In 2017/2018 we agreed policies and procedures across all four CCGs to ensure a consistent offer around personal health budgets across the patch. We have continued to speak to health and social care teams about personal health budgets to improve understanding and begin to embed personalised approaches. We worked with Treetops Hospice Care and are one of five pilot sites to develop personal health budgets at end of life.

End of Life

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

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

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

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

Place Development

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

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

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

Falls Reduction

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

- In their falls prevention pack person/s will receive information about the local 'Strictly No Falling' (SNF) offer including details of all local classes. The standardised GP invitation letter will be modified to encourage attendance of a local SNF class
- A baseline questionnaire will be included that will outline their current physical activity level, SNF attendance history, barriers preventing them from attending and willingness to be referred to or contacted by the SNF team/local instructor
- The number referred to and commencing SNF classes will be monitored and individual outcomes will be monitored through the SNF project

Delivering Urgent Care

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

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

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

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

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

the service provided to patients, as they are then able to see the most appropriate person within a timely manner.

Please see Performance Analysis section for more detail.

Medicines Management

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

Antimicrobial Prescribing

For 2017/18 the antimicrobial quality premium targets are aimed at improving prescribing for Urinary Tract Infections. The medicines management team worked with all practices in North Derbyshire, and provider organisations including the out of hours provider to help meet these targets. Practices were provided with regular updates of their antimicrobial prescribing throughout the year and prescribing was also discussed at the quarterly prescribing leads' meetings. High antimicrobial prescribing practices were offered audits to compare their prescribing with current guidelines and formularies, and results were then fed back to practices along with an update on current prescribing advice.

Hardwick CCG has shown significant improvement in antimicrobial prescribing during 17-18, it is very close to achieving the antimicrobial quality premium targets. The medicines management team has supported the data collection and audit of patients that have had an E coli Bloodstream infection, to support learning from cases and reducing future infections through improved antimicrobial use.

Stop Over Medicating of Patients with Learning Disabilities (STOMPLD) Review

Following a national 'call to action' to improve the care of patients with a learning disability, the medicines management team developed a review sheet for patients on the Quality outcome Framework (QoF) learning disability register who are prescribed an antipsychotic and/or an antidepressant (excluding patients prescribed an antidepressant for pain).

This in-depth review included:

- Who started the medication
- How long they have been on it
- What previous medication they have been prescribed
- What other CNS drugs they are prescribed
- Whether they are currently under any mental health or learning disability specialist service

The medicines management team has worked closely with the learning disability specialists and they have delivered education to the GPs at the prescribing leads meetings. We have collated the outcome of the work to demonstrate whether patients have a documented medication review, and if they have whether they have had their medicines changed or stopped. Feedback has been provided to practices and the learning disability team to support further future improvements to continue to reduce over medicating patients with learning difficulties.

Cost Saving Work

The medicines management team have worked exceptionally hard with support from general practice and Chesterfield Royal Hospital to deliver over £1.2million in prescribing savings. These savings have been delivered from a number of schemes:

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

Gluten Free Prescribing Consultation

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

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

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

Local Hardwick Initiatives

Examples of initiatives and innovations developed and led by Hardwick CCG include:

Red Bag Hospital Transfer pathway

Following on from the work undertaken in the Vanguards, the Derbyshire CCG's are developing the Red Bag Hospital Transfer Pathway. This programme shows how a partnership across health, social care and the voluntary sector can come together to make a difference for people in care homes who have to be admitted to hospital. The work is expected to 'go live' in May 2018 and in the meantime we are talking to partners about training and communications for staff, developing the paperwork (which goes with the person) in readiness and preparing to deliver around 350 bags to care homes across the county.

The work of the vanguards has seen improvements in communication between health and social care during the persons journey from care home to hospital and back again. It has seen improvements in lost belongings and reduced cost of taxis to transport belongings and medication to the care home after discharge. There is also a reported reduction in length of stay of 4 days on average so these are all areas that we are keen to measure when Derbyshire goes live.

House of Care Programme

The House of Care programme has enabled GP practices to work within a framework to identify people with cardiovascular disease and other co-morbidities, and then to offer them a holistic approach to managing their condition(s) taking account not just of their medical conditions but of their 'whole person' challenges.

The aim of NHS Hardwick CCG's House of Care project was to get to a point where people could say "I can plan my care with people who work together to understand me and my carer(s), allow me control and bring together services to achieve the outcomes important to me."

Hardwick CCG partnered with the British Heart Foundation, the Year of Care Team, Public Health, Primary and Secondary Care to develop and implement the House of Care approach over 3 years. During this time nearly 1500 people have received the new House of Care approach to care and support planning for their long term condition(s).

Feedback from patients has been largely positive. When asked about coping, feedback showed overwhelmingly that, as a result of the consultation, respondents were able to cope better or much better with life, understand their condition(s) better or much better and cope better or much better with their condition(s).

One of the differences with the new approach is that patients are sent their test results in advance of their consultation. Over the two years of active implementation, more than half of respondents reported that the experience of the consultation was better than the previous review. Earlier studies in Gateshead and Newcastle using the House of Care approach also show improvements in 4 clinical outcomes i.e. HbA1c, Blood Pressure, Cholesterol, and weight of between 6.5% and 11% (compared to -0.8% and +2.4% in the control groups) with similar cohorts of patients to those in Hardwick. The next stage for Hardwick will be to look at the impact on clinical outcomes for our populations who have undertaken the House of Care approach.

Paramedic pilot launched in Hardwick

Hardwick CCG is taking part in a Health Education England (HEE) £600,000 pilot to trial a new working model for specialist and advanced paramedics. This will involve deploying them in rotation across a variety of settings including primary and community-based care, as well as within the ambulance service.

Key objectives are to improve patient care by helping frail older people remain at home wherever clinically appropriate, develop new ways to maximise the clinical skills of paramedic practitioners, offer paramedics variety to encourage them to stay in their substantive paramedic roles rather than leave to take up other roles in the health system and reduce workload pressure. Introducing the paramedics into the established Clay Cross integrated care team is the next natural step in Hardwick CCG's development of place-based care.

Working with South Hardwick GP practices, East Midlands Ambulance Service, Derbyshire Community Health Services and Derbyshire Healthcare NHS Foundation Trust, the rotational model in this part of the CCG's pilot aims to further develop the multi-disciplinary elements (MDT) of the rotation in the first phase.

Awards and Innovations

Hardwick CCG was highly commended at the 2017 PrescQIPP Innovation Awards in the Polypharmacy and deprescribing category and for our work on the Falls Medication Optimisation Trigger (MOT) tool.

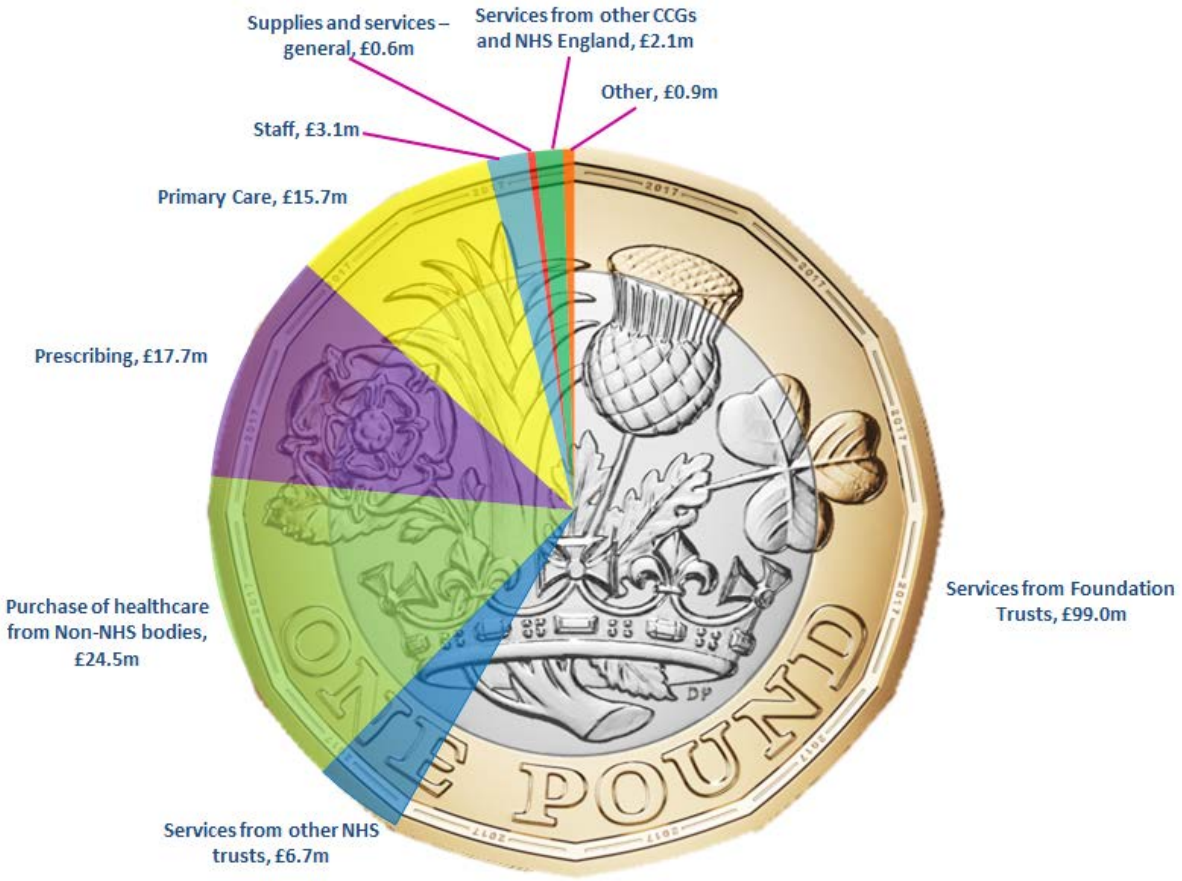
Addressing our financial challenge during 2017/18

CCG funding

The financial environment within the NHS remains extremely challenging. Annual funding settlements for the NHS are set at the minimum level that will deliver the promise of real terms growth, but population increases, demographic factors and underlying growth in demand all have to be met from that minimal increase. In addition Hardwick, an area of significant health inequality and deprivation, continues to be assessed as "above target" for funding. This means that future years' growth will be below the average of the NHS as a whole even though demand tends to grow at above-average rates.

In 2017/18 the CCG has received £169.5m with which to commission the healthcare services that meet the needs of our local people, and to run our organisation. This is compared to the £162.9m received in 2016/17.

A breakdown of the CCG's spend in 2017/18 is shown pictorially below in the Derbyshire pound:



2017/18 Financial Performance

CCG's have a number of statutory financial duties:

- to achieve financial balance by ensuring that annual income exceeds annual expenditure;
- to operate within the annual limit for Revenue expenditure;
- to operate within the annual limit for capital expenditure; and
- to ensure the expenditure on Running Costs is within the annual limit.

The CCG has met achieved all statutory duties. A summary of the CCG's performance against these statutory financial duties can be found in Note 42 of the accounts.

Our CCG was set a financial target (control total) of delivering a balanced position in 2017/18. The CCG financial plan was based on a level of activity growth in each of the main service areas, and budgets were set to meet this expenditure and deliver this position. In order to achieve this financial position, we had to identify planned savings totalling £6.8m and these were set in in our QIPP programme for 2017/2018. This is more than 50% up on the previous year's target and represents over 4% of the CCG's annual expenditure.

Impact on 2018/2019 Financial Planning

Moving forward we recognise that the risks to financial stability have again stepped up across all organisations and there is work to do to improve our financial resilience as a CCG and across Derbyshire. The Derbyshire CCGs are working in conjunction with NHS England to develop our financial recovery plan, which will enable us to improve our financial position.

The CCG will receive an additional £3.2m in recurrent resources in 2018/19 but estimated increases in patient care demands from population growth and developments in treatment will add around £11.3m to CCG spending. In order to meet the agreed 2018/19 control total deficit of £2.5m the CCG therefore faces savings initiatives required of £5.6m.

This is a very significant challenge and substantial planning and effort is underway to identify and deliver this major task over the next 12 months.

Performance Analysis

One of the key areas of focus outlines in the CCGs Operational Plan for 207/18 was to maintain system resilience, performance and meeting all constitutional exceptions.

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

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

How performance is measured

Performance against the NHS Constitution targets is monitored regularly in the Derbyshire CCGs. We look at a range of data, validated and 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 STP during the year. Ensuring good access to effective local primary care and community services remains a priority. The Derbyshire CCGs have continued to support a successful transformation programme that began in 2015/16. These individual projects that make up this transformation programme all have identified target measurements that show:

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

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

2017/18 Performance Summary

The overall performance of the CCG in 2017/2018 has been strong. We have delivered 14 of the 30 constitutional or mandated standards for our patients.

Those standards that have not been achieved are detailed by exception in the Performance analysis section of this report.

The following table shows how we have performed against the standards for 2017/18:

Indicator		Standard	CCG	County Wide
Referral to Treatment	18 weeks Referral to Treatment – Elective Surgery	92%	**92.5%**	**92.8%**
	18 weeks Referral to Treatment - 52+ week wait	0	**6**	**83**
Diagnostic waits	Diagnostic test waiting more than 6 weeks from referral	1%	**0.87%**	**1.11%**
A&E waits	A&E <4 hours	95%	**92.5%**	**89.7%**
Cancer waits - <14 days	Urgent GP referral to 1st outpatient appointment	93%	**90.8%**	**94.4%**
	Urgent GP referral to 1st outpatient appointment. (Breast symptoms)	93%	**83.1%**	**91.1%**
Cancer waits - <31 days	Diagnosis to first definitive treatment for all cancers	96%	**96.2%**	**96.6%**
	Subsequent Surgery within 31 days of Decision to treat.	94%	**96.9%**	**96.8%**
	Subsequent Drugs treatment within 31 days of decision to treat.	98%	**98.9%**	**98.7%**
	Subsequent radiotherapy treatment within 31 days of decision to treat.	94%	**95.6%**	**95.0%**
Cancer waits - <62 days	Urgent GP referral to first definitive treatment for cancer	85%	**73.1%**	**79.5%**
	NHS screening service to first definitive treatment for all cancers	90%	**93.0%**	**91.8%**
	First definitive treatment following a consultant's decision to upgrade (all cancers)	N/A	**75.0%**	**84.9%**
Mental Health	CPA 7 days follow up	95%	**96.8%**	**98.1%**
	IAPT Access	15%	**21.9%**	**24.3%**
	IAPT Recovery	50%	**56.3%**	**54.4%**
	IAPT Waiting times (6 weeks)	75%	**88.1%**	**81.4%**
	IAPT Waiting times (18 weeks)	95%	**99.8%**	**99.8%**
	Early Intervention in Psychosis – Completed	50%	**100%**	**89.0%**
	Dementia Diagnosis	67%	**76.6%**	**73.2%**
Infection control	C. Diff	**43**	**28**	**270**
	MRSA	0	**2**	**3**
Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	**3**	**145**

2017/2018 Performance Exceptions

Patients waiting more than 52 Weeks for treatment

During 2017/18, Hardwick CCG reported 6 patients waiting longer than 52 weeks from referral to treatment.

In response to pressures faced by hospitals over the winter period, NHSE asked hospitals to defer non-urgent operations to free up capacity to deal with winter pressures. This has resulted in a short term impact on patient waiting times resulting in an increased number of 52+ week waiters.

The CCG actively monitors all patients waiting over 40 weeks, requesting a timeline analysis for patients waiting for longer than 52 weeks. The CCG have raised a contract performance notice with Chesterfield Royal Hospital to reduce the number of patients waiting over 52

weeks A recovery plan has been agreed with the trust and assurance has been received that no patient will have to wait longer than 52 weeks for treatment from May 18.

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

Hardwick CCG failed to deliver against the national stand of 95% of patients being seen within 4 hours of attending A&E, with annual performance position at 92.5%. The failure to meet the national standard can be attributed to performance at Chesterfield Royal Hospital FT (84.7%) and Sherwood Forest Hospitals (92.3%). The CCG continues to work with the acute providers and lead commissioners to ensure robust recovery action plans are in place and monitored.

Cancer

During 2017/18 Hardwick CCG is failed to achieve the 95 % national standard for the Cancer 62 day urgent GP referral with performance 73.1%. The failure can be attributed to internal hospital delays at various providers. The vast majority of H CCG patients attend CRHFT. A 62 day recovery action plan is in place which details how improvements will be made. The date for recovery is by June 2018. The CCG continue to work with local providers and regulators to ensure that pathways are aligned and offer reduced waiting times for patients.

Cancer 2 week waits have failed to achieve against the standard during 2017/18. This is as a result of increased referrals due to public awareness campaigns and low outpatient appointment capacity within 14 days of referral at Chesterfield Royal Hospital NHS FT between April and September 2017. Performance improved between October 2017 and February 2018 but has since failed in March 2018.

Subsequent radiotherapy treatment within 31 days of decision to treat failed to achieve the national standard. This target was achieved in 7 out of the 12 months for 17/18. One of the issues which resulted in non-compliance for the year was due to a lack of capacity at Sheffield Teaching Hospital NHS FT.

IAPT Recovery Times

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

Healthcare Acquired Infections

Clostridium difficile (C. Difficile)
Each CCG has an individual objective for Clostridium difficile infection. Across the four CCG's as a whole Derbyshire is under objective. Hardwick CCG has an annual objective of 43 cases and at the 2017/18 year end there have been 28 cases.

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

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

MRSA

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

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

Escherichia coli (E.coli) bacteremia

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

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

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

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

Mixed Sex Accommodation

The NHS has a zero target for mixed sex accommodation breaches. The CCG reported 3 breaches during 2017/18.

Ambulance Response Times

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

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

Over the winter period EMAS experienced demand pressures resulting in frequent application of their Capacity Management Plan (CMP) level 4, which is the highest level. Handover delays at Acute Trusts continue to cause further operational pressures, with work ongoing between Acute Hospitals, Commissioners and Regulators to improve.
A demand and capacity review was undertaken during 2017/18 which identified that EMAS required additional front line resources to deliver national performance standards at a County level. Given the timeline to recruit, locally agreed trajectories have been agreed from Quarter Two 2018/19 onwards which work towards delivery of national standards at a county level from Quarter One 2019/20.

NHS 111

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

The NHS111 service across Derbyshire is provided by DHU111 (East Midlands) CIC, (DHU111), the contract is regional and covers four other counties also. This contract has been in place now for the last 19 months. The past 12 months have seen significant change in the NHS111 service. Part of this change has been directed nationally with the publication of the Integrated Urgent Care Service Specification.

This document mandates the implementation of ambulance disposition validation, which DHU111 have been doing for the past year. This has saved thousands of ambulance referrals to EMAS. Another element that DHU111 have delivered is to increase the number of calls that have clinical input.

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

There has been a significant increase in awareness and utilisation of the service, which has put pressure on the provider to deliver. Performance was strong in the first six months of the year however was not maintained throughout the last six months. A number of factors have contributed to this not least the increase in the number of calls the service has seen, which has been exacerbated by an NHSE media campaign across the region. Performance in a NHS111 service is inextricably linked to staffing levels and much effort has been placed here over the past year. DHU111 have a rolling recruitment programme and have invested considerable time and money on improving staff retention and reducing sickness and absence levels to deliver a more robust workforce model.

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

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

CCG Improvement and Assessment Framework (CCG IAF)

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

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

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

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

The IAF also contains six clinical priority areas – the standards for these are included in the 51 indicators mentioned above but are assessed separately by a panel. The final assessments will be published in July 2018.

Children's Wheel Chairs

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

- Review the Eligibility Criteria for the Service, and compare this to what is available in other parts of the country
- Set up a panel, with independent clinical representation, to make decisions on unusual cases which don't fall within the Eligibility Criteria. This ensures that decisions are taken swiftly, within agreed timescales
- Agree what information commissioners need to understand how well the service is performing, and ensure that this is received every month
- Worked with NHS England on the development of personal wheelchair budgets
- Researched what works well in other areas, particularly those services who have a 'child in a chair in a day' system

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

Serious Incident reporting

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

Never Events

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

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

Better Care Fund (BCF) metrics

In 2017/18, the CCG has pooled £10.8m of its resources directly with Derbyshire County Council (£21.3m in total including other CCG spend on BCF) 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 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 where improvements are needed. It is a quick and anonymous way for patients to give their views after receiving care or treatment across the NHS. From April 2014, the Staff FFT was introduced to allow staff feedback on NHS Services based on recent experience. Staff are asked to respond to two questions. The 'Care' question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care. The 'Work' question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work. Staff FFT is conducted on a quarterly basis.

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

Sustainable Development

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

"The aim of NHS Hardwick 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 programmer development. The CCG is compliant with those

elements of the Climate Change Act and adaptation reporting requirements, which are relevant to them as a commissioning organisation with no responsibility for estate/property assets.

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

- **Energy:** by reducing total consumption.
- **Consumables:** by sending key meeting papers electronically instead of print copies and encouraging recycling.
- **Travel:** by reducing the carbon footprint through Sustainable Travel Plans.
- **Procurement:** by taking account of the Procurement for Carbon Reduction (P4CR) Sustainable Procurement tool.

Improving Quality

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

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

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

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

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

- CRHFT have worked to reduce avoidable harm to patients focusing on recognising and responding to deteriorating patients and the development of a new trust wide observation policy and chart.
- The CCG has seen significant work across the system in the implementation of D2AM pathways, including at CRHFT where there has been significant work around communication and discharges with the introduction of a multi-agency discharge hub and integrated working across the system to introduce discharge to assess and manage pathways which has directly improved patient care through the reductions in delayed discharges and ensuring that patients are assessed closer to home.
- The CCG has seen evidence of significant work being undertaken at DTHFT in relation to pressure ulcers with a thematic review identifying medical device related injuries as a contributory factor to pressure ulcer incidents. Communication between departments, training and awareness has been rolled out and a significant fall in medical device related harms associated with casts and splints has been seen.

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

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

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

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

Commissioning for Quality and Innovation

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

National indicators for 2017/18 included:

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

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

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

- Managing some of the most common chronic diseases, e.g. asthma, diabetes and heart disease.
- Managing major public health concerns, e.g. smoking and obesity.

- Implementing preventative measures, e.g. regular blood pressure checks and screening

Care Homes

Hardwick CCG holds the NHS standard contract (AQP) on behalf of all of the four Derbyshire Clinical Commissioning Groups and host the Care Home Clinical Quality team. The Clinical Quality Team is responsible for quality monitoring the standards of care homes across Derbyshire to improve the outcomes and experiences for people who live in care homes.

The team work closely with Local Authorities in Derbyshire to support people to remain in care homes rather than be admitted to hospital; and to improve standards of clinical care.

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

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

Engaging People and Communities

Public Engagement and Consultation

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

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

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

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

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

Better Care Closer to Home

In 2016 NHS Hardwick Clinical Commissioning Group and NHS North Derbyshire Clinical Commissioning Group agreed a Pre-Consultation Business Case which proposed changes in:

- Specialist Older Peoples Mental Health
- Older Peoples Mental Health Day Services
- Community Bedded Care
- Other Services

The public consultation ran from 29/06/16 to 05/10/16 with a further month's clarification process.18 public meetings attended by over 1,500 people. 20 drop in sessions held in GP practices. Targeted communication was made to seldom-heard voices. Attended stakeholder meetings, self-help groups, 2,260 response forms, over 150 telephone help-line enquirers and letters and petitions, information and listening stalls displayed in towns and communities.

The Governing Body of NHS Hardwick Clinical Commissioning Group and the Governing Body of NHS North Derbyshire Clinical Commissioning Group met in public on Monday 24 July, 7pm at County Hall in Matlock to discuss the feedback received during the Better Care Closer to Home consultation and make decisions on the proposals that were put forward. https://www.northderbyshireccg.nhs.uk/latest_news/press_releases/better_care_closer_to_home/

Prescribing Public Consultations

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

Better Health Starts at Home 'Self Care' Public Consultation

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

The Gluten Free Prescribing Public Consultation

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

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

Better Births Derbyshire

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

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

South Yorkshire, Mid Yorkshire, Bassetlaw and North Derbyshire Service Reviews

Hardwick and North Derbyshire CCGs participated in a Sheffield CCG led consultation with the public on proposals to change the way Hyper Acute Stroke Services and some out of hours Children's Surgery and Anaesthesia are provided. The public consultation took place between 3 October 2016 and 14 February 2017. Decisions were taken at the South Yorkshire and Bassetlaw joint committee of clinical commissioning groups Children's Surgery & Anaesthesia in June 2017, and Hyper Acute Stroke Services in November 2017.

Hospital Services Review

In August 2017 the South Yorkshire and Bassetlaw Accountable Care System commenced an independent review of five hospital services at: Barnsley Hospital, Chesterfield Royal Hospital, Doncaster and Bassetlaw Teaching Hospitals, Rotherham Hospital, Sheffield Children's Hospital, Sheffield Teaching Hospitals.

The work will explore how the five services could be future-proofed to ensure local people have access to safe, high quality care provided by the most appropriate healthcare professional and in the best place. The services are: Urgent and emergency care, Maternity services, Hospital services for children who are particularly ill, Gastroenterology services, Stroke (early supported discharge and rehabilitation).

Patient, public and clinical involvement has been key to the ongoing review, with engagement including conversations with seldom heard communities, a demographically representative tele-survey with 1000 people, an online survey and regional and local meetings, stalls and events. The findings from the engagement to date can be found here. North Derbyshire will continue to work collaboratively with SYB to incorporate the views of local people. www.workingtogethernhs.co.uk.

Patient and Public Involvement in Derbyshire

Further information is available on the link below of how the CCG involves on an ongoing basis patients and the public in its commissioning arrangements (planning, decision-making and proposals for change)

http://www.hardwickccg.nhs.uk/patient-and-public-participation/

Engaging Patients in STP

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

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

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

The engagement focused on:

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

Find out more, visit joinedupcarederbyshire.co.uk/

Reducing Health Inequality

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

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

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

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

Working together with a wider team means we will be able to provide a more coordinated approach to patient care. It will ensure patients have access to the organisations that are the most appropriate to help and support them. The clinicians involved will be able to provide the skills and mentorship for each other, to work together, freeing up more time for them to focus on their areas of expertise. In addition, the closer working relationships will mean improved access

to support and advice when needed. Collaborative working across 'places' means that there will be a pooled workforce which should create flexibility in clinicians' roles.

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

The Patient Experience Team are regular participants in the Chesterfield Equality & Diversity Forum which provides a forum to consider Equalities issues. The team has been able to participate in specialist training such as Lesbian, Gay, Bisexual and Transgender (LGBT) awareness and LGBT Deaf Awareness. Contacts made led us to link the Derbyshire LGBT forum with Quality Managers in the CCG in order to pursue LGBT awareness training for care home staff. Through the forum we were also able to participate in the Links CVS Celebrating Diversity lunch and mingle events which have proven a valuable forum for us to make links with diverse groups in our community.

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

Health and Wellbeing in Derbyshire

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

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

The wider determinants of health underpin lifestyle risk factors; in Derbyshire 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* which is worse than the England average and represents 75 stays per year.

Priorities for Derbyshire include reducing inequalities in healthy life expectancy, emotional health and wellbeing of children and young people, and smoking in pregnancy.

* rate per 100,000 population

Health and Wellbeing Board and Health Improvement Scrutiny Committee

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

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

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

Health and Wellbeing Strategy

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

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

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

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

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

Equality Delivery System (EDS2)

The Derbyshire CCGs have demonstrated a proactive approach to meeting the requirements of the Public Sector Equality Duty through the use of the NHS Equality Delivery System 2 (EDS2). The CCG's equality objectives and EDS2 report can be found via the following link: http://www.hardwickccg.nhs.uk/ccg-documentation/

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:

Hardwick 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, Hardwick 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 adopts 'due regard' in all 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 the decision making process. This is evidenced in the design of policies, service specifications and contracts. Such evidence is reviewed as part of the decision process and summarised in all Committee and Governing Body cover sheets.

Due regard

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

ACCOUNTABILITY REPORT

Dr Chris Clayton
Accountable Officer
NHS Hardwick CCG
23 May 2018

Corporate Governance Report

Members Report

Member Practices

The CCG is comprised of the following 15 member practices:

NHS Hardwick CCG Member Practices	
Practices	**Branch Surgeries**
Blackwell Medical Centre	
Blue Dykes Surgery	Grassmoor Surgery
Castle Street Medical Centre	
Clay Cross Medical Centre	Tupton Surgery
Crags Health Care	Crags Healthcare - Creswell
Creswell and Langwith Medical Centres	Langwith Surgery
Emmett Carr Surgery	Eckington Health Centre
Friendly Family Surgery	
Limes Medical Centre	
North Wingfield Medical Centre	
Shires Health Care	Church Warsop Surgery
St. Lawrence Road Surgery	
Staffa Health	Holmewood, Stonebroom and Pilsley
The Village Surgery	The HUB at South Normanton
Wingerworth Surgery	North Wingfield Surgery

A Membership Forum has been established by the CCG, with representation from each of the member practices and provides the forum for the discussion of matters reserved to the membership.

Composition of Governing Body

The Governing Body Members for the CCG are:

NHS Hardwick CCG Governing Body Members	
Position	**Name**
Chair (Clinical Lead)	Dr Steven Lloyd
Accountable Officer (Chief Officer)	Andy Gregory (to 30 September 2017)
Accountable Officer	Dr Chris Clayton (from 1 October 2017)
Elected GP Member	Dr Ruth Cooper
Elected GP Member	Dr Sudeep Chawla
Chief Finance Officer	Miles Scott (to 31 October 2017)
Chief Finance Officer	Louise Bainbridge (from 1 November 2017)
Chief Nurse Officer	David (Jim) Connolly (to 31 August 2017)
Interim Chief Nurse & Quality Officer	Jayne Stringfellow (from 1 September 2017)
Lay Member (Audit & Governance)	Jill Dentith

NHS Hardwick CCG Governing Body Members	
Position	**Name**
Lay Member (Patient & Public Involvement)	Gillian Orwin
Secondary Care Specialist Doctor	Dr Lucy Morley
Chair of Hardwick Practice Managers'	Post Vacant
Senior Public Health Representative	Maureen Whittaker, *Associate Director of Public Health, Derbyshire County*
Officer of Derbyshire County Council	Julie Vollor, *Assistant Director Strategy & Commissioning, Adult Care*

Audit Committee Membership

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

NHS Hardwick CCG Audit Committee Members	
Position	**Name**
Chair – Governing Body Lay Member (Audit & Governance)	Jill Dentith
Governing Body Lay Member (Patient & Public Involvement)	Gillian Orwin
Lay Representative appointed by the Governing Body	Valerie Beattie
Lay Representative appointed by the Audit Committee	David Heathcote

Further information and details of other committees and sub-committees, including the Remuneration Committee can be found in the Governance Statement.

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 at *http://www.hardwickccg.nhs.uk/ccg-documentation/* and is available on request at the CCG Headquarters.

Personal Data Related Incidents

No incidents involving data loss or confidentiality breaches by the CCG have been reported during the year.

Statement of Disclosure to Auditors

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

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

Modern Slavery Act

NHS Hardwick CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2018 is published on our website at http://www.hardwickccg.nhs.uk/modern-slavery-act/. 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 are transparent, accountable and auditable; and are free from ethical ambiguities.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) (the NHS Act 2006) states that each Clinical Commissioning Group (CCG) shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Dr Chris Clayton to be the Accountable Officer of NHS Hardwick CCG.
The responsibilities of an Accountable Officer are set out under the NHS Act 2006, Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- Keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction;
- Such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error;
- Safeguarding the CCGs assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- The relevant responsibilities of accounting officers under Managing Public Money;
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the NHS Act 2006 and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the NHS Act 2006; and
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the NHS Act 2006.

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

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Assess the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the NHS Act 2006, Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information; and
- The annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Dr Chris Clayton
Accountable Officer
NHS Hardwick CCG
23 May 2018

Governance Statement

Introduction and Context

NHS Hardwick Clinical Commissioning Group ("the CCG") is a body corporate established by NHS England on 1 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 1 April 2017, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

The CCG covers a population of over 102,000 patients registered with 15 practices, plus those unregistered patients within the geographical boundary of the CCG. The CCG has been founded on established relationships, built on years of practice-based commissioning and resulting in a cohesive and well-established group of engaged primary care clinicians and managers. The primary care providers across the Hardwick geography consist of 12 independent practices, which have formed North Eastern Derbyshire Healthcare, a federation of GP practices. In addition, there are two GP practices which are operated by Derbyshire Community Healthcare Services NHS Foundation Trust and one practice which is operated by Royal Primary Care, a subsidiary of Chesterfield Royal Hospital NHS Foundation Trust.

The population served by the CCG predominantly lives within the boundaries of two district local authorities, North East Derbyshire District Council and Bolsover District Council. There is a mix of urban and rural communities, with centres of population in and around a number of small towns and villages across the north eastern part of Derbyshire, bordering Nottinghamshire to the east and South Yorkshire to the north.

Scope of Responsibility

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

I am responsible for ensuring that the 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 15 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 November 2015, and is currently under review to bring consistency across the four Derbyshire CCG's constitutions.

Membership Forum

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

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

Governing Body

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

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

NHS Hardwick CCG Governing Body Membership
Chair (the designated Clinical Leader), elected by members
Two GPs, elected by members
Accountable Officer
Chief Finance Officer
Chief Nurse Officer (Registered Nurse)
Two Lay Members, of whom: one is Deputy Chair, and lead for audit, and governance matters one is Lead for patient and public participation matters
Secondary Care Specialist Doctor
Officer representative of Derbyshire County Council
Senior representative from Derbyshire County Council, Public Health
Chair of Hardwick Practice Managers' Group (vacant)

The Governing Body met a total of 10 times in public during 2017/18, with one urgent decision meeting in December 2017. The Governing Body also met jointly with North Derbyshire Clinical Commissioning Group in July 2017 to agree the 21st Century Better Care Closer to Home Business Case; and both publicly and confidentially with Erewash Clinical Commissioning Group, North Derbyshire Clinical Commissioning Group and Southern Derbyshire CCG to discuss the future working arrangements of the Derbyshire CCGs.

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

Governing Body Performance

Examples of the performance, effectiveness and improvements identified during the fifth year since authorisation include:

- 21st Century Better Care Closer to Home Business Case
- Better Health Starts at Home medicines 'Self-care' public consultation outcome and policy

Following a decision by the CCG to appoint a joint Executive Team across the 4 Derbyshire CCGs the CCG Remuneration Committee approved an exit payment for the existing Accountable Officer. October 2017, saw the appointment of a single Derbyshire Accountable Officer, Chris Clayton and in November 2017 a single Derbyshire Chief Finance Officer, Louise Bainbridge.

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

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

The following governance arrangements were agreed to be established by the Governing Bodies:

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

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

Building on the significant 21st Century Better Care Closer to Home (BCCTH) public consultation during 2016/2017, North Derbyshire CCG Governing Body continued to play an active role in working together with Hardwick CCG Governing Body. In July 2017, the two Governing Bodies held a public extraordinary meeting where the BCCTH proposals were considered and approved. The implementation of the proposals is well underway and Governing Body play a key role in the decisions and ensure that the agreed principles for the programme are adhered to.

Governing Body are also fully involved in the development of the STP and the progression to a Strategic Commissioner.

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

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

Business cases for services to be brought in-house were developed and submitted to NHSE in February 2017 for consideration, and approval given in September 2017. The following services were in housed to the Derbyshire CCGs and TUPE transfer took place on the 1st February 2018: Communications and Engagement, Information Governance, Human Resources – business partner element, Equality, Inclusion and Human Rights, IFRs, Voluntary Sector contracts, Business Continuity, PALS & Complaints, Freedom of Information, Collaborative Contracting. CSU Finance services will transfer to the Derbyshire CCG's from 1st May 2018.

The Governing Body received assurance on the effectiveness of its committees/groups through minutes from its committees groups.

Sub Committees of the Governing Body

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

The governance structure of the CCG comprises:

- Membership Forum
- Governing Body
- Committees of the Governing Body:
  - Audit Committee
  - Commissioning Delivery Group
  - Corporate Performance Committee
  - Patient Reference Group
  - Quality Committee
  - Remuneration Committee

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

Audit Committee

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

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

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

The composition of the Audit Committee is as follows:

NHS Hardwick CCG Audit Committee Membership
Chair – Governing Body Lay Member, Audit and Governance
Deputy Chair – Governing Body Lay Member
Two Lay Representatives

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

Significant items approved/discussed by Audit Committee 2017/18
Governance, Risk Management and Internal Control
Annual Report and Accounts
Board Assurance Framework / Risk Register 2017/18
Financial Recovery Plan
Risk Management Strategy and Framework
Service Auditor Reports
Internal Audit
Internal Audit Progress Reports
Head of Internal Audit Opinion
Internal Audit Plan 2017/18
External Audit
Annual Audit Letter
External Audit Plan 2017/18
KPMG International Standard on Auditing 260 Report
Counter Fraud
Counter Fraud, Bribery & Corruption Risk Assessment Work Plan and Self Assessment against Counter Fraud Commissioner Standards

Audit Committee Attendance Record 2017/18

Audit Committee Member	20 Apr 2017	23 May 2017	19 Oct 2017	19 Mar 2018	% Total
Jill Dentith *Chair,* *Governing Body Lay Member (Audit and Governance)*	✓	✓	✓	✓	100
Gillian Orwin *Deputy Chair,* *Governing Body Lay Member (Patient & Public Involvement)*	✓	✓	✓	✓	100
Valerie Beattie *Lay Representative*	✓	✓	✓	✓	100
David Heathcote *Lay Representative*	✓	x	✓	✓	75

A benchmark of one meeting per quarter at appropriate times in the reporting and audit cycle is suggested.

The Committee met four times in 2017/18. The quorum necessary for the transaction of business is two of the four members of the Audit Committee. This requirement was met and exceeded at each meeting.

Remuneration Committee

The composition of the Remuneration Committee is as follows:

NHS Hardwick CCG Remuneration Committee Membership
Governing Body Lay Member, Audit & Governance (Chair)
Governing Body Lay Member, Patient & Public Involvement
Governing Body Secondary Care Specialist Doctor

The Membership was supported by a Human Resources advisor at each meeting and officers of the CCG attended as appropriate.

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

Significant items approved/discussed by Remuneration Committee 2017/18
Payment of redundancy and associated exit payments to the Accountable Officer
Payments for Clinical Sessions
Remuneration of a substantive Accountable Officer and Chief Finance Officer across the four Derbyshire CCGs
Remuneration and relocation package for an Accountable Officer across the four Derbyshire CCGs
Remuneration of Governing Body Secondary Care Doctor
Salary Review for the Derbyshire CCGs Very Senior Managers

The Remuneration Committee met a total of five times in 2017/18.

The quorum necessary for the transaction of business is two voting members and this was met at all meetings, which were chaired by the Governing Body Lay Member for Audit and Governance.

Corporate Performance Committee

The composition of the Corporate Performance Committee is as follows:

NHS Hardwick CCG Corporate Performance Committee Membership
Chair – Governing Body Lay Member, Patient & Public Involvement
Deputy Chair – Lay Representative
CCG Practice Manager
Chief Commissioning Officer
Chief Finance Officer
Chief Officer
Engagement Lead
Governance Lead
Governing Body GP Member
Patient Reference Group Representative
Performance Lead
Registered Nurse

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

Significant items approved/discussed by Corporate Performance Committee 2017/18
Primary Care Commissioning
Care Quality Commission Reports
Derbyshire Sustainability and Transformation Plan Primary Care Workforce Report
GMS Contract Changes 2017/18
GP Five Year Forward View
Local Planning Policy
National Patient Survey Results
Primary Care Strategic Advisory Group
Finance
Quality, Innovation, Productivity and Prevention
Performance
360 Assurance Internal Audit – Procurement of Healthcare Service Contracts
CCG Communications Report
Commissioning Performance
Emergency Planning
Integrated Performance, Quality & Finance Report
Corporate Governance
Board Assurance Framework 2017/18
Business Continuity Planning
Cyber Security
Emergency Planning, Preparedness and Resilience
Equality and Diversity Compliance
Freedom of Information Requests

Significant items approved/discussed by Corporate Performance Committee 2017/18
Health & Safety Compliance
Human Resources
Information Governance Compliance
Risk Register
Security Management
Workforce Reports

The Corporate Performance Committee met a total of six times in 2017/18.

The quorum for the meeting requires four members to attend, including the Chair or Deputy Chair. The quorum also requires a GP/Member Practice Representative, except in the case that the decision relates to a matter in which a conflict of interest exists. This requirement was met and exceeded at each meeting. Other attendees were invited to the meeting to report on specific areas, thereby providing the Committee with wider assurance.

Commissioning Delivery Group

The composition of the Commissioning Delivery Group is as follows:

NHS Hardwick CCG Commissioning Delivery Group Membership
Chair – CCG Chair
Chief Commissioning Officer
Chief Finance Officer
Chief Nurse Officer
Chief Officer
Clinician or Practice Manager from each Member Practice
Director of Transformation and Clinical Programmes
Patient Reference Group Representative

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

Significant items approved/discussed by Commissioning Delivery Group 2017/18
Vision and Strategy
21st Century Better Care Closer to Home
CCG and Place: Planning for the Future
Engagement Scheme
GP Five Year Forward View and Place
Primary Care Commissioning 2018/19
Primary Care Governance
The Future for Hardwick CCG Membership Practices moving to Place
Clinical Commissioning/ Leadership
Acute Kidney Injury Audit
Atrial Fibrillation Detection Devices
Basket of Services Specifications
Chronic Pain of the Chest and Abdomen
Contracting and Commissioning Position
Live Better Derbyshire Specialist Weight Management Services

Significant items approved/discussed by Commissioning Delivery Group 2017/18
Mental Health Enablement Service
Procedures of Limited Clinical Value
Reinvestment of Basket Funding
Repeat Dispensing
Two Week Wait Referral Forms
Winter Pressures Funding 2017/18
Review and monitoring of CCG and practice activity
Financial Position
Quality, Innovation, Productivity and Prevention
Quality Premium – Use of the Electronic Referrals Service (ERS)
Winter Pressures Funding 2017/18

The Commissioning Delivery Group met a total of five times in 2017/18.

The quorum for the meeting requires eight member practices to attend and this requirement has been met and exceeded at each meeting, averaging 10 per meeting across the five meetings in 2017/18.

Patient Reference Group

The composition of the Patient Reference Group is as follows:

NHS Hardwick CCG Patient Reference Group Membership
Voting Members
Chair – Governing Body Lay Member, Patient & Public Involvement
Chair of each CCG Patient Participation Group
Hardwick CCG Practice Managers' Group representative
Nominated representative from each practice patient list
Non-Voting Members
CCG representative
Chief Officer (or other senior manager as deputy)
Co-opted members, as appropriate
GP Lead
Representative of the Hardwick Practice Managers' Group
Representatives of appropriate community groups (especially those representing seldom-heard groups)

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

Significant items approved/discussed by Patient Reference Group 2017/18
Engagement
21st Century Better Care Closer to Home
Ambulance Response Programme
Care Homes
Financial Plan
Patient Survey
Primary Care Workforce Report

Significant items approved/discussed by Patient Reference Group 2017/18
Involvement
Patient and Public Participation in Community Health and Care
Patient Engagement Charter
Self-Care Consultation
Influence
High Intensity User Service
Patient and Community Engagement
Patient Participation and Involvement
Phlebotomy arrangements at Walton Hospital
Procedures of Limited Clinical Value

The Patient Reference Group met a total of seven times in 2017/18.

While the group has no decision-making responsibilities, it may however wish to vote on issues where there is not a clear consensus, to ensure there is agreement on the views it provides to the CCG's Governing Body. If this is the case, the quorum for the meeting requires the Chair of the group, Chairs or deputies representing at least four Patient Participation Groups and a CCG management representative to be present. This requirement has been met and exceeded at each meeting, averaging six representatives from the Patient Participation Groups per meeting across the six meetings in 2017/18.

Quality Committee

The composition of the Quality Committee is as follows:

NHS Hardwick CCG Quality Committee Membership
Chair – GP
CCG Clinical Lead
CCG Patient Reference Group representative
CCG Practice Managers' Group representative
Chief Nurse and Quality Officer
Chief Officer
Deputy Chair – Governing Body Lay Member, Patient & Public Involvement
Governing Body Secondary Care Specialist Doctor

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

Significant items approved/discussed by Quality Committee 2017/18
Care UK
CCG Incidents
Chesterfield Royal Hospital NHS Foundation Trust
Complaints and Patient Concerns Report
Derbyshire and Nottinghamshire Safeguarding
Derbyshire Healthcare NHS Foundation Trust
East Midlands Ambulance Service
Healthcare Associated Infections Year-end Position
Healthwatch Derby Local Intelligence Reports

Significant items approved/discussed by Quality Committee 2017/18
Infection Control
Integrated Quality Report
Medicines Management
Modern Slavery Statement
National Guidance on Learning from Deaths
Quality Performance and Monitoring of Care Homes
Risk Register
Serious Incidents and Never Events
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals NHS Foundation Trust

The Quality Committee met a total of seven times in 2017/18.

The quorum for the meeting requires four members, including the Chair or Deputy Chair, Patient Reference Group Representative, GP/Member Practice Representative and the Chief Nurse/Deputy Director of Quality. All meetings were quorate in 2017/18.

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 CCGs for the financial year ended 31 March 2018.

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

Discharge of Statutory Functions

In light of recommendations of the 1983 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 Risk Management Strategy was reviewed and approved in March 2017. The strategy outlines the CCG's approach to risk and the manner in which it seeks to eliminate or control all significant risks. It is supplemented by a Risk Management Framework. Staff at all levels of the organisation are responsible for identifying and recording risk, with appropriate levels of staff trained to evaluate risks and treat them accordingly.

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

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

Risk management is embedded in the activities of the organisation. Through its main Committees and line management structures, the CCG is able to ensure accountability for risk at all levels of the organisation.
The CCG identifies, assesses, manages and governs risk in line with widely available standards and guidance, and specifically in line with ISO 31000:2009. In summary, the risk management process as it applies to the CCG is as follows:

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

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

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

Stakeholder involvement in managing risks

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

Public events including Stakeholder Forums and 21st Century JoinedUpCare Transformation Forums and Community Forums have taken place throughout the year with population and community groups. These provide the opportunity to engage with the public and highlight areas of risks. There have also been specific engagement events including the Young

People Forum, and listening events which actively engage with the public. Governing Body meetings are held in public and for the Joint Governing Body with North Derbyshire CCG the meeting was attended by around 200 members of the public plus nearly 1,000 via live-streaming to observe the decision making process, including the consideration of risks associated with the business case versus maintaining the status quo.

Prevention and deterrence of risk

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

The CCG has a mature Serious Incident reporting system and this is continually being improved, the Serious Incident Policy has been reviewed and strengthened during the year. Staff are trained in carrying out systematic Root Cause Analysis investigations in line with the National Patient Safety Agency guidance. Any Serious Incidents which have occurred are reported to NHS England and other appropriate bodies. Serious Incidents are also reported through the Strategic Executive Information System (STEIS). Any breaches of Information Governance which meet the level 2 criteria of the Information Commissioners Office (ICO) will be reported using the Information Governance Toolkit to the ICO as appropriate. 360 Assurance (Internal Audit) provide specialist advice with regard to Counter Fraud and guidance on the Good Governance Institute.

Hardwick CCG continues to work closely with neighboring CCG's, Local Authorities, Local Health Resilience Partnership other partnership groups and has an established relationship with NHS England in respect of Emergency Preparedness Resilience and Response (EPRR). Hardwick CCG gained Full Assurance for the 2017/18 EPRR Core Standards Assessment from NHS England together with North Derbyshire, Erewash and Southern Derbyshire CCG.

Capacity to Handle Risk

The accountabilities, roles and responsibilities for Risk Management are detailed within section 5 of the CCG Risk Management Framework, in brief:

- Governing Body – oversight and holding management to account
- Corporate Performance 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
- Corporate Secretary – responsible for the development, implementation and maintenance of the risk management arrangements for the CCG

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

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

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

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

Risk Assessment

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

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

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

Areas in which the CCG has identified specific risks to Governance, Risk Management and Internal Control are as follows:

Significant risks identified during 2017/18

Risk 5 – Failure to align cross-system investment and savings plans leads to poor value and insufficient funds to invest in service priorities and delivery of the CCG's strategic objectives

Risk 7 – Failure to lead and partner effectively and get better value from working with other CCGs (Lead/ Associate arrangements) will lead to poor use of resources and an inconsistent commissioner approach

Risk 8 – Failure to deliver QIPP leads to lack of financial balance/ viability and an inability to fund transformation in our communities

Risk 9 – Insufficient capacity and resilience in primary care adversely affects quality and access to service impacting service viability

Risk 10 – Failure to manage activity pressures leads to constitutional failures, financial challenge and reputational damage

Risk 11 – Inability to deliver the Sustainability and Transformation Plan across Derbyshire may lead to failure to address Health and Wellbeing gaps, outcomes and cost effectiveness

Full details of each risk can be found in Appendix three.

Other Sources of Assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.
The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

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

The CCG fulfils its duties in relation to the Equality Act 2010 and the Public Sector Equality Duty (PSED) contained within that Act, through a robust equality analysis of all policies, procedures and decisions. This ensures that due regard is given to Equality, Inclusion and Human Rights with the aim of eliminating discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations. The CCG adopts the Derbyshire-wide Quality Schedule, which includes explicit reference to compliance with the PSED, enabling a robust and auditable process going forward.

The CCG is committed to maximising public involvement through the use of the Patient Reference Group, Stakeholder Groups and Public Events. During 2017/18, the 21st Century Better Care Closer to Home programme of work across the Derbyshire Unit of Planning has ensured that patients and the public from the area are fully represented. The CCG is committed to ensuring that patients and the public are fully involved at all levels of the CCG's activity and have a meaningful impact on commissioning decisions, as required by the public involvement duty in section 14Z2 of the Act.

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

Annual Audit of Conflicts of Interest Management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support this task, NHS England has published a template audit framework. The management of conflicts of interest and potential conflicts of interest is a high priority for the CCG to ensure complete transparency in its decision making process. During 2016/17 enhanced systems and process for identifying, recording, reporting and dealing with conflicts of interest were introduced based on the revised guidance from NHS England. These have been further embedded within the CCG during 2017/18. During 2018/19 all CCG staff are required to complete Managing Conflicts of Interest training, made up of three modules. By 31st May 2018 all staff will have completed module one with the remaining two modules to be completed before the 31st March 2019. This training has 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 January 2018, the outcome of which was an overall **significant assurance**.

Data Quality

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

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

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

Information Governance

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

On 12th May 2017, many NHS organisations across the country reported that they were unable to use IT and clinical systems following a cyber-attack. This was triggered by a form of malware named by NHS Digital as 'Wanna Cry'. The cyber-attack was not specifically targeted at the NHS and affected many organisations around the world from a range of sectors.

The IT service provider (Arden & GEM Commissioning Support Service) took the decision to close down the CCG's IT systems as a precautionary measure to mitigate risk of data loss, which may have included patient sensitive data held by GP practices. At the time of reporting, there is no evidence to suggest that patient data has been compromised by the attack. The CCG worked with its IT provider to return systems back to normal. Early information from the IT provider indicated that none of the CCG's systems were infected and that the anti-virus software was up to date, which quarantined the specific malware virus.

The CCG enacted its business continuity plan and was able to continue to operate and mitigate risk to critical functions. Working with partners, which includes providers, the CCG undertake a post recovery phase de-brief in co-operation with NHSE North Midlands to understand the effectiveness of the CCG's plans and to further improve IG resilience as a result of cyber-attack. As from October 2017 the IT service is now provided by North of England Commissioning Support Services.

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

The Information Governance Committee supports and drives the broader Information Governance agenda, including ensuring that risks relating to Information Governance including Cyber Risk are identified and managed. The Committee meets monthly.
We have ensured all staff have undertaken annual Information Governance training relevant to their role with more comprehensive training for the Senior Information Risk Owner, Deputy Senior Information Risk Owner, 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 also appoints a Caldicott Guardian who plays a key role in ensuring that the organisation satisfies the highest practical standards for handling patient identifiable information. 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, and a programme has been

established to fully embed an information risk culture throughout the organisation against identified risks.

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

The CCG's Internal Auditors, 360 Assurance, reviewed the Information Governance Toolkit evidence in February 2018 giving 'Full Assurance' on compliance with the standards of the Information Governance Assurance Framework.

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

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

Data Security

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

Business Critical Models

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

Third Party Assurances including Service Auditor Reports

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

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

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

NHS England

The CCG has full delegated powers for the commissioning of Primary Medical Care. The detailed financial transactions are processed by NHS England into the CCG ledger from the Exeter/NHAIS system. Capita is responsible for primary care support services at all NHS sites, including CCGs. The report for Capita, produced by KPMG, gave an adverse opinion in 2016-17. The interim report covering the period October to December 2017 gave a qualified opinion and the CCG are awaiting the final report. NHS England have advised that an improvement programme is underway therefore the Audit teams were expecting to

perform substantive testing of transactions on this area again.

A Service Auditor Report was also received for NHS Digital which is the trading name of the "Health and Social Care Information Centre". This report was produced by PwC. NHS Digital provide IT services, processing of NHS payments and deductions to providers of general practice services in England. NHS Digital services collect data, calculate achievement and generate a payment requests for payment to practices. This report provides reasonable assurance that the control objectives tested operated effectively.

Control Issues

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

CCG's Failure to discharge statutory financial duties

The CCG declared internal Financial Turnaround in 2016/17 and subsequently was able to deliver all statutory targets for the year. The QIPP target was greater again in 2017/18 and was compounded by a number of financial pressures outside the direct control of the CCG. A Finance Recovery Plan (FRP) was developed along with strengthened arrangements for the delivery of QIPP. A Financial Recovery Group met throughout 2017/18 to consider potential CCG expenditure areas open to decommissioning and/or disinvestment. The CCG engaged a third party to run detailed acute Contract Challenges, and has led a programme to address Primary Care Variation in Prescribing and Referral practices. Full FRP delivery reports were shared with Governing Body and the CCG continued to work closely with NHS England on progress.

A&E Waiting Time

Derbyshire failed to deliver against the national 95% standard during December 2017 (86.7%). Underperformance has been attributed predominantly to underperformance at Derby Teaching Hospitals NHS Foundation Trust (DTHFT) and Chesterfield Royal Hospital NHS Foundation Trust (CRHFT).

Derby (DTHFT) - The trust has failed to deliver against the national standard for 27 consecutive months, with current performance for December (81.6%) and year to date (YTD) (87.2%). A Recovery Action Plan is in place with recovery planned for March 2018, however the trust have failed against the proposed trajectory in December. The trust has identified the increase in numbers and acuity of patients during December as the main contributing factors for non-delivery. Actions being taken include an update to the current Recovery Action Plan which was presented to the Contract Management Delivery Group on 8 January and the 4 hour programme board now convenes on a weekly basis instead of monthly to focus solely on performance in Adults Emergency Department.

Chesterfield (CRHFT) - The trust has failed to deliver against the national standard for 1 consecutive month, with current performance for December (92.8%) and YTD (92.9%). Recovery Action Plan is in place with recovery planned for March 2018, the trust has delivered against the 91.3% NHSI trajectory in December. The trust have identified bed issues as a contributing factor in delivering the performance standard, this is also compounded with insufficient side rooms given the amount of influenza and viral enteritis currently presenting in Emergency Department (ED). Actions being taken include cancelling of elective and outpatient activity, opening of the Portland ward offering an additional 16 beds and ED seniors are assessing all ED admissions and only admit if there is no other safe option.

Chesterfield Royal Hospital NHS Foundation Trust Patient > 52 week waits

Derbyshire reported four patients waiting over 52 weeks for treatment during November, three attributed to Southern Derbyshire Clinical Commissioning Group and one to North Derbyshire Clinical Commissioning Group.

Six Week Diagnostics

Derbyshire failed to deliver against the national 1.0% standard during December (1.09%), with underperformance mainly being attributed to underperformance at Sheffield Teaching Hospital NHS Foundation Trust reporting 42 breaches (7.5 %) and East Cheshire NHS Trust reporting 27 breaches (12%) during December. Staffing, and Capacity and Demand issues have been highlighted as the contributing factors for non-delivery. Recovery plans are in place with improvement expected in Quarter 4.

Failure to meet Cancer targets

Derbyshire failed to deliver against two of the national cancer targets during November – the Cancer 62 day target (85%) (December performance (74.4%)) and 62 day screening target (90%) (Derbyshire performance (88%)). Underperformance has been attributed predominantly to underperformance at Derby Teaching Hospitals NHS Foundation Trust and Chesterfield Royal Hospital NHS Foundation Trust for the 62 day standard; and Sheffield Teaching Hospital NHS Foundation Trust for the 62 day screening target.

62 day Standard

Derby (DTHFT) - Although the trust had failed to deliver against the national 62 day standard for 18 months, the adjusted figure for October 2018 was 85.7%. The current unadjusted figure for November is 82.45%, expected to be around 84% once adjusted. There have been a number of complex patients and also patient choice has been a significant factor in a few cases. Actions being taken include weekly Cancer Escalation meetings where any difficulties can be escalated to divisional directors. The trust expects to achieve or be very close to 85% for December.

Chesterfield (CRHFT) - The trust has failed to deliver against the national standard for 7 consecutive month, with current performance for December (74.4%) and YTD (78.1%). The trust has identified the Sheffield Teaching Hospital (STHFT) Urology satellite clinic running out of CRHFT where historically the patients have remained on the CRHFT waiting list. However this clinic is prone to cancellation by STHFT resulting in waiting list breaches for CRHFT. Discussions between Medical Directors at both trusts have resulted in an agreement to withdraw the current service from 1 February 2018 and treat patient's onsite at STHFT. The CCG is raised a Contract performance notice with the trust in January.

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

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

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

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

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

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

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

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

Delegation of Functions

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

The CCG has two external delegation chains:

- delegated responsibility for Primary Medical Care from NHS England (NHSE). This responsibility is led by the Corporate Performance 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 NHSE into the CCG ledger from the Exeter/ NHAIS system. Capita is responsible for primary care support services at all NHS sites and the CCG is aware that the Capita Service Auditor Report will not give the required assurance over primary care services for 2017/18. As a result the CCG has been working closely with NHSE and External Auditors to obtain sufficient evidence to assure itself that primary medical care expenditure in the ledger is complete and accurate.

The CCG attends the BCF Finance and Performance Sub-Group and the BCF Programme Board. Through attendance at these monthly meetings the CCG is fully aware of the performance of the BCF and any associated risks.

Counter Fraud Arrangements

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

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

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

Head of Internal Audit Opinion

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

I am providing an opinion of **Significant Assurance,** that there is generally a sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

This opinion is based on my review of your systems of internal control, primarily through the operation of your Governing Body Assurance Framework (GBAF) in the year to date, the outcome of individual assignments completed and your response to recommendations made.

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

My opinion is, therefore, limited to those reviews where final reports have been issued or where we have had an opportunity to discuss findings with CCG lead officers.

I have reflected on the context in which the CCG operates, as well as significant challenges currently facing many organisations operating in the NHS, and my opinion recognises that the system of internal control is designed to manage risk to a reasonable level, rather than eliminate all risk of failure to the achievement of strategic objectives.

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

Area of Audit	Level of Assurance Given
Procurement of Healthcare Service Contracts	Significant Assurance
Conflicts of Interest	Significant Assurance
Information Governance Toolkit	Full Assurance
Governance and Risk Management	Significant Assurance
Payroll Expenditure, Budgetary Control and Financial Reporting; and Integrity of the GL and Control Environment	Significant Assurance

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

My review of the effectiveness of governance, risk management and internal control is informed by the work of the Internal Auditors, executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the Internal Control Framework. I have drawn on performance information available to me. My review is also informed by comments made by the External Auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principle objectives have been reviewed.

I have been advised on the implications of the result of this review by the Governing Body, Audit Committee, Corporate Performance Committee and Quality Committee, and have addressed weaknesses during the year and ensure continuous improvements of the system are in place.

The effectiveness of the governance, risk management and internal control is reviewed by the Audit Committee which scrutinises and challenges the reports provided by the CCG. In addition, the reports in relation to the programme of work in the Internal Audit Plan are presented to the Audit Committee. 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 IAF and allows users to compare the CCG position against other CCGs)
- 360 Assurance – Internal Audit reviews and Head of Internal Audit Opinion
- KPMG – External Audit
- AGEM CSU – Monthly contract monitoring meetings
- North of England Commissioning Support – Monthly contract monitoring meetings
- Sub-Committees of the Governing Body
- Executive Team
- Collaborative and joint working with associate CCGs

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 was comprised of the following members in 2017/18:

NHS Hardwick CCG Remuneration Committee Membership	
Jill Dentith	Governing Body Lay Member, Audit & Governance (Chair)
Gillian Orwin	Governing Body Lay Member, Patient & Public Involvement
Dr Lucy Morley	Governing Body Secondary Care Specialist Doctor

Policy on the remuneration of senior managers

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

Remuneration of Very Senior Managers

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

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

The Chair, 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.

Remuneration Report Tables

Senior manager total salaries for 2017/18 and 2016/17 are shown in the following tables:

Salaries and Allowances 2017/18

2017-18						
Name and Title	**(a) Salary (bands of £5,000)**	**(b) Expense payments (taxable) to nearest £100**	**(c) Performance pay and bonuses (bands of £5,000)**	**(d) Long term performance pay and bonuses (bands of £5,000)**	**(e) All pension-related benefits (bands of £2,500)**	**(f) TOTAL (a to e) (bands of £5,000)**
	£000	£00	£000	£000	£000	£000
Dr Steven Lloyd - Governing Body Chair & GP	70-75	0	0	0	0-2.5	70-75
Dr Ruth Cooper - Governing Body GP	30-35	0	0	0	0-2.5	30-35
Andy Gregory - Chief Officer	260-265	0	0	0	37.5-40	295-300
Miles Scott - Chief Finance Officer	185-190	0	0	0	45-47.5	230-235
Jim Connolly - Chief Nursing Officer	95-100	0	0	0	37.5-40	130-134
Clive Newman - Chief Transformation Officer	85-90	0	0	0	20-22.5	105-110
Gareth Harry - Chief Commissioning Officer	85-90	0	0	0	20-22.5	105-110
Dr Lucy Morley - Governing Body - Secondary Care Doctor	5-10	0	0	0	0-2.5	5-10
Gillian Orwin - Lay Member	15-20	0	0	0	0-2.5	15-20
Jill Dentith - Lay Member	15-20	0	0	0	0-2.5	15-20
Karen Watkinson - Corporate Secretary	45-50	0	0	0	15-17.5	60-65
Jackie Jones - Director of Commissioning for Ambulance Services	80-85	0	0	0	10-12.5	90-95
Dr Sudeep Chawla - Governing Body GP	5-10	0	0	0	0-2.5	5-10
Dr Chris Clayton - Chief Executive Officer	5-10	0	0	0	12.5-15	20-25
Jayne Stringfellow - Interim Chief Nurse & Quality Officer	0-5	0	0	0	65-67.5	65-70
Louise Bainbridge - Chief Finance Officer	0-5	0	0	0	15-17.5	20-25
Maureen Whittaker - Public Health Representative	0-5	0	0	0	0-2.5	0-5
Julie Voller - Derbyshire County Council Representative	0-5	0	0	0	0-2.5	0-5

Notes to Salaries and Allowances - 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 Hardwick CCG's share of the 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 Hardwick CCG from Sept 2017).
2. The total remuneration disclosed in the table above for Dr Steven Lloyd and Dr Ruth Cooper includes £10k and £27k respectively for clinical advisory services provided to the CCG unrelated to their roles on the Governing Body.
3. Julie Voller and Maureen Whittaker are remunerated by their own organisations, with no financial contributions from the CCG.
4. Disclosures have not been made in 2017/18 for Valerie Beattie or David Heathcote, Lay Representatives, to ensure the senior management reporting is consistent across the 4 Derbyshire CCGs. Each CCG is now reporting those senior managers who are members of the Governing Body and those who regularly attend.
5. '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.

6. The 'All Pension related benefits' identified for Chris Clayton, Louise Bainbridge and Jayne Stringfellow, represent the total benefits across all four Derbyshire CCGs.
7. Andy Gregory received a redundancy payment of £160,000 and payment in lieu of notice of £43,040, for loss of office. Miles Scott also received a redundancy package of £133,616, for loss of office (see note 4.4 of the financial statements 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. Hardwick CCG received £249,000 income from the other Derbyshire CCGs as a contribution towards the costs (reported in note 4.1.2 of the financial statements).
8. The following table identifies the changes occurring in the Governing Body membership during 2017/18:

Name	Title	Start Date	End Date
Lucy Morley	Secondary Care Doctor	April-17	Mar-18
Andy Gregory	Accountable Officer		Sept-17
Jim Connolly	Chief Nurse		Aug-17
Jayne Stringfellow	Interim Chief Nurse & Quality Officer	Sept-17	
Chris Clayton	Chief Executive Officer	Oct-17	
Louise Bainbridge	Chief Finance Officer	Nov-17	
Miles Scott	Chief Finance Officer		Mar-18
Maureen Whittaker	Senior Representative from Public Health		Mar-18

Salaries and Allowances 2016/17

2016-17						
Name and Title	**(a) Salary (bands of £5,000)**	**(b) Expense payments (taxable) to nearest £100**	**(c) Performance pay and bonuses (bands of £5,000)**	**(d) Long term performance pay and bonuses (bands of £5,000)**	**(e) All pension-related benefits (bands of £2,500)**	**(f) TOTAL (a to e) (bands of £5,000)**
	£000	£00	£000	£000	£000	£000
	£000	£00	£000	£000	£000	£000
Dr Steven Lloyd - Governing Body Chair & GP	75-80	0	0	0	0	75-80
Andy Gregory - Chief Officer	110-115	0	0	0	52.5-55	165-170
Miles Scott - Chief Finance Officer	85-90	0	0	0	17.5-20	105-110
Jim Connolly - Chief Nursing Officer	85-90	0	0	0	20-22.5	110-115
Clive Newman - Chief Transformation Officer	80-85	100	0	0	55-57.5	140-145
Gareth Harry - Chief Commissioning Officer	80-85	0	0	0	22.5-25	105-110
Jackie Jones - Director of Commissioning for Ambulance Services	85-90	0	0	0	0-2.5	85-90
Karen Watkinson - Corporate Secretary	45-50	0	0	0	12.5-15	60-65
Jill Dentith - Lay Member	15-20	0	0	0	0	15-20
Gillian Orwin - Lay Member	15-20	0	0	0	0	15-20
Valerie Beattie - Lay Representative	0-5	0	0	0	0	0-5
David Heathcote - Lay Representative	0-5	0	0	0	0	0-5
Dr Ruth Cooper - Governing Body GP	25-30	0	0	0	0	25-30
Dr Sudeep Chawla - Governing Body GP	5-10	0	0	0	0	5-10
Dr Clare Dieppe - Governing Body - Secondary Care Doctor	5-10	0	0	0	0	5-10
Maureen Whittaker - Public Health Representative	0-5	0	0	0	0	0-5
Julie Voller - Derbyshire County Council Representative	0-5	0	0	0	0	0-5

Notes to Salaries and Allowance – 2016/17

1. The disclosures and figures above relate to those individuals who hold or have held office as a director of the CCG during the reporting year.
2. 'All Pension related benefits' shows the increase in 'lifetime' pension which has arisen in 2016/17. The sum reported reflects the amount by which the annual pension received on retirement age has increased in 2016/2017, multiplied by 20 (the average number of years a pension is paid to members of the NHS scheme following retirement). 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
3. The following table identifies the changes occurring in the Governing Body membership during 2016/17:

Name	Title	Start Date	End Date
Clare Dieppe	Secondary Care Doctor		Mar-17

Pension benefits as at 31st March 2018

Name and Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2017 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employers contribution to stakeholder pension £000
Miles Scott - Chief Finance Officer	0-2.5	2.5-5.0	20-25	70-75	486	49	540	0
David Connolly - Chief Nursing Officer	0-2.5	5.0-7.5	35-40	115-120	685	78	770	0
Andy Gregory - Chief Officer	2.5-5.0	0-2.5	30-35	75-80	421	55	480	0
Clive Newman - Chief Transformation Officer	0-2.5	0-2.5	20-25	55-60	330	38	371	0
Karen Watkinson - Corporate Secretary	0-2.5	0-2.5	5-10	0	82	17	100	0
Gareth Harry - Chief Commissioning Officer	0-2.5	0-2.5	20-25	45-50	239	32	274	0
Jacqueline Jones - Director of Commissioning for Ambulance Services	90-95	2.5-5.0	30-35	90-95	588	52	646	0
Chris Clayton - Chief Executive Officer	0-2.5	0-2.5	15-20	35-40	211	13	239	0
Jayne Stringfellow - Interim Chief Nurse Officer	2.5-5.0	10-12.5	45-50	140-145	838	102	1023	0
Louise Bainbridge - Chief Finance Officer	0-2.5	0-2.5	15-20	40-45	229	19	278	0

Notes to Pension Benefits

Chris Clayton, Louise Bainbridge 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. The real increase in pension, lump sum and cash equivalent transfer value reflects an apportionment of their total pension benefits for the period employed by Hardwick CCG.

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

Two payments were made during the year for loss of office. See the Exit Packages note on page 82 for further details.

No payments were made in respect of early retirements.

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 Clinical Commissioning Group includes non-executive directors and agency and interim staff. This follows the guidance provided in the Hutton report. There are a number of staff, including three executive directors, that are shared across the Derbyshire Clinical Commissioning Groups (Hardwick Clinical Commissioning Group receives an apportioned charge for its share of the costs). However for the purpose of pay multiple calculations, all calculations are based on the annual full-time equivalent salaries, rather than the apportioned shares.

The midpoint of the banded remuneration of the highest paid director/member in NHS Hardwick Clinical Commissioning Group in the financial year 2017-18 was £162.5k (2016-17, £162.5k). This was 3.89 times (2016-17, 3.93) the median remuneration of the workforce, which was £41,787 (2016-17, £41,373). The highest paid director/ Governing Body member is not a full time appointment, however for this disclosure; all calculations are based on full time equivalent salaries.

The change in ratio is as a result of the Agenda for Change Pay Award, whilst the highest paid Director/Governing Body member's salary remain unchanged from the prior year.

In 2017-18, zero (2016-17, zero) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £16,968 to £161,825 (2016-17 £16,372 revised to £161,825 (originally reported £2,075 to £161,825)). The 2016/17 minimum remuneration has been revised from the figure reported in 2016/17 Annual Report as it has since been noted the minimum value reflected actual remuneration received rather than the full time equivalent salary as required for this calculation.

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

Staff Report

Number of Senior Managers and Staff Composition

	Male	Female	Total
Executive Members	3	1	4
Band 8c	2	1	3
Band 8b	0	8	8
Band 8a	0	2	2
Other Banded CCG Employees	4	20	24
Total CCG Employees	9	32	41
Other Non Permanent Engagements including non-executive directors and lay members	4	4	8
Total	**13**	**36**	**49**

Staff numbers and costs

Employee Benefits 2017-18

Employee Benefit	2017-18								
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	**2,262**	1,968	293	1,534	1,449	85	728	519	208
Social security costs	**225**	225	0	166	166	0	59	59	0
Employer Contributions to NHS Pension scheme	**264**	264	0	197	197	0	68	68	0
Other pension costs	**0**	0	0	0	0	0	0	0	0
Apprenticeship Levy	**0**	0	0	0	0	0	0	0	0
Other post-employment benefits	**0**	0	0	0	0	0	0	0	0
Other employment benefits	**0**	0	0	0	0	0	0	0	0
Termination benefits	**337**	337	0	337	337	0	0	0	0
Gross employee benefits expenditure	**3,088**	**2,795**	**293**	**2,234**	**2,149**	**85**	**854**	**646**	**208**
Less recoveries in respect of employee benefits (note 4.1.2)	**(411)**	(355)	(56)	(346)	(346)	0	(65)	(9)	(56)
Total - Net admin employee benefits including capitalised costs	**2,677**	**2,439**	**238**	**1,888**	**1,803**	**85**	**789**	**637**	**153**
Less: Employee costs capitalised	**0**	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,677**	**2,439**	**238**	**1,888**	**1,803**	**85**	**789**	**637**	**153**

Employee benefits 2016-17

Employee Benefit	2016-17								
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	**2,252**	2,010	242	1,521	1,422	99	731	588	143
Social security costs	**224**	224	0	157	157	0	67	67	0
Employer Contributions to NHS Pension scheme	**268**	268	0	198	198	0	70	70	0
Other pension costs	**0**	0	0	0	0	0	0	0	0
Apprenticeship Levy									
Other post-employment benefits	**0**	0	0	0	0	0	0	0	0

Employee Benefit	2016-17								
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Other employment benefits	**0**	0	0	0	0	0	0	0	0
Termination benefits	**0**	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,745**	**2,503**	**242**	**1,877**	**1,778**	**99**	**868**	**725**	**143**
Less recoveries in respect of employee benefits (note 4.1.2)	**(166)**	(84)	(83)	(75)	(75)	0	(92)	(9)	(83)
Total - Net admin employee benefits including capitalised costs	**2,579**	**2,419**	**159**	**1,802**	**1,703**	**99**	**776**	**716**	**60**
Less: Employee costs capitalised	**0**	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,579**	**2,419**	**159**	**1,802**	**1,703**	**99**	**776**	**716**	**60**

Average number of people employed

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

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**47**	**44**	**4**	**50**

Sickness Absence Data

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

	2017/18 Number	2016/17 Number
Total days lost	234	285
Average number of permanent employees for the year	44	46
Average working days lost	5	6

Staff Policies

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

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

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

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

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

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

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

Our Health and Safety at work responsibilities are given equal priority along with our other statutory duties and objectives. To assist us in fulfilling our statutory obligations, expertise and advice is provided to the four Derbyshire CCGs by a private professional company called 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 2017/18 for the CCG was £124,000 (2016/17 £200k).

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 31 March 2018, for more than £245 per day and that last for longer than six months:

	Number
No. of existing engagements as of 31 March 2018	2
Of which…	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one & two years at time of reporting.	1
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	1

Table 2: New Off-payroll engagements
For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months:

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

Table 3: Off-payroll board member/senior official engagements
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

	Number
No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	18

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

Andy Gregory, Accountable Officer, left the CCG, 30 September 2017 and received a redundancy payment of £160,000 and payment in lieu of notice of £43,040, for loss of office. These payments were subject to approval by the Remuneration Committee. Miles Scott, Chief Finance Officer, left the CCG, 7 March 2018 and received a redundancy package of £133,616, for loss of office. These payments were calculated using the NHS redundancy terms and conditions and are included in the senior manager's salaries and allowances table. These exit packages are also identified in table 4.4 of the accounts and the numbers disclosed are subject to audit.

Parliamentary Accountability and Audit Report

NHS Hardwick 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 HARDWICK CCG FINANCIAL STATEMENTS 2017/2018

Dr Chris Clayton

Accountable Officer

NHS Hardwick CCG

23 May 2018

CONTENTS **Page Number**

The Primary Statements:

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

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(3,287)	(2,441)
Other operating income	2	(493)	(279)
Total operating income		**(3,780)**	**(2,720)**
Staff costs	4	3,088	2,745
Purchase of goods and services	5	167,092	159,762
Depreciation and impairment charges	5	0	0
Provision expense	5	45	0
Other Operating Expenditure	5	46	45
Total operating expenditure		**170,271**	**162,552**
Net Operating Expenditure		**166,491**	**159,832**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**166,491**	**159,832**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**166,491**	**159,832**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**166,491**	**159,832**

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	13	0	0
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		0	0
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	3,699	1,570
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	14	20
Total current assets		**3,713**	1,590
Non-current assets held for sale	21	0	0
Total current assets		**3,713**	1,590
Total assets		**3,713**	1,590
Current liabilities			
Trade and other payables	23	(11,853)	(8,100)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(45)	0
Total current liabilities		**(11,898)**	(8,100)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(8,185)**	(6,510)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(8,185)**	(6,510)
Financed by Taxpayers' Equity			
General fund		(8,185)	(6,510)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(8,185)**	(6,510)

The notes on pages 91 to 116 form part of this statement

The financial statements on pages 85 to 116 were approved by the Audit Committee on 23rd May 2018 and signed on its behalf by:

Chris Clayton
Chief Executive Officer
23rd May 2018

Louise Bainbridge
Chief Finance Officer
23rd May 2018

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(6,510)	0	0	**(6,510)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(6,510)**	**0**	**0**	**(6,510)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(166,491)			(166,491)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(166,491)**	**0**	**0**	**(166,491)**
Net funding	164,816	0	0	164,816
Balance at 31 March 2018	**(8,185)**	**0**	**0**	**(8,185)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	**(7,445)**	**0**	**0**	**(7,445)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(7,445)**	**0**	**0**	**(7,445)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(159,832)			(159,832)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(159,832)**	**0**	**0**	**(159,832)**
Net funding	160,767	0	0	160,767
Balance at 31 March 2017	**(6,510)**	**0**	**0**	**(6,510)**

The notes on pages 91 to 116 form part of this statement

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(166,491)	(159,832)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(2,130)	(11)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	3,754	(979)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	45	0
Net Cash Inflow (Outflow) from Operating Activities		**(164,822)**	(160,822)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(164,822)**	(160,822)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		164,816	160,767
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**164,816**	160,767
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(6)**	(55)
Cash & Cash Equivalents at the Beginning of the Financial Year		**20**	75
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		**14**	20

The notes on pages 91 to 116 form part of this statement

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.
The issue of a report to the Secretary of Health under Section 30 of the Local Audit and Accountability Act 2014 does not prevent the adoption of the going-concern principle, as the provision of service and its funding continues.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

1.5 Charitable Funds

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

1.6 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
If the Clinical Commissioning Group is in a “jointly controlled operation”, the Clinical Commissioning Group recognises:
· The assets the Clinical Commissioning Group controls;
· The liabilities the Clinical Commissioning Group incurs;
· The expenses the Clinical Commissioning Group incurs; and,
· The Clinical Commissioning Group’s share of the income from the pooled budget activities.
If the Clinical Commissioning Group is involved in a “jointly controlled assets” arrangement, in addition to the above, the Clinical Commissioning Group recognises:
· The Clinical Commissioning Group’s share of the jointly controlled assets (classified according to the nature of the assets);
· The Clinical Commissioning Group’s share of any liabilities incurred jointly; and,
· The Clinical Commissioning Group’s share of the expenses jointly incurred.

Notes to the financial statements

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

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

1.7.1 **Critical Judgements in Applying Accounting Policies**

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:
· The Clinical Commissioning Group has assessed the pooled element of the Better Care Fund as being a lead commissioning arrangement under IFRS 11 – Joint Arrangements. The Clinical Commissioning Group will report balances with the lead commissioner (local authority) only and not the providers with the local authority contracts.

1.7.2 **Key Sources of Estimation Uncertainty**

The following are the key estimations that management has made in the process of applying the Clinical Commissioning Group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:
· The continuing healthcare accrual is based upon the most likely settlement value. The caseload is reviewed by commissioning staff who have considerable knowledge and experience in handling these types of claims. There is still a backlog in these reviews and an estimate has been made of the impact of those for which NHS Hardwick Clinical Commissioning Group is responsible commissioner.

1.8 **Revenue**

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

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

1.9.2 **Retirement Benefit Costs**

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

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

1.10 **Other Expenses**

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

Notes to the financial statements

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

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

1.11.2 **Valuation**

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.
Land and buildings used for the Clinical Commissioning Group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
· Land and non-specialised buildings – market value for existing use; and,
· Specialised buildings – depreciated replacement cost.
HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value.
Assets are re-valued and depreciation commences when they are brought into use.
Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**

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

1.12 **Intangible Assets**

The Clinical Commissioning Group owns no intangible assets

Notes to the financial statements

1.13 **Depreciation, Amortisation & Impairments**

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

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

1.14 **Donated Assets**

The Clinical Commissioning Group has no donated assets.

1.15 **Government Grants**

The Clinical Commissioning Group has received no government grants.

1.16 **Non-current Assets Held For Sale**

The Clinical Commissioning Group has no assets held for sale.

1.17 **Leases**

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

1.17.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate 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.

1.17.2 **The Clinical Commissioning Group as Lessor**

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

1.18 **Private Finance Initiative Transactions**

The Clinical Commissioning Group has no Finance leases, PFI or LIFT Schemes.

1.19 **Inventories**

The Clinical Commissioning Group holds no inventories.

Notes to the financial statements

1.20 **Cash & Cash Equivalents**

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

1.21 **Provisions**

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

· Timing of cash flows (0 to 5 years inclusive): **Minus 2.42%** (previously: minus 2.70%)
· Timing of cash flows (6 to 10 years inclusive): **Minus 1.85%** (previously: minus 1.95%)
· Timing of cash flows (over 10 years): **Minus 1.56%** (previously: minus 0.80%)

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

A restructuring provision is recognised when the Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.22 **Clinical Negligence Costs**

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

1.23 **Non-clinical Risk Pooling**

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

1.24 **Continuing Healthcare Risk Pooling**

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

Notes to the financial statements

1.25 **Carbon Reduction Commitment Scheme**

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

1.26 **Contingencies**

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

1.27 **Financial Assets**

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

1.27.1 **Financial Assets at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Clinical Commissioning Group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.
The Clinical Commissioning Group does not have any financial assets at fair value through profit and loss.

1.27.2 **Held to Maturity Assets**

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

1.27.3 **Available For Sale Financial Assets**

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

Notes to the financial statements

1.27.4 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
The Clinical Commissioning Group considers that the fair values of financial assets and liabilities are materially the same as the carrying value and therefore no valuations have been undertaken.
The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.
At the end of the reporting period, the Clinical Commissioning Group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.27.5 **Impairment**

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.
The Clinical Commissioning Group considers that the fair values of financial assets and liabilities are materially the same as the carrying value and therefore no valuations have been undertaken.

1.28 **Financial Liabilities**

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

1.28.1 **Financial Guarantee Contract Liabilities**

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

1.28.2 **Financial Liabilities at Fair Value Through Profit and Loss**

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

1.28.3 **Other Financial Liabilities**

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

1.29 **Value Added Tax**

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

1.30 **Foreign Currencies**

The Clinical Commissioning Group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Clinical Commissioning Group's surplus/deficit in the period in which they arise.

Notes to the financial statements

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 **Subsidiaries**

Material entities over which the Clinical Commissioning Group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Clinical Commissioning Group or where the subsidiary's accounting date is not co-terminus.

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

1.34 **Associates**

Material entities over which the Clinical Commissioning Group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Clinical Commissioning Group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Clinical Commissioning Group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Clinical Commissioning Group from the entity.

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

1.35 **Joint Ventures**

Material entities over which the Clinical Commissioning Group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.36 **Joint Operations**

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

1.37 **Research & Development**

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

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

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

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

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

2. Other Operating Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Recoveries in respect of employee benefits	411	346	65	167
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	1	1	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	82	0	82	107
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	3,286	964	2,322	2,441
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Non cash apprenticeship training grants revenue	0	0	0	0
Other revenue	0	0	0	5
Total other operating revenue	**3,780**	**1,311**	**2,469**	**2,720**

The majority of the revenue received is from clinical commissioning groups for services provided by Hardwick CCG on their behalf.

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services and also includes re-charges for the East Midlands Ambulance Service (EMAS) contract commissioning team which NHS Hardwick CCG has hosted from 1 September 2015.

Recoveries in respect of employee benefits is revenue from other commissioning groups and providers for staff costs incurred on their behalf. See note 4.1.2 for further details.

The Non-NHS charitable contribution from the British Heart Foundation is for the continuation of a project which started in 2015/16, to support the development of care and planning for patients at risk of or already diagnosed with Cardiovascular disease.

Revenue in this note does not include cash drawn down from NHS England, which is received directly into the bank account of the clinical commissioning group and credited to the General Fund. It does, however, include revenue received from NHS England for the Prime Minister's Challenge Fund, and payments in respect of public health prescribing and offender healthcare.

3. Revenue

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
From rendering of services	3,780	1,311	2,469	2,720
From sale of goods	0	0	0	0
Total	**3,780**	**1,311**	**2,469**	**2,720**

4. Employee benefits and staff numbers

4.1.1 Employee benefits — **2017-18** — **Total**

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	2,262	1,969	293
Social security costs	225	225	0
Employer Contributions to NHS Pension scheme	264	264	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	337	337	0
Gross employee benefits expenditure	**3,088**	**2,795**	**293**
Less recoveries in respect of employee benefits (note 4.1.2)	(410)	(355)	(55)
Total - Net admin employee benefits including capitalised costs	**2,678**	**2,440**	**238**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**2,678**	**2,440**	**238**

The former Accountable Officer received a redundancy payment of £160,000 and payment in lieu of notice of £43,040 for loss of office, and the former Chief Finance Officer received a redundancy payment of £103,099 and a pension capitalisation of £30,517 (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.

The payroll costs and pension contributions shown above include the clinical commissioning group's proportion of the shared Derbyshire CCG's Executive team. Similarly each CCG will include their respective share of the costs.

4.1.1 Employee benefits — **2016-17** — **Total**

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	2,253	2,011	242
Social security costs	224	224	0
Employer Contributions to NHS Pension scheme	268	268	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**2,745**	**2,503**	**242**
Less recoveries in respect of employee benefits (note 4.1.2)	(167)	(84)	(83)
Total - Net admin employee benefits including capitalised costs	**2,578**	**2,419**	**159**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**2,578**	**2,419**	**159**

4.1.2 Recoveries in respect of employee benefits

	2017-18 Total £'000	2017-18 Permanent Employees £'000	2017-18 Other £'000	2016-17 Total £'000
Employee Benefits - Revenue				
Salaries and wages	(161)	(106)	(55)	(167)
Social security costs	0	0	0	0
Employer contributions to the NHS Pension Scheme	0	0	0	0
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	(249)	(249)	0	0
Total recoveries in respect of employee benefits	**(410)**	**(355)**	**(55)**	**(167)**

4.2 Average number of people employed

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**47**	**44**	**3**	**50**
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	**0**

4.3 Staff sickness absence and ill health retirements

This information is shown in the Annual Report.

4.4 Exit packages agreed in the financial year *

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	1	43,040	1	43,040
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	1	133,616	0	0	1	133,616
£150,001 to £200,000	1	160,000	0	0	1	160,000
Over £200,001	0	0	0	0	0	0
Total	**2**	**293,616**	**1**	**43,040**	**3**	**336,656**

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2017-18 Departures where special payments have been made		2016-17 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

4.4 Exit packages agreed in the financial year cont'd*

Analysis of Other Agreed Departures

	2017-18		2016-17	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	1	43,040	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**1**	**43,040**	**0**	**0**

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

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures has been recognised in 2017/18.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Redundancy Scheme.

Exit costs are accounted for in accordance with relevant accounting standards and in full in the year of departure.

Where **entities** have agreed early retirements, the additional costs are met by NHS **Entities** and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables. There were none.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

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

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

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

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

4.5.1 Accounting valuation

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

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

4.5.2 Full actuarial (funding) valuation

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

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

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

For 2017-18, employers' contributions of £264k were payable to the NHS Pensions Scheme (2016-17: £268k) at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1.

5. Operating expenses

	2017-18 Total £'000	2017-18 Admin £'000	2017-18 Programme £'000	2016-17 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	2,321	1,470	851	2,323
Executive governing body members	767	764	3	422
Total gross employee benefits	**3,088**	**2,234**	**854**	**2,745**
Other costs				
Services from other CCGs and NHS England	2,074	609	1,465	2,085
Services from foundation trusts	99,009	0	99,009	94,047
Services from other NHS trusts	6,714	1	6,713	7,999
Sustainability Transformation Fund	0	0	0	0
Services from other WGA bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	20,137	0	20,137	17,307
Purchase of social care	4,411	0	4,411	4,018
Chair and Non Executive Members	46	46	0	45
Supplies and services – clinical	0	0	0	0
Supplies and services – general	580	220	360	320
Consultancy services	124	4	120	201
Establishment	229	59	170	162
Transport	6	4	2	8
Premises	39	86	(47)	156
Impairments and reversals of receivables	0	0	0	0
Inventories written down and consumed	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	45	45	0	57
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	17,710	0	17,710	17,996
Pharmaceutical services	26	0	26	28
General ophthalmic services	30	0	30	34
GPMS/APMS and PCTMS	15,693	10	15,683	14,934
Other professional fees excl. audit	122	36	86	125
Legal fees	111	21	90	56
Grants to Other bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	32	5	27	25
Change in discount rate	0	0	0	0
Provisions	45	9	36	0
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions	0	0	0	204
Non cash apprenticeship training grants	0	0	0	0
Other expenditure	0	0	0	0
Total other costs	**167,183**	**1,155**	**166,028**	**159,807**
Total operating expenses	**170,271**	**3,389**	**166,882**	**162,552**

Programme expenditure is the spend on the direct provision of healthcare or healthcare services.
Admin expenditure is all other expenditure.

In 2017-18 NHS England have split the following lines: 'Purchase of healthcare from non-NHS bodies' and 'Other professional fees excl. audit'.

The 'Purchase of social care' value was previously included within 'Purchase of healthcare from non NHS bodies' and 'legal fees' were included within 'Other professional fees'. This is a change in presentation due to how the NHS England Annual accounts templates are mapped.

Audit Fees
Audit Fees include VAT charges of £7,000 and additional fees of £2,500 for extra work carried out by external audit for the 2016-17 Statutory Audit.

Other Professional Fees

Internal Audit services are provided to the clinical commissioning group by 360 Assurance who are hosted by Leicestershire Partnership Trust. For 2017-18 these costs are now shown within 'Other Professional Fees' , whereas in 2017-18 they were shown within 'Services from Other NHS trusts'.

6. Better Payment Practice Code (BPPC)

6.1 Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 **Number**	2016-17 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	1,756	15,085	1,665	14,384
Total Non-NHS Trade Invoices paid within target	1,720	14,894	1,635	14,237
Percentage of Non-NHS Trade invoices paid within target	**97.95%**	**98.74%**	**98.20%**	**98.98%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,700	117,621	2,241	112,652
Total NHS Trade Invoices Paid within target	2,695	117,614	2,229	112,478
Percentage of NHS Trade Invoices paid within target	**99.81%**	**99.99%**	**99.46%**	**99.85%**

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

7. Income Generation Activities

The clinical commissioning group has not undertaken any income generating activities this year or during the prior year.

8. Investment revenue

The clinical commissioning group did not have any investment revenue in 2017-18 or prior year.

9. Other gains and losses

There were no other gains and losses in 2017-18 or prior year.

10. Finance costs

No finance costs were incurred by the clinical commissioning group in 2017-18 or prior year.

11. Net gain/(loss) on transfer by absorption

The clincal commissioning group had no transferred function(s) that could give rise to a recognised gain or loss in 2017-18 or prior year.

12. Operating Leases

12.1 As lessee

The costs set out below are for payments on leased buildings, cars and voids and subsidies.

NHS Hardwick Clinical Commissioning Group receives charges from NHS Property Services Limited for the void space and subsidies in the property portfolio covering NHS Hardwick Clinical Commissioning Group's locality. Even though no formal lease contract is in place between NHS Hardwick Clinical Commissioning Group and NHS Property Services Limited, the transactions involved do convey the right of NHS Hardwick Clinical Commissioning Group to use the property.

12.1.1 Payments recognised as an Expense

	2017-18				2016-17			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	**Land £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense								
Minimum lease payments	0	27	6	**33**	0	139	9	**148**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**27**	**6**	**33**	**0**	**139**	**9**	**148**

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

12.1.2 Future minimum lease payments

	2017-18				2016-17			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	**Land £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payable:								
No later than one year	0	0	0	**0**	0	0	0	**0**
Between one and five years	0	0	0	**0**	0	0	0	**0**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

12.2 As lessor

The clinical commissioning group is not the lessor in any operating lease arrangements in 2017-18 nor was it for 2016-17.

13. Property, plant and equipment

The clinical commissioning group did not hold property, plant or equipment at any time during 2017-18 or the prior year.

14. Intangible non-current assets

The clinical commissioning group did not hold intangible assets at any time during 2017-18 or the prior year.

15. Investment property

The clinical commissioning group did not hold investment property at any time during 2017-18 or the prior year.

16. Inventories

The clinical commissioning group did not hold inventories at any time during 2017-18 or the prior year.

17. Trade and other receivables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	485	0	601	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	700	0	245	0
NHS accrued income	2,201	0	261	0
Non-NHS and Other WGA receivables: Revenue	148	0	118	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	120	0	73	0
Non-NHS and Other WGA accrued income	9	0	239	0
Provision for the impairment of receivables	0	0	0	0
VAT	34	0	15	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	2	0	18	0
Total Trade & other receivables	**3,699**	**0**	**1,570**	**0**
Total current and non current	**3,699**		**1,570**	
Included above:				
Prepaid pensions contributions	0		0	

The majority of the receivables are with NHS England or clinical commissioning groups. A Department of Health group agreement of balances exercise is routinely undertaken to provide assurance on recoverability of NHS receivable balances.

There are no financial assets included above that would otherwise be past due date or impaired, whose terms have been renegotiated.

17.1 Receivables past their due date but not impaired	2017-18 £'000 DH Group Bodies	2017-18 £'000 Non DH Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	94	62	52
By three to six months	7	8	158
By more than six months	9	3	63
Total	**110**	**73**	**273**

£53,818 of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2018.

17.2 Provision for impairment of receivables

The clinical commissioning group did not make any provision for impairment of receivables in 2017-18 or in the prior year.

18. Other financial assets

The clinical commissioning group did not have any other financial assets during 2017-18 or 2016-17.

19. Other current assets

The clinical commissioning group did not have any other current assets during 2017-18 or 2016-17.

20. Cash and cash equivalents

	2017-18	2016-17
	£'000	£'000
Balance at 01 April 2017	20	75
Net change in year	(6)	(55)
Balance at 31 March 2018	**14**	**20**
Made up of:		
Cash with the Government Banking Service	14	20
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	**14**	**20**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**14**	**20**
Patients' money held by the clinical commissioning group, not included above	0	0

The clinical commissioning group does not hold any monies on behalf of patients.

21. Non-current assets held for sale

The clinical commissioning group did not have any non current assets held for sale as at 31st March 2018 or 31st March 2017.

22. Analysis of impairments and reversals

The clinical commissioning group did not have any impairments or reversals of impairments recognised in expenditure in 2017-18 or 2016-17.

23. Trade and other payables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	1,609	0	1,198	0
NHS payables: capital	0	0	0	0
NHS accruals	4,055	0	2,396	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	590	0	132	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	4,625	0	3,574	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	28	0	29	0
VAT	0	0	0	0
Tax	53	0	28	0
Payments received on account	0	0	0	0
Other payables and accruals	893	0	743	0
Total Trade & Other Payables	**11,853**	**0**	**8,100**	**0**
Total current and non-current	**11,853**		**8,100**	

The clinical commissioning group had no liability in respect of payments due in future years under arrangements to buy out the liability for early retirement over 5 year instalments.

Other payables include £131k outstanding pension contributions at 31st March 2018 (£150k: 31st March 2017).

24. Other financial liabilities

The clinical commissioning group had no other financial liabilities as at 31st March 2018 or 31st March 2017.

25. Other liabilities

The clinical commissioning group had no other liabilities as at 31st March 2018 or 31st March 2017.

26. Borrowings

The clinical commissioning group had no borrowings as at 31st March 2018 or 31st March 2017.

27. Private finance initiative, LIFT and other service concession arrangements

The clinical commissioning group had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31st March 2018 or 31st March 2017.

28. Finance lease obligations

The clinical commissioning group had no finance lease obligations as at 31st March 2018 or 31st March 2017.

28.1 Finance leases as lessee

The clinical commissioning group had no future sublease payments expected to be received as at 31st March 2018 or 31st March 2017.

29. Finance lease receivables

The clinical commissioning group did not have any finance lease receivables as at 31st March 2018 or 31st March 2017.

29. Finance lease receivables cont'd

29.1 Finance leases as lessor

The clinical commissioning group did not have any unguaranteed residual values accruing at 31st March 2018 or 31st March 2017.

Nor did it have any accumulated allowances for uncollectable lease receivables at 31st March 2018 or 31st March 2017.

The clinical commissioning group had no contingent rent recognised in expenditure during 2017-18 or 2016-17.

29.2 Rental revenue

The clinical commissioning group did not have any rental revenue as at 31st March 2018 or 31st March 2017.

30. Provisions

	Current 2017-18 £'000	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	45	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	0	0	0	0
Other	0	0	0	0
Total	**45**	**0**	**0**	**0**
Total current and non-current	**45**		**0**	

	Pensions Relating to Former Directors	**Pensions Relating to Other Staff**	**Restructuring**	**Redundancy**	**Agenda for Change**	**Equal Pay**	**Legal Claims**	**Continuing Care**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Balance at 01 April 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Arising during the year	0	0	45	0	0	0	0	0	0	45
Utilised during the year	0	0	0	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	0	0	0	0	0	0
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body under absorption	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2018	**0**	**0**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**45**
Expected timing of cash flows:										
Within one year	0	0	45	0	0	0	0	0	0	45
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2018	**0**	**0**	**45**	**0**	**0**	**0**	**0**	**0**	**0**	**45**

Legal claims in respect of clinical negligence liabilities are fully covered by NHS Resolution and consequently the clinical commissioning group makes no provision for such claims.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the clinical commissioning group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this clinical commissioning group at 31st March 2018 is £113k (2016-17 £120k).

As a result of the re-organisation of the four Derbyshire Clinical Commissioning Groups executive management structure to a shared one, a provision of £45k has been established for associated costs expected to materialise in the early part of 2018/19. This represents the apportioned costs for NHS Hardwick Clinical Commissioning Group. The other Derbyshire Clinical Commissioning Groups have likewise set up a provision for their share of the costs.

31. Contingencies

NHS Hardwick Clinical Commissioning Group has one contingent liability of £115k, relating to the re-organisation of the executive management structure; and £nil contingent assets (£nil contingent liabilities or contingent assets in 2016-17).

32. Commitments

32.1 Capital commitments

The clinical commissioning group did not have any contingent assets or liabilities as at 31st March 2018 or 31st March 2017.

32.2 Other financial commitments

The clinical commissioning group had not entered into any non-cancellable contracts (which are not leases) as at 31st March 2018 or 31st March 2017.

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 the clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

33.1.1 Currency risk

The clinical commissioning group is principally a domestic organisation with all 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

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group has no borrowings, and therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the clinical commissioning group 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.

33.1.3 Liquidity risk

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

33. Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £'000	Loans and Receivables 2017-18 £'000	Available for Sale 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,686	0	2,686
· Non-NHS	0	157	0	157
Cash at bank and in hand	0	13	0	13
Other financial assets	0	2	0	2
Total at 31 March 2018	**0**	**2,858**	**0**	**2,858**

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	862	0	862
· Non-NHS	0	357	0	357
Cash at bank and in hand	0	20	0	20
Other financial assets	0	18	0	18
Total at 31 March 2017	**0**	**1,257**	**0**	**1,257**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	Other 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	5,664	5,664
· Non-NHS	0	6,108	6,108
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2018	**0**	**11,772**	**11,772**

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,594	3,594
· Non-NHS	0	4,449	4,449
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**8,043**	**8,043**

34 Operating segments

The clinical commissioning group considers that it has only one operating segment; the commissioning of healthcare services.

35. Pooled budgets

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

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

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

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

The clinical commissioning group's contribution towards the pool is £12,447,000 (14.02%) (£8,179,000 in 2016-17).

Under the agreement, the BCF Plan for Derbyshire is split into 2 areas:

- Contributions to a pooled fund by all partners and commissioned
- Commissioning of existing funded schemes directly by each partner

The clinical commissioning group also has a pooled budget arrangement for Children and Young People with Complex Needs.

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

Under the Section 75 arrangements of the NHS Act 2006, total funds pooled by the clinical commissioning group are as follows:

	2017-18	2016-17
	£'000	£'000
Income	12,752	8,451
Expenditure	(12,752)	(8,451)

The memorandum account for the Better Care Fund pooled budgets is:

	2017-18	**2017-18**	**2016-17**	**2016-17**
	2017-18	**Pool Share**	**2016-17**	**Pool Share**
	£'000	**%**	**£'000**	**%**
Income				
NHS North Derbyshire CCG	21,289	23.98	21,324	32.81
NHS Southern Derbyshire CCG	19,170	21.59	18,809	28.94
NHS Hardwick CCG	12,447	14.02	8,179	12.58
NHS Erewash CCG	7,199	8.11	7,129	10.97
NHS Tameside and Glossop CCG	2,252	2.54	2,212	3.40
Derbyshire County Council	26,419	29.76	7,338	11.29
Total Income	**88,776**	**100.00**	**64,991**	**100.00**

	2017-18	**2016-17**
Expenditure	**£'000**	**£'000**
CCG schemes aimed at reducing non elective activity	31,870	24,739
CCG schemes - wheelchairs	0	2,899
Derbyshire County Council schemes	5,966	5,481
ICES (Integrated Community Equipment Service)	6,123	6,716
Reablement	8,046	7,706
7 Day working	1,346	1,477
Administration, Performance and Information Sharing	490	491
Care Bill	2,058	2,058
Delayed Transfer of Care	5,481	4,859
Carers	1,962	1,962
Integrated Care	1,500	1,590
Workforce Development	2,570	2,570
Dementia Support	981	1,451
Autism and Mental Health	2,165	992
iBCF	18,218	0
Total Expenditure	**88,776**	**64,991**
Net position for Pool	**0**	**0**

35. Pooled budgets cont'd

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

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

36. NHS Lift investments

The clinical commissioning group did not have any LIFT investments as at 31st March 2018 or 31st March 2017.

37. Intra-Government & Other Balances

	Current Receivables £'000	Non-current Receivables £'000	Current Payables £'000	Non-current Payables £'000
Balances with:				
· Other Central Government bodies	49	0	214	0
· Local Authorities	41	0	545	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	0	0	0	0
· NHS bodies within the NHS England Group	2,253	0	1,765	0
· NHS Trusts and Foundation Trusts	1,133	0	3,899	0
Total of balances with NHS bodies:	3,386	0	5,664	0
· Public Corporations and Trading Funds	0	0	0	0
· Bodies external to Government	223	0	5,430	0
Total at 31 March 2018	**3,699**	**0**	**11,853**	**0**
Balances with:				
· Other Central Government bodies	52	0	206	0
· Local Authorities	241	0	2	0
· NHS bodies outside the Departmental Group	0	0	0	0
· NHS bodies within the NHS England Group	227	0	1,074	0
· NHS Trusts and Foundation Trusts	880	0	2,520	0
· Public Corporations and Trading Funds	0	0	0	0
· Bodies external to Government	170	0	4,298	0
Total at 31 March 2017	**1,570**	**0**	**8,100**	**0**

38. Related party transactions

Details of related party transactions with individuals are as follows:

	2017-18			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Sudeep Chawla (Governing Body Member) - Wingerworth Surgery/ Welbeck Drive Surgery	749	0	0	0
Dr Ruth Cooper (Governing Body Member) - Staffa Health	2,408	0	0	0
Dr Steven Lloyd (Governing Body Member) - St Lawrence Road Surgery	617	0	0	0
Dr Steven Lloyd (Governing Body Member) - Wildman Medical Services Ltd	9	0	0	0
Louise Bainbridge (Chief Finance Officer - Derbyshire Wide Role) and Jayne Stringfellow (Interim Chief Nurse Officer - Derbyshire Wide Role) - employed by NHS North Derbyshire CCG	639	(554)	1,418	(585)
Dr Chris Clayton (Chief Executive Officer - Derbyshire Wide Role) - employed by NHS Southern Derbyshire CCG	166	(886)	55	(1,118)
Jill Dentith (Governing Body Member) - Lay Member for Governance & Audit at North Derbyshire CCG	639	(554)	1,418	(585)
North Eastern Derbyshire Healthcare Ltd *	138	0	110	0

* North Eastern Derbyshire Healthcare Ltd (NEDH) is a company established and jointly owned by a group of primary care medical practices who are also member practices of NHS Hardwick CCG. Each of those practices holds a minority shareholding in NEDH. These include the practices in which Governing Body members Drs Sudeep Chawla, Ruth Cooper and Steven Lloyd are partners.

	2016-17			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Dr Sudeep Chawla (Governing Body Member) - Wingerworth Surgery/ Welbeck Drive Surgery	548	0	0	0
Dr Ruth Cooper (Governing Body Member) - Staffa Health	2,335	0	6	0
Dr Steven Lloyd (Governing Body Member) - St Lawrence Road Surgery	586	0	0	0
Dr Steven Lloyd (Governing Body Member) - Wildman Medical Services Ltd	45	0	0	0
North Eastern Derbyshire Healthcare Ltd.*	250	0	25	0

All the transactions have been at arms length as part of the clinical commissioning group's primary health commissioning and public health responsibilities.

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 of Health is regarded as the parent Department. For example:

- NHS England;
- Chesterfield Royal Hospitals NHS Foundation Trust
- Doncaster and Bassetlaw NHS Foundation Trust
- NHS Resolution;
- East Midlands Ambulance Services NHS Trust
- Sherwood Forest Hospital Foundation Trust
- Derbyshire Community Health Services Foundation Trust
- Derby Teaching Hospitals NHS Foundation Trust
- NHS England North Midlands
- Lincolnshire Partnership NHS Foundation Trust
- NHS Arden and GEM CSU
- NHS Midlands and Lancashire CSU
- Nottinghamshire Healthcare NHS Trust
- Nottinghamshire Healthcare Foundation Trust
- Nottingham University Hospitals NHS Trust
- NHS Business Services Authority
- Sheffield Childrens NHS Foundation Trust
- Sheffield Teaching Hospital NHS Foundation Trust
- Derbyshire Healthcare Foundation Trust
- NHS Pension Agency
- NHS Erewash CCG
- NHS North Derbyshire CCG
- NHS Southern Derbyshire CCG
- NHS North of England CSU

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

- Derbyshire County Council
- HMRC

39. Events after the end of the reporting period

There are no events which have occurred after the reporting period which will have a material effect on the financial statements of the clinical commissioning group.

40. Losses and Special Payments

The clinical commissioning group had no lossesor special payments during 2017-18 or 2016-17.

41. Third party assets

The clinical commissioning group held no third party assets as at 31st March 2018 or 31st March 2017.

42. Financial performance targets

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

	2017-18	**2017-18**	**2017-18**	2016-17	2016-17	2016-17
	Target	**Performance**	**Duty Achieved?**	Target	Performance	Duty Achieved?
	£'000	**£'000**		£'000	£'000	
Expenditure not to exceed income	170,278	170,271	Yes	165,597	162,552	Yes
Capital resource use does not exceed the amount specified in Directions	n/a	n/a	n/a	n/a	n/a	n/a
Revenue resource use does not exceed the amount specified in Directions	166,498	166,491	Yes	162,877	159,832	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	n/a	n/a	n/a	n/a	n/a	n/a
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	13,355	13,283	Yes	13,207	12,723	Yes
Revenue administration resource use does not exceed the amount specified in Directions	2,255	2,077	Yes	2,261	2,065	Yes

The 2017-18 targets and performance reported in this note show in year performance against a target of break-even as required by the Directions. This is different to the 2016-17 comparator figures, which show the cumulative targets and performance for the CCG.

43. Impact of IFRS

Accounting under the IFRS had no impact on the results of the clinical commissioning group during the 2017-18 and 2016-17 financial years.

44. Analysis of charitable reserves

The clinical commissioning group did not hold any charitable funds as at 31st March 2018 or 31st March 2017.

KPMG

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

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

In our opinion the financial statements:

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

Basis for opinion

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

Going concern

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

Other information in the Annual Report

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

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

Annual Governance Statement

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

Remuneration and Staff Report

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

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 49, the Accountable Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

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

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

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

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

We have nothing to report in this respect.

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

As explained more fully in the statement set out on page 49, 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 Hardwick 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

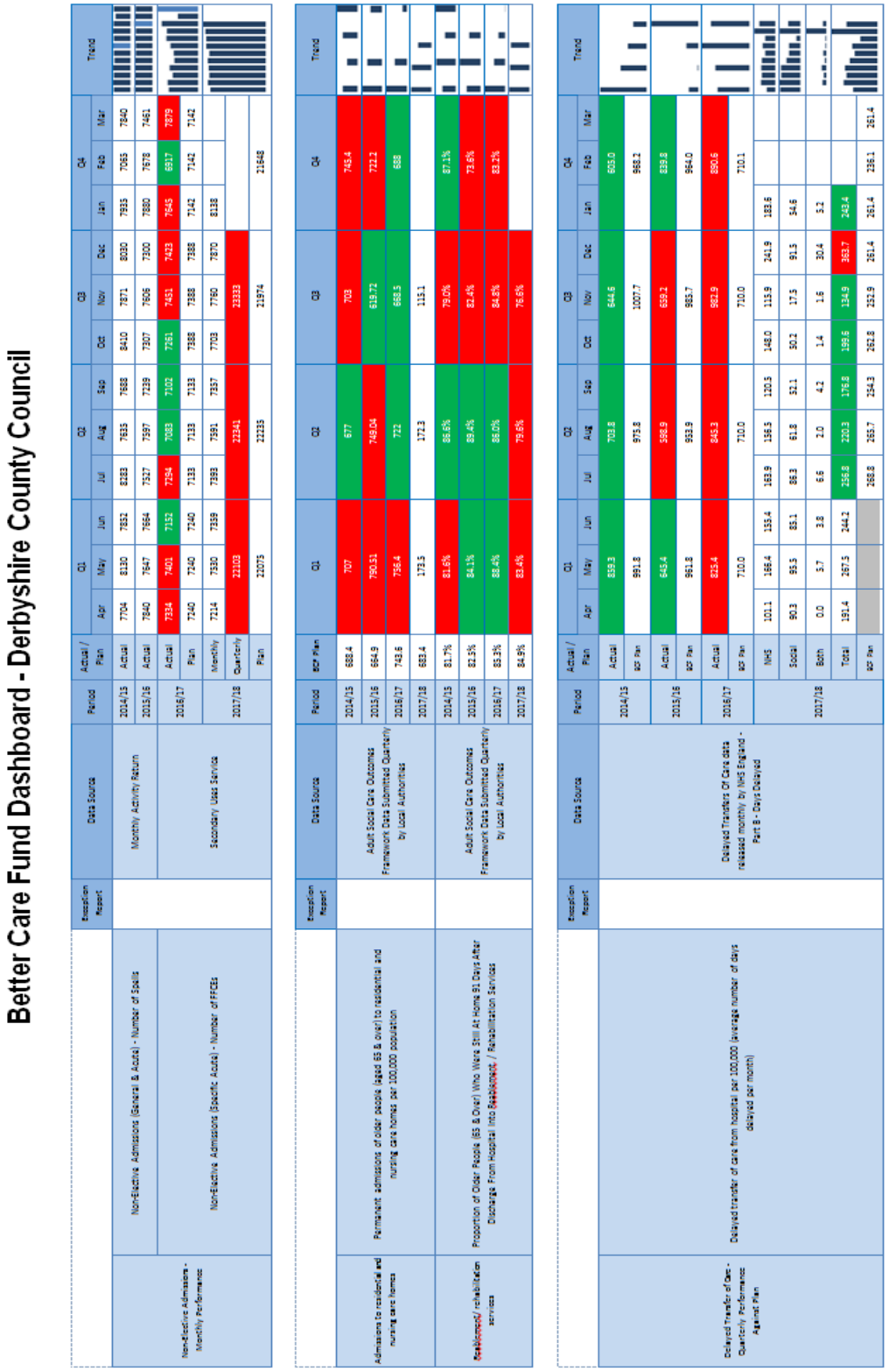
We certify that we have completed the audit of the accounts of NHS Hardwick CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Bostock
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
One Snowhill
Snow Hill Queensway
Birmingham
B4 6GH

24 May 2018

APPENDICES

Better Care Fund metrics



Governing Body Attendance Record 2017/18

Governing Body Member	25 Apr 2017	30 May 2017	27 Jun 2017	25 Jul 2017	26 Sep 2017	31 Oct 2017	28 Nov 2017	30 Jan 2018	27 Feb 2018	27 Mar 2018	% Total
Dr Steven Lloyd *Chair, CCG Clinical Chair*	✓	✓	✓	x	X	✓	✓	✓	✓	✓	80
Jill Dentith *Deputy Chair, Lay Member (Audit & Governance)*	✓	✓	x	✓	✓	✓	✓	✓	✓	x	80
Dr Sudeep Chawla *GP Member*	✓	✓	✓	✓	X	✓	✓	x	✓	x	70
Dr Ruth Cooper *GP Member*	x	✓	✓	✓	✓	x	✓	✓	x	✓	70
Andy Gregory *Chief Officer*	x	x	✓	✓	✓						30
Dr Chris Clayton *Chief Executive Officer*						✓	✓	✓	✓	✓	50
Miles Scott *Chief Finance Officer*	✓	✓	✓	✓	X	✓					50
Louise Bainbridge *Chief Finance Officer*							✓	✓	✓	✓	40
David (Jim) Connolly *Chief Nurse Officer*	✓	x	✓	✓	X						30
Jayne Stringfellow *Chief Nurse & Quality Officer*						✓	✓	✓	✓	x	40
Gillian Orwin *Lay Member (Patient & Public Involvement)*	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	90
Dr Lucy Morley *Secondary Care Specialist Doctor*	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	90
Julie Vollor *Officer representative of Derbyshire County Council*	x	x	✓	✓	X	✓	X	✓	✓	✓	60
Maureen Whittaker *Senior representative from Derbyshire*	x	✓	x	x	✓	x	✓	x	x	x	30

Governing Body Member	25 Apr 2017	30 May 2017	27 Jun 2017	25 Jul 2017	26 Sep 2017	31 Oct 2017	28 Nov 2017	30 Jan 2018	27 Feb 2018	27 Mar 2018	% Total
Vacant post *Chair of Hardwick Practice Managers' Group*	x	x	x	x	X	x	X	x	x	x	0

Commissioning Delivery Group Attendance Record 2017/18

Commissioning Delivery Group Member	4 Apr 2017	1 Aug 2017	3 Oct 2017	5 Dec 2018	6 Feb 2018	% Total
Blackwell Medical Centre	✓	✓	✓	✓	x	80
Blue Dykes Medical Centre	x	x	x	x	✓	20
Castle Street Medical Centre	✓	x	x	x	x	20
Clay Cross Medical Centre	x	✓	✓	✓	✓	80
Crags Health Care	✓	✓	✓	✓	✓	100
Creswell Medical Centre	✓	x	x	x	x	20
Emmett Carr Surgery	✓	x	✓	✓	✓	80
Friendly Family Surgery	x	x	x	x	x	0
Limes Medical Centre	✓	✓	✓	✓	✓	100
North Wingfield Medical Centre	✓	✓	✓	✓	✓	100
Shires Health Care	✓	x	✓	✓	✓	80
St Lawrence Road Surgery	x	✓	✓	✓	✓	80
Staffa Health	✓	✓	✓	✓	✓	100
The Village Surgery	x	x	✓	✓	✓	60
Wingerworth Surgery	x	✓	x	x	✓	40
Dr Steven Lloyd *Chair, CCG Clinical Chair*	x	✓	✓	✓	✓	80
Andy Gregory *Chief Officer*	x	x				0
Dr Chris Clayton *Chief Executive Officer*			x	x	x	0
Miles Scott *Chief Finance Officer*	✓	✓	x			40
Louise Bainbridge *Chief Finance Officer*				x	x	0
David (Jim) Connolly *Chief Nurse Officer*	✓	x				20
Jayne Stringfellow *Chief Nurse & Quality Officer*			x	x	x	0
Gareth Harry *Chief Commissioning Officer*	x	x	x	✓	✓	40

Commissioning Delivery Group Member	4 Apr 2017	1 Aug 2017	3 Oct 2017	5 Dec 2018	6 Feb 2018	% Total
Clive Newman *Interim Director of Primary Care*	✓	✓	✓	✓	✓	100
Patient Reference Group Representative	✓	✓	✓	x	✓	80

Corporate Performance Committee Attendance Record 2017/18

Corporate Performance Committee Member	20 Jun 2017	28 Jul 2017	19 Sep 2017	17 Oct 2017	19 Dec 2017	% Total
Gillian Orwin *Chair, Governing Body Lay Member (Patient & Public Involvement)*	✓	✓	✓	✓	✓	100
Valerie Beattie *Deputy Chair, Lay Representative*	x	✓	x	✓	✓	60
Jill Badger *Performance Lead*	✓	x	x	✓	x	40
Ruth Cater *Practice Manager, Staffa Health*	✓	✓	✓	✓	✓	100
David (Jim) Connolly *Chief Nurse Officer*	x	x				0
Jayne Stringfellow *Chief Nurse & Quality Officer*			x	x	x	0
Dr Ruth Cooper *Governing Body GP Member*	✓	x	✓	✓	✓	80
Guy Freeland *Patient Reference Group Representative*	✓	✓	✓	✓	x	80
Andy Gregory *Chief Officer*	x	x	x			0
Dr Chris Clayton *Chief Executive Officer*				x	x	0
Gareth Harry *Chief Commissioning Officer*	x	✓	x	x	x	20
Jean Richards *Primary Care Commissioning Manager*	✓	✓	✓	✓	✓	100
Miles Scott *Chief Finance Officer*	✓	✓	x	x		60
Louise Bainbridge *Chief Finance Officer*					x	0

Corporate Performance Committee Member	20 Jun 2017	28 Jul 2017	19 Sep 2017	17 Oct 2017	19 Dec 2017	% Total
Karen Watkinson Corporate Secretary	✓	✓	✓	✓	✓	100

Invitee (Representative of:)	20 Jun 2017	28 Jul 2017	19 Sep 2017	17 Oct 2017	19 Dec 2018	% Total
Health and Wellbeing Board	x	x	x	x	x	0
HealthWatch	x	x	x	✓	x	20
Local Medial Council	x	x	x	x	x	0
NHS England	✓	✓	✓	x	✓	80

Patient Reference Group Attendance Record 2017/18

Patient Reference Group Member	11 Apr 2017	13 Jun 2017	8 Aug 2017	10 Oct 2017	12 Dec 2017	13 Feb 2018	% Total
Blackwell Medical Centre	x	X	x	✓	x	✓	33.3
Blue Dykes Medical Centre	x	X	✓	✓	✓	✓	66.6
Castle Street Medical Centre	✓	✓	✓	✓	✓	x	83.3
Clay Cross Medical Centre	✓	✓	✓	✓	✓	✓	100
Crags Health Care	✓	✓	✓	x	✓	✓	83.3
Creswell Medical Centre	✓	X	✓	✓	✓	x	66.6
Emmett Carr Surgery	x	X	x	x	x	x	0
Friendly Family Surgery	x	X	✓	✓	x	✓	50
Limes Medical Centre	x	X	✓	x	✓	x	33.3
North Wingfield Medical Centre	x	X	x	x	x	x	0
Shires Health Care	x	X	x	x	x	x	0
St Lawrence Road Surgery	x	X	x	x	x	x	0
Staffa Health	✓	✓	✓	✓	x	✓	83.3
The Village Surgery	x	X	x	x	x	x	0
Wingerworth Surgery	x	✓	x	x	x	✓	33.3
Gillian Orwin *Chair, Governing Body Lay Member (Patient & Public Involvement)*	✓	✓	✓	✓	✓	✓	100
CCG Management	✓	X	✓	✓	✓	✓	83.3

Quality Committee Attendance Record 2017/18

Quality Committee Member	11 Apr 2017	9 May 2017	13 Jun 2017	11 Jul 2017	14 Nov 2017	16 Jan 2018	% Total
Dr Tim Scott *Chair, GP*	✓	✓	x	✓	✓	✓	83.3
Gillian Orwin *Deputy Chair, Governing Body Lay Member (Patient & Public Involvement)*	✓	✓	✓	✓	✓	✓	100
Dr Steven Lloyd *CCG Clinical Chair*	✓	✓	x	x	✓	x	50
David (Jim) Connolly *Chief Nurse Officer*	x	✓	✓	x			33.3
Jayne Stringfellow *Chief Nurse & Quality Officer*					x	x	0
Phil Sugden *Deputy Director of Quality*	✓	✓	✓	✓	✓	✓	100
Andy Gregory *Chief Officer*	x	X	x	x			0
Dr Chris Clayton *Chief Executive Officer*					x	x	0
Dr Lucy Morley *Governing Body Secondary Care Specialist Doctor*	x	X	✓	✓	✓	✓	83.3
Connie Cann *Patient Reference Group Representative*	x	X	✓	x	x	x	16.7
Jean Richards *Primary Care Commissioning Manager*	✓	X	x	x	x	x	16.7

Remuneration Committee Attendance Record 2017/18

Remuneration Committee Member	25 Apr 2017	8 Aug 2017	7 Sept 2017	31 Oct 2017	6 Feb 2018	% Total
Voting Members						
Jill Dentith *Chair, Governing Body Lay Member (Audit & Governance)*	✓	✓	✓	✓	✓	100
Gillian Orwin *Deputy Chair, Governing Body Lay Member (Patient & Public Involvement)*	✓	x	✓	x	✓	60

Remuneration Committee Member	25 Apr 2017	8 Aug 2017	7 Sept 2017	31 Oct 2017	6 Feb 2018	% Total
Dr Lucy Morley *Governing Body* *Secondary Care* *Specialist Doctor*	✓	✓	✓	✓	x	80

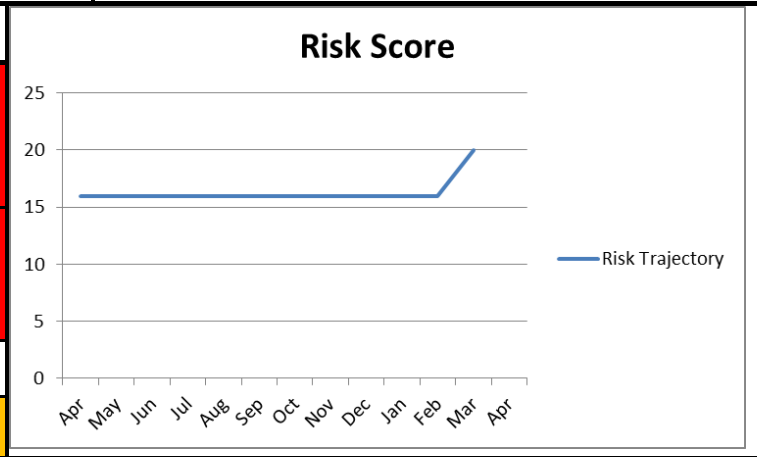
Strategic Objective: 5 *Is committed to commissioning the right care to be delivered in the right place at the right time*	**RISK 5** *Failure to align cross-system investment and savings plans leads to poor value and insufficient funds to invest in service priorities and delivery of HCCG's strategic objectives*	*Executive Lead:* Gareth Harry *Committee:* Governing Body

What would success look like?
Integrated Health and Social Care service delivery
Investments aligned to 21st Century Programme
Provider risk managed in a planned way

Principal threat(s) to delivery of the strategic objective
Investment follows traditional lines into secondary care
Limited funds available to invest in community based care
System incentives do not support joint efficiency

Risk rating	Likelihood	Consequence	Total
Initial	4	4	**16**
Current	5	4	**20**

Risk Appetite	Level	Category	Score
	Moderate	Collaborative Working	**8**



Date reviewed March 2018

Rationale for risk rating (and any change in score):
Historical patterns of contracting have continued. Little evidence of risk being shared across organisations. Contract settlements for 2017/18–19 not in line with STP or achieving HCCG strategic objectives. Risk of STP-wide solution to contract values not being made may result in arbitrations. CCG financial situation may result in strategic investments in place-based integrated care not being made.

Link to Risk Register
Risk 093

KEY CONTROLS TO MITIGATE THREAT:

Internal	External
Detailed QIPP Programme/Delivery Plan 5 Year Strategy Collaboration between CCGs and Providers Hardwick CCG resource into joint planning and contracting approach for 2017/18–2018/19 contracts Single Derbyshire Contracting and Performance Team from Autumn 2017	System wide modelling STP Programme and planned approach to planning cycle 2 year contracts/plans 17/18-19 contracts negotiated bilaterally. Not in line with Sustainability and Transformation Plan STP Provider Alliance Group established

SOURCES OF ASSURANCE

Internal	External
Governing Body minutes	Sustainability and Transformational Plan planning assurance 21st Century PDG meeting NHS England planning assurance

POSITIVE ASSURANCES RECEIVED

Internal	External
None identified.	NHS England review of System Plans

GAPS IN CONTROL

Internal	External
None identified.	No current oversight of separate organisations planning financial assumptions Lack of cross-system planning forum Lack of open-book approach Lack of joint approach to cost savings and system financial recovery plan

GAPS IN ASSURANCE

Internal	External
None identified.	Potential for further year of bilateral negotiations rather than aligned system recovery plan

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)

Internal	Timeframe	External	Timeframe
Work with partners to identify resource to invest in Place.	Ongoing	Cross-system planning forum to be established as part of the STP	Ongoing

Strategic Objective: 5 *Is committed to commissioning the right care to be delivered in the right place at the right time*	**RISK 7** *Failure to lead and partner effectively and get better value from working with other CCGs (Lead/ Associate arrangements) will lead to poor use of resources and an inconsistent commissioner approach*	*Executive Lead:* Gareth Harry *Committee:* Governing Body

What would success look like?
CCGs partner effectively with other CCGs to ensure most efficient use of resources

Principal threat(s) to delivery of the strategic objective
Duplication of limited CCG resource
CCG commissioning plans not aligned to 21st Century Programme
NDCCG Capacity and capability to manage contracts on our behalf

Risk rating	Likelihood	Consequence	Total
Initial	3	4	**12**
Current	2	4	**8**
Risk Appetite	**Level**	**Category**	**Score**
	Moderate	Collaborative Working	**8**

Date reviewed March 2018

Rationale for risk rating (and any change in score):
Single management team in place as interim, with permanent team in place from May. Single Deputy of Finance across organisations.

Link to Risk Register
Risks 017, 108 and 126

KEY CONTROLS TO MITIGATE THREAT:

Internal
Close relationships with NDCCG Performance Management
CCG Memorandum of Understanding
4+4 Group
Leadership of work to develop single ways of working/shared functions across CCGs via a single team
CCGs decision to appoint Joint Accountable Officer and single Executive Team
Establishment of Interim Joint Execs Team from October 2017

External
21st Century Programme
Contract Management Boards
Working within STP groups to develop single ways of working/shared functions across CCGs
Development and agreement of single performance reporting process across 4 Derbyshire CCGs
Development of single contracting team across the Derbyshire CCGs

SOURCES OF ASSURANCE

Internal
None identified.

External
Other CCGs in Derbyshire and Nottinghamshire
Contract Management Boards for other contracts

POSITIVE ASSURANCES RECEIVED

Internal
None identified.

External
Internal Audit Report
North Derbyshire CCG Provider Monthly Performance Report

GAPS IN CONTROL

Internal
Lack of co-ordination of CCG resource into contract management and associate lead roles

External
Limited appetite to issue contract payment challenges from CCGs

GAPS IN ASSURANCE

Internal
None identified.

External
None identified.

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)

Internal	Timeframe	External	Timeframe
None identified.		None identified.	

Strategic Objective: 5 *The CCG is committed to commissioning the right care to be delivered in the right place at the right time*	**RISK 8** *Failure to deliver QIPP leads to lack of financial balance/ viability and an inability to fund transformation in our communities*	*Executive Lead:* Miles Scott *Committee:* Corporate Performance Committee

What would success look like?

Clear metrics for each QIPP scheme and prompt measurement of outcomes

Exec Responsibility for individual elements of QIPP

Reporting of QIPP successes and review and re-direction of those areas that are not delivering

Principal threat(s) to delivery of the strategic objective

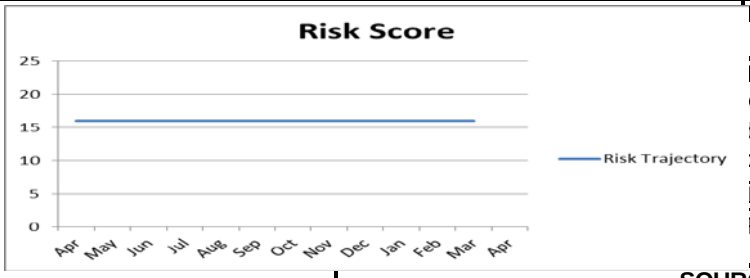
Serious issues with data quality from Acute Trusts

Some QIPP projects will have input measures but will be more difficult to link to outturn financial performance

Delays to/Slippage in implementation of individual schemes

Increased challenge for 2017/18 QIPP

Risk rating	Likelihood	Consequence	Total
Initial	4	4	16
Current	4	4	16
Risk Appetite	**Level**	**Category**	**Score**
	Low	Financial Statutory Duties	5



Date reviewed December 2017

Rationale for risk rating (and any change in score):

Very significant risk of failing to achieve financial balance with severe operational and reputational consequences

Link to Risk Register

Risks 106 and 128

KEY CONTROLS TO MITIGATE THREAT:

Internal	External
Transformation Team appointed with individuals responsible for delivery	Deep-dive meetings with Area Team
Financial Recovery Plan includes additional identified schemes	Regular prescribing analytics in place
Appointment of Turnaround Director	Engagement of Optum for work on contract challenges
QIPP Lead and PMO in place	Appointment of new provider for CHC services
Development of Derbyshire-wide PMO & Turnaround	Closer working with GP Federation

SOURCES OF ASSURANCE

Internal	External
QIPP delivery report	Area Team assurance report
Finance Plan delivered to Governing Body for approval	Letters from NHS E following deep dive meetings
FRG scrutiny of plans	Improved reporting on CHC by Midlands & Lancs CSU

POSITIVE ASSURANCES RECEIVED

Internal	External
QIPP reports and KPIs	360 Report on Transformation
Weekly QIPP updates	

GAPS IN CONTROL

Internal	External
None identified.	Data quality issues at major Acute providers
	Time lag in receiving Prescribing information
	Weak CHC information system

GAPS IN ASSURANCE

Internal	External
None identified	Acute Data quality

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)

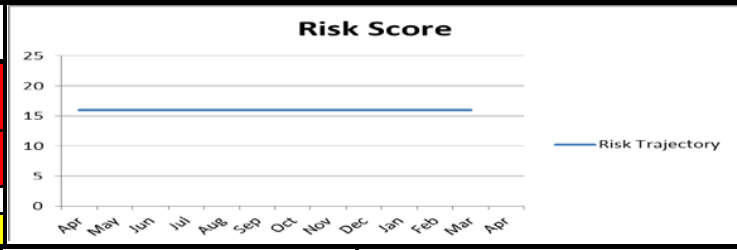
Internal	Timeframe	External	Timeframe
Improved prescribing analytics	Ongoing October 2017	First OPTUM queries delivered and initial success rates agreed – challenges are being transacted. Further engagement with provider (CRHFT) requested	October 2017
Developing CHC scorecard	December 2017	Triangulation exercise – resolution due in December	December 2017
Better understanding of impact of HRG4+			

Strategic Objective: 6 *Has strong financial health that invests to transform and improve care for our population*	**RISK 9** *Insufficient capacity and resilience in primary care adversely affects quality and access to service impacting service viability*	*Executive Lead:* Clive Newman *Committee:* Corporate Performance Committee

What would success look like?
Practices in place offering high quality service to patients within integrated model of service delivery

Principal threat(s) to delivery of the strategic objective
Lack of GPs and failing to recruit
Collapse of individual practices under workforce, regulatory or financial pressure
Practices continuing but unable to deliver to high quality or participate in planning for the future

Risk rating	Likelihood	Consequence	Total
Initial	4	4	16
Current	4	4	16
Risk Appetite	**Level**	**Category**	**Score**
	Low	Clinical Quality & Patient Safety	5



Date reviewed March 2018

Rationale for risk rating (and any change in score):
No specific immediate threat identified for any individual practice but soft intelligence is that capacity remains significant, if unspecified, risk across all.

Link to Risk Register
Risk 094

KEY CONTROLS TO MITIGATE THREAT:

Internal	External
Corporate Performance Committee	Care Quality Commission
Practice Engagement Programme	LMC
Practice Managers Group	GP Transformation Action Group
Membership Forum	GP Five Year Forward View
Commissioning Delivery Group	STP plans for place
Development of GP Federation	Derbyshire GPFV Plan
Support via Practice Engagement Programme	
Local implementation of GP Five Year Forward View and place	

SOURCES OF ASSURANCE

Internal	External
GP Survey	LMC
Feedback from Practice Engagement Programme	CQC

POSITIVE ASSURANCES RECEIVED

Internal	External
None identified.	Care Quality Commission reports for practices
	Federation feedback on practices' position

GAPS IN CONTROL

Internal	External
Finalised plans for resilience funding (GPFV)	Real time feedback from practices
	Clear long term plans from each practice

GAPS IN ASSURANCE

Internal	External
None identified.	Lack of knowledge of practices' real time financial and staffing position
	Lack of knowledge of practices' long term plans as providers

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)

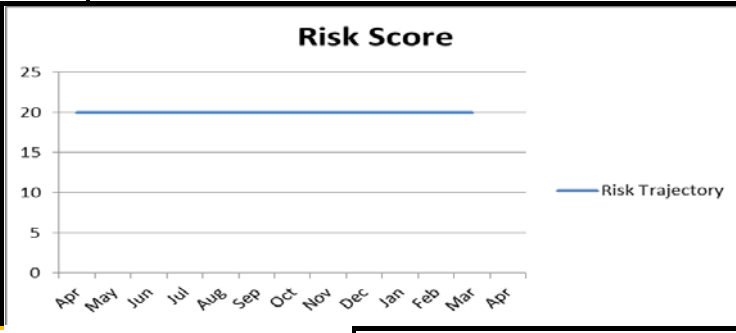
Internal	Timeframe	External	Timeframe
The CCG is working with individual practices around Care Quality Commission report		The Federation has been commissioned to work on practice planning and sustainability	
The CCG is working with NEDH and with all practices to review practices' current position and future plans	February 2018	The Primary Care Development Centre and Health Education East Midlands are supporting practices with education and training	February 2018
The CCG is working with individual practices to understand current processes and future plans		Derbyshire CCGs have a single GPFV plan, which has been signed off by NHSE	
The CCG is working on plans to implement GP Five Year Forward View locally		GPFV programme board has started to co-ordinate and lead work across the county	

Strategic Objective: 6 *Has strong financial health that invests to transform and improve care for our population*	**RISK 10** *Failure to manage activity pressures leads to constitutional failures, financial challenge and reputational damage*	*Executive Lead:* Gareth Harry *Committee:* Corporate Performance Committee

What would success look like?
Activity managed in line with CCG plans
All contractual targets met
CCG in financial balance

Principal threat(s) to delivery of the strategic objective
Activity price increases due to coding changes
Constitutional target failures due to capacity issues rather than demand

Risk rating	Likelihood	Consequence	Total
Initial	4	5	20
Current	4	5	20
Risk Appetite	**Level**	**Category**	**Score**
	Low	Commissioning & Contracting	8



Date reviewed March 2018

Rationale for risk rating (and any change in score):
Risk that resource continues to flow into models of care. Over activity means less resource to input in 21st Century strategic direction. Delay in QIPP delivery means any contractual pressure brings increased risk of CCG not meeting financial target.

Link to Risk Register
Risks 048, 069 and 136

KEY CONTROLS TO MITIGATE THREAT:

Internal	External
Financial Recovery Plan QIPP Programme Practice Managers Group Use of contract levers Engagement of Optum to identify contract challenges Data Sharing Agreement in place	Contract Management Boards

SOURCES OF ASSURANCE

Internal	External
Performance Reports Activity Reports Update notice boards in the corridor	SLAM/ SUS data

POSITIVE ASSURANCES RECEIVED

Internal	External
None identified.	NHS England planning assurance process

GAPS IN CONTROL

Internal	External
None identified.	SLAM/ SUS data quality issues Contract queries not responded to Acute Invoice Validation (AIV) not responded to

GAPS IN ASSURANCE

Internal	External
None identified.	None identified.

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)

Internal	Timeframe	External	Timeframe
OPTUM in place with data flow mapping Payment reductions transacted	Ongoing Ongoing	None identified.	

Strategic Objective: 6 *Has strong financial health that invests to transform and improve care for our population*	**RISK 11** *Inability to deliver the Sustainability and Transformation Plan across Derbyshire may lead to failure to address Health and Wellbeing gaps, outcomes and cost effectiveness*	*Executive Lead:* Clive Newman *Committee:* Corporate Performance Committee

What would success look like?

Single STP developed and agreed by all partners and by local and national NHSE teams

ST Funding received linked to plan

Process in plan to deliver STP across whole system

Principal threat(s) to delivery of the strategic objective

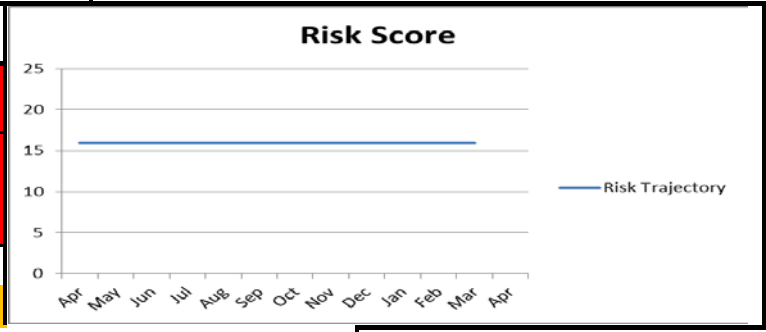
Requirement and pressure to deliver as individual organisations

Lack of willingness to work together

Lack of willingness to pool resources and to concede and compromise to agree common goals

Risk rating	Likelihood	Consequence	Total
Initial	4	4	16
Current	4	4	16

Risk Appetite	Level	Category	Score
	Low	Innovation	12



Date reviewed March 2018

Rationale for risk rating (and any change in score):
STP submission (30/06) shows ability to agree single high level plan and STP meetings in place to enable discussion & ensure governance. Ability to invest is limited

Link to Risk Register

Risks 113, 122, 123, 124 and 135

KEY CONTROLS TO MITIGATE THREAT:

Internal	External
Chief Officer and Exec input into STP process Support and input into development of business cases STP discussed at CDG, Quest and extraordinary membership meeting Establishment of place meetings and relationships STP is now public and communicated Care Home Project	STP meetings and governance set up STP plan (1st submission) STP plan (2nd submission – end October 2016) Chairs & Chief Officers STP meeting Development of new projects to continue principles of STP (eg care home projects)

SOURCES OF ASSURANCE

Internal	External
CO reporting to GB Exec reporting to CDG.	NHSE feedback

POSITIVE ASSURANCES RECEIVED

Internal	External
Interim leadership arrangements now in place	Feedback on STP submission (30/06) NHSE December feedback positive

GAPS IN CONTROL

Internal	External
Logistical difficulties in sharing developments in real time	Bilateral negotiations. Failure to operationalize and fund STP in December 2016 Financial position

GAPS IN ASSURANCE

Internal	External
Substantive leadership needs to be agreed	None identified.

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)

Internal	Timeframe	External	Timeframe
Ongoing discussions on STP planned for future GB and CDG meetings Development of Care Home project in HCCG	February 2018	Development of provider led care home/frailty projects to pick up STP	Ongoing

Glossary

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

CNO	Chief Nursing Officer
COP	Court of Protection
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuing Professional Development
CPN	Contract Performance Notice
CQC	Care Quality Commission
CQN	Contract Query Notice
CQUIN	Commissioning for Quality and Innovation
CPN	Contract Performance Notice
CPRG	Clinical & Professional Reference Group
CRG	Clinical Reference Group
CSE	Child Sexual Exploitation
CSU	Commissioning Support Unit
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CTR	Care and Treatment Reviews
CVD	Chronic Vascular Disorder
CYP	Children and Young People
D2AM	Derbyshire Dis-charge to address and manage
DAAT	Drug and Alcohol Action Teams
DCC	Derbyshire County Council
DCCPC	Derbyshire Affiliated Clinical Commissioning Policies
DCHS	Derbyshire Community Health Services
DCHSFT	Derbyshire Community Healthcare Services NHS Foundation Trust
DCO	Designated Clinical Officer
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHU	Derbyshire Health United
DNA	Did not attend

DoH	Department of Health
DoLS	Deprivation of Liberty Safeguards
DRRT	Dementia Rapid Response Service
DSN	Diabetic Specialist Nurse
DTHFT	Derby Teaching Hospitals NHS Foundation Trust
DTOC	Delayed Transfers of Care – the number of days a patient deemed medically fit is still occupying a bed.
D2AM	Discharge to Assess and Manage
ED	Emergency Department
EDEN	Effective Diabetes Education Now
EDS2	Equality Delivery System 2
EIHR	Equality, Inclusion and Human Rights
EIP	Early Intervention in Psychosis
EMAS	East Midlands Ambulance Service
EMAS Red 1	The number of Red 1 Incidents (conditions that may be immediately life threatening and the most time critical) which resulted in an emergency response arriving at the scene of the incident within 8 minutes of the call being presented to the control room telephone switch.
EMAS Red 2	The number of Red 2 Incidents (conditions which may be life threatening but less time critical than Red 1) which resulted in an emergency response arriving at the scene of the incident within 8 minutes from the earliest of; the chief complaint information being obtained; a vehicle being assigned; or 60 seconds after the call is presented to the control room telephone switch.
EMAS A19	The number of Category A incidents (conditions which may be immediately life threatening) which resulted in a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner, arriving at the scene within 19 minutes of the request being made.
EMLA	East Midlands Leadership Academy
ENT	Ear Nose and Throat
EOL	End of Life
EPRR	Emergency Preparedness Resilience and Response
FFT	Friends and Family Test
FGM	Female Genital Mutilation

FIRST	Falls Immediate Response Support Team
FRP	Financial Recovery Plan
GAP	Growth Abnormalities Protocol
GBAF	Governing Body Assurance Framework
GP	General Practitioner
GPSI	GP with Specialist Interest
HCAI	Healthcare Acquired Infections
HDU	High Dependency Unit
HSJ	Health Service Journal
GBAC	Governing Body Assurance Committee
GBAF	Governing Body Assurance Framework
GDPR	General Data Protection Regulation
GNBSI	Gram Negative Bloodstream Infection
GPFV	General Practice Forward View
GPWSI	GPs with a special interest
GPSOC	GP System of Choice
HCAI	Healthcare Associated Infection
HLE	Healthy Life Expectancy
HSJ	Health Service Journal
HWB	Health & Well-being Board
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICM	Institute of Credit Management
ICO	Information Commissioner’s Office
ICS	Integrated Care Service
ICU	Intensive Care Unit
IGC	Information Governance Committee
IGT	Information Governance Toolkit

IP&C	Infection Prevention & Control
IT	Information Technology
IWL	Improving Working Lives
JAPC	Joint Area Prescribing Committee
JSAF	Joint Safeguarding Assurance Framework
JSNA	Joint Strategic Needs Assessment
k	Thousand
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked after Children
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LGB&T	Lesbian, Gay, Bi-sexual and Trans-gender
LHRP	Local Health Resilience Partnership
LMC	Local Medical Council
LMS	Local Maternity Service
LOC	Local Optical Committee
LPC	Local Pharmaceutical Council
LPF	Lead Provider Framework
m	Million
MAPPA	Multi Agency Public Protection arrangements
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MH	Mental Health
MHIS	Mental Health Investment Standard
MIG	Medical Interoperability Gateway

MIUs	Minor Injury Units
MMT	Medicines Management Team
MoM	Map of Medicine
MoMO	Mind of My Own
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MTD	Month to Date
NDCCG	NHS North Derbyshire Clinical Commissioning Group
NECS	North of England Commissioning Services
NEPTS	Non-emergency Patient Transport Services
NHAIS	National Health Application and Infrastructure Services
NHSE	NHS England
NHS e-RS	NHS e-Referral Service
NICE	National Institute for Health and Care Excellence
NOAC	New oral anticoagulants
NUH	Nottingham University Hospitals NHS Trust
OJEU	Official Journal of the European Union
OOH	Out of Hours
ORG	Operational Resilience Group
PAD	Personally Administered Drug
PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PCCC	Primary Care Co-Commissioning Committee
PCD	Patient Confidential Information
PCDG	Primary Care Development Group
PEARS	Primary Eye care Assessment Referral Service
PEC	Patient Experience Committee
PHB’s	Personal Health Budgets

PHSO	Parliamentary and Health Service Ombudsman
PIR	Post-Infection Review
PLCV	Procedures of Limited Clinical Value
POA	Power of Attorney
POD	Point of Delivery
PPG	Patient Participation Groups
PPP	Prescription Prescribing Division
PRIDE	Personal Responsibility in Delivering Excellence
PSED	Public Sector Equality Duty
PSO	Paper Switch Off
PwC	Price, Waterhouse, Cooper
QA	Quality Assurance
QAG	Quality Assurance Group
Q1	Quarter One reporting period: April – June
Q2	Quarter Two reporting period: July – September
Q3	Quarter Three reporting period: October – December
Q4	Quarter Four reporting period: January – March
QIPP	Quality, Innovation, Productivity and Prevention
QUEST	Quality Uninterrupted Education and Study Time
QOF	Quality Outcome Framework
RAP	Recovery Action Plan
RCA	Root Cause Analysis
REMCOM	Remuneration Committee
RTT	Referral to Treatment
RTT Admitted	The percentage of patients waiting 18 weeks or less for treatment of the patients on admitted pathways
RTT Non-admitted	The percentage if patients waiting 18 weeks or less for treatment of the patients on non-admitted pathways

RTT Incomplete	The percentage of patients waiting 18 weeks or less of the patients on incomplete pathways at the end of the period
SAAF	Safeguarding Adults Assurance Framework
SAR	Service Auditor Reports
SAT	Safeguarding Assurance Tool
SBS	Shared Business Services
SDCCG	Southern Derbyshire CCG
SDMP	Sustainable Development Management Plan
SEND	Special Educational Needs and Disabilities
SHFT	Stockport NHS Foundation Trust
SFT	Stockport Foundation Trust
SNF	Strictly no Falling
SOC	Strategic Outline Case
SPA	Single Point of Access
SQI	Supporting Quality Improvement
SRG	Systems Resilience Group
SIRO	Senior Information Risk Owner
SRT	Self-Assessment Review Toolkit
STEIS	Strategic Executive Information System
STHFT	Sheffield Teaching Hospital Foundation Trust
STOMPLD	Stop Over Medicating of Patients with Learning Disabilities
STP	Sustainability and Transformation Plan
TCP	Transforming Care Partnership
TDA	Trust Development Authority
T&O	Trauma and Orthopaedics
TWG	Transition Working Group
UEC	Urgent and Emergency Care
YTD	Year to Date
111	The out of hours service delivered by Derbyshire Health United: a call

	centre where patients, their relatives or carers can speak to trained staff, doctors and nurses who will assess their needs and either provide advice over the telephone, or make an appointment to attend one of our local clinics. For patients who are house-bound or so unwell that they are unable to travel, staff will arrange for a doctor or nurse to visit them at home
52WW	52 week wait