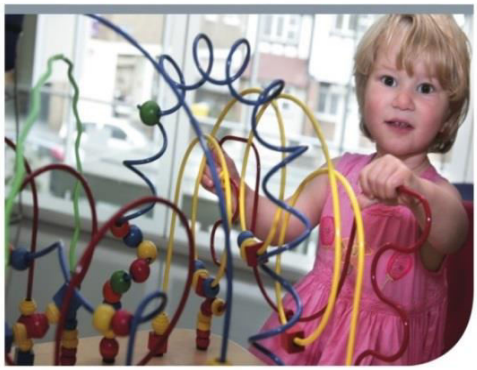
NHS
Southern Derbyshire
Clinical Commissioning Group

Annual Report & Accounts 2017 - 2018

NHS Southern Derbyshire Clinical Commissioning Group


Contents

FOREWORD

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

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

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

As part of this process, our four previous Chief Executive Officers and Chief Finance Officers left their respective CCGs during the second half of the year to take up new opportunities, so in Southern Derbyshire CCG we said farewell to Gary Thompson and Phil Cowley along with our sincere thanks for their contributions and 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 southern Derbyshire. To support that objective we have continued to invest in strategic relationships including Derby City and Derbyshire County Councils and Public Health to share our thinking and planning, and to ensure that we achieve maximum impact for our patients based upon the resources at our disposal.

There are many examples of projects and programmes which have delivered a positive impact. I would particularly like to highlight our achievements in mental health, an area where one in four people will experience a mental health problem in their lifetime. In 2017/18 we exceeded the targets for dementia diagnosis and for those who have moved into the 'recovery' phase following access to psychological therapy. Mental health is an area I am particularly passionate about and has been one of my key priorities this year; it will continue to be so in the future.

The prevention agenda is another priority; tackling the strain diabetes is putting on the NHS is critical, so I am pleased that we are encouraging patients who have been diagnosed as pre-diabetic to attend the 'Healthier You' structured education programme. We have also seen almost 2,000 Type 2 diabetic patients take control of their diabetes by attending our local X-PERT structured education programme. Encouraging our patients to manage their conditions is vital and I am proud that we are supporting them to stay well.

I am honoured to continue as Chair of the CCG and look forward to working with all of our partners to make a real difference to the health and wellbeing of the people of southern Derbyshire.

Dr Paul Wood
Chair
NHS Southern Derbyshire Clinical Commissioning Group

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Southern Derbyshire CCG

23 May 2018

Performance Overview

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

Chief Officer's Statement

As described by our Chair in his foreword, the 2017/18 operational year has seen vitally important change for Southern Derbyshire CCG and the four CCGs across Derbyshire, and as this is my first Annual Report it feels appropriate for me to introduce myself.

My name is Dr Chris Clayton, and until 1 October 2017 when I started my role as Chief Executive for the four Derbyshire CCGs I was Chief Executive Officer of Blackburn & 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 4-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
Chief Executive Officer
NHS Southern Derbyshire Clinical Commissioning Group

23 May 2018

Purpose and Activities of the CCG

NHS Southern Derbyshire 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 southern Derbyshire. The CCG has representation from 55 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 residents across the southern half of Derbyshire, including the whole population of Derby city, as well as those living in Amber Valley, south Derbyshire and the south part of Derbyshire Dales, and serves a population of over 554,000.

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

The CCG is striving to achieve this by:

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

There are clear health inequalities within the CCG area and there is a shared purpose amongst members and stakeholders to improve health outcomes and lift the health of the population. The CCG is focused on ensuring that the patient's experience of care is the best possible, with joined up care and support in place in the most appropriate setting. Working together with partner organisations is part of the whole system approach articulated in our Derbyshire Sustainability and Transformation Partnership (STP). The latest update on developments can be found at: https://joinedupcarederbyshire.co.uk/

We were allocated £758 million of public money, split between £746 million to spend on health services and £12 million for running costs. The running cost allocated amounts to £21 per head of population. This report will explain how this has been used to support your care, and how this fits in to the second year of a five-year plan to meet key priorities.

Patients in our area have access to services from a wide range of providers, including Derbyshire Healthcare NHS Foundation Trust, Derbyshire Community Health Services NHS Foundation Trust and East Midlands Ambulance Service NHS Trust. Our largest contract is with Derby Teaching Hospitals NHS Foundation Trust, which accounts for approximately 40% of our funding.

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

Our 55 member practices lie within Derby City and the southern part of Derbyshire (detailed on page 49). We also work with our fellow CCGs in Derbyshire, Hardwick, Erewash and North Derbyshire; together we cover a total population of over one million people.

Key Issues and Risks that Could affect the CCG Delivering its Objectives

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

Risk 001. The CCG fails to reach agreement on additional activity reductions over and above those contracted.
Risk 002. Risk to the CCG if it is unable to produce a (credible) Recovery Plan, which is clinically sustainable and financially viable.
Risk 003. The Acute provider contract may over perform against agreed plan and/ or not deliver A&E standards.
Risk 004. The Sustainability & Transformation Plan (STP) and Strategic Outline Case (SOC) are not clearly defined.
Risk 005. Risk to the CCG if it does not have sufficient capacity of staff to deliver objectives.
Risk 006. There is a risk that the successful delivery of 'Place' will be delayed.
Risk 007. There is a risk that the quality of service is impacted due to financial pressures.

Adoption of the Going Concern Approach

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

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

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

Key Developments during 2017/18

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

Transformation

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 (LMS), 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 the 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 stand-alone 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 with local women and their families, embracing change to ensure high-quality services for the women, babies and their families in 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 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 requires a cultural shift in many communities, organisations and 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 which 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 is to meet the needs of the person, not just delivering a service.
- **Coordinated** - when there is more than one service providing care, this needs to be organised in an effective and efficient manner for the patient.

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

The Derbyshire CCGs have individually been working towards delivering more integrated care over the last few years and now this 21st Century (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.

Below 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 Belper’.

Community support beds and integrated community services

Since the decision to progress with Better Care Closer to Home and Joined Up Care Belper 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 re-ablement 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 result 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.

Dementia Rapid Response Team

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

The DRRT is a community-based service that aims to improve the health and wellbeing 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.

In southern Derbyshire, we have exceeded the national target for dementia formal diagnosis of 67% by 4%, to 71%. Derbyshire-wide the overall rate is 72.5%.

Mental Health

Achieving parity of esteem for people with mental health needs is one of the NHS' 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 being treated in IAPT services. By February 2018, 23.5% of southern Derbyshire 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; 53% of southern Derbyshire 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 had exceeded this target in southern Derbyshire and 80% of patients were seen within two weeks, whilst the figure for patients Derbyshire-wide is 91%.

Improving mental health services has been a priority for the Derbyshire CCGs. All four Derbyshire CCGs have met the requirements of the Mental Health Investment Standard (MHIS) with an increased expenditure on mental health care in line with the CCG's 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: primary care mental health; responsive community mental health and in-patient services; dementia and delirium; rehabilitation and forensic services. The CCGs have seen continued good performance against national indicators for: early intervention in psychosis; dementia diagnosis; and access to psychological therapies in primary care. Mental Health Liaison Teams in Chesterfield Royal Hospital have been enhanced with both of our major hospitals providing 24-hour mental health cover to the hospital emergency departments.

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

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

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

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

Children's Mental Health

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

The Children's Commissioners are now working as one team across the Sustainability & Transformation Plan (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. The 'Be A Mate' anti-stigma campaign was launched in 2017 to encourage young people to talk, support one another, but also to 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 one-to-one 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 peoples' mental health needs within their local communities. There remains a challenge in the transition between children's and adult's mental health, particularly for children with other vulnerabilities, this will be a focus for 2018/19.

Children's Commissioning

The CCG's 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 gathered pace in 2017/18. We concentrated 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 (LD), 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 a mental health and ASD dual diagnosis more than doubled from last year. In 2017/18 we

agreed a Derbyshire-wide Autism Strategy which supported the Health and Wellbeing Boards. A Staywell with Autism service was also procured. Autism diagnosis services were reviewed; for children the waiting times for an ASD assessment fell from three years to 18 weeks on average. Community services used their combined skills to start collaborating to help care for people recognised as having Autism and mental illness. The TCP has applied for funding from NHS England to upskill 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.

At March 2018, from Derbyshire residents in the cohort we had 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 was 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 coordinated way alongside probation and social care. In 2017/18 Derbyshire had 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 is finalising the Funding Transfer Agreements, and 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 learning disabilities and mental health Crisis Team capability working over seven days a week. This will ensure there are developing skills within the system to manage the increasingly recognised dual diagnosis issues of acute mental ill health alongside learning disabilities and/or 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. 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. This achievement prompted a letter of support from NHS England expressing confidence in the structure of the Transforming Care Plan, and in December we were de-escalated from a ‘Red’ rating.

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 has worked closely with Derbyshire Healthcare NHS Foundation Trust to review current provision, specifically assessments for looked after 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 worked collaboratively to develop a more consistent approach to both the commissioning and quality of primary care commissioned services for the population of Derbyshire.

Five-Year GP Forward View (GPFV)

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

A delivery plan was submitted and approved by NHS England outlining the Derbyshire Vision for General Practice 2017-21. 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:

- Improve population health, particularly amongst those at risk of illness or injury
- Manage short term, non-urgent episodes of minor illness or injury
- Manage and co-ordinate the health and care of those with long-term conditions
- Manage urgent episodes of illness or injury
- Manage and coordinate 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 8am till 8pm Monday to Friday. This will support increased access to urgent on-the-day appointments and planned appointments. We are working with member practices to coordinate 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 seven 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 coordinated 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 timeframe 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 available on the CQC website.

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

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

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

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

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

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

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

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 a Practice Nurse Forum (Erewash and 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 2016/17 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 (e-RS), an electronic booking and referral system for GP referrals to first outpatient consultant-led services. This electronic system enables GPs to safely and securely send referral information and allows patients to book their own appointment, on a time and date to suit them.

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

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

NHS.Net

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

Enhanced Care Home Service

The CCGs have continued to commission Enhanced Care Home Schemes, delivered by general practice or community providers who are aligned to individual care homes. Whilst still maintaining patient choice of GP surgery, this service provides better management of patient care that is carried out jointly by care home staff, local practices and local providers. During 2017/18 this service has continued to demonstrate improved outcomes from both qualitative and quantitative perspectives, 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

In 2016/17 we allocated over £659,000 in primary care to support member practices to provide additional appointments for their patients over the winter period. Unallocated Locally Commissioned Services Framework (LCSF) money was used to fund the initiative which produced positive outcomes for our patients. Funding supports additional face-to-face patient appointments, which have enabled practices to respond to extra patient demand and need over the winter period in a planned way. This has produced increased patient satisfaction and enabled patients to receive timely, appropriate clinical care provided locally by their own practice team.

This year the focus has been on capacity in general practice and an evaluation 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 are 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.

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 (1,286 against a target if 587). By March 2017 1,952 patients started the programme. Additionally, we also 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.

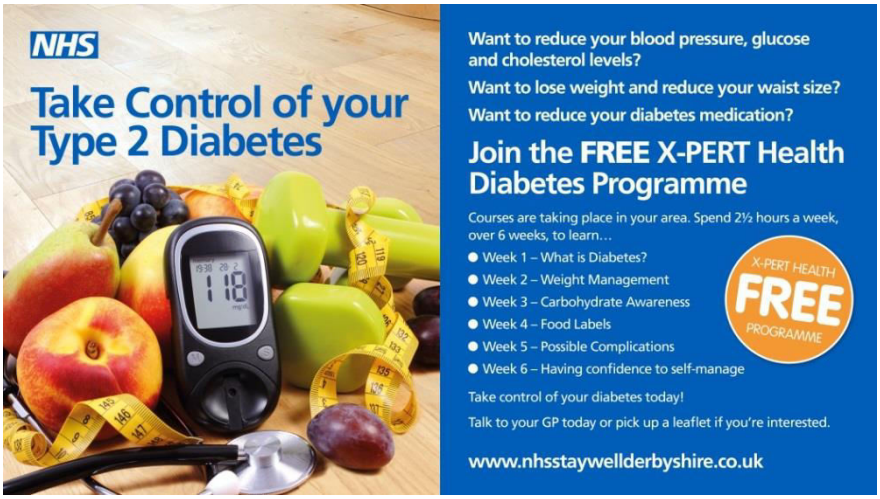
As a result I have lost two stones. I'm delighted and feel better than I have felt in years. I can't believe it - I need to wear different sized clothes now."

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

Supporting Type 2 Diabetics

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

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



By December 2017 a total of 577 new patients started the programme, which is run by qualified X-PERT educators. The programme is continually being updated in line with national guidance and evidence base, to support individuals to best manage their lifestyle choices and consequently improve their diabetes condition.

Harpal Kaur from Derby City attended the programme and said:

> *"I attended the X-PERT programme in June 2017 and learnt a lot about the food that I eat and how that has an impact on my diabetes and how my HB1ac was being affected. When I started the programme my HBA1c was 8.6 or 70 mmol, then I gradually started to incorporate small changes into my diet and exercise and almost a year on it has gone down to 7.3 or 56 mmol.*
>
> *I have lost a stone and a half and dropped three dress sizes; I feel and look so much better. After 17 years, I've managed to reduce my medication and would like to*

reduce it even further in the future. The X-PERT programme has given me control and the ability to know how to manage my health. As people often say if I can do it anyone can do it. It is so true and I would recommend it. If you're open to new things and take on board what you are being taught, start to make gradual changes you will see the difference".

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

Engaging Different Communities

Diabetes is particularly prevalent in South Asian communities and recognising the diverse population in Derby city we worked closely with our inner city practices (Peartree Medical Centre, Derby Family Medical Centre, St Thomas Road Surgery and Lister House Surgery) to encourage take up of the X-PERT structured education programme by the local south Asian diabetic community. Tailored programmes were run from Peartree Clinic, by Hindi and Punjabi speaking educators, focussing on the Asian diet and lifestyle and how sustainable changes could be made, e.g. by understanding carbohydrates in the Asian diet, offering advice around lifestyle choices, understanding what their health results actually mean and how to introduce new ways to achieve weight loss.

Due to the success of these programmes and increasing demand for similar tailored courses, the service has successfully recruited a new Punjabi speaking educator to complement its existing pool of educators.

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 undertaken across primary care, using the Effective Diabetes Education Now (EDEN) tool. The results are that 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 the 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 Hospital 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.

Respiratory RightCare

RightCare is a national NHS England programme committed to delivering the best care to patients, making the NHS' money go as far as possible and improving patient outcomes. Our local Respiratory RightCare programme brings together expertise from across the CCG, Public Health, partner organisations and clinicians from both primary and secondary care to focus on improving the health of patients across southern Derbyshire diagnosed with, or at risk of, a respiratory condition.

We also work closely with local respiratory support groups, patients and carers to understand what is important to them living day to day with a respiratory condition to help to inform the changes required. Achievements for the Respiratory RightCare programme to date include:

Inpatient Smoking Cessation Service

There is now a dedicated Smoking Cessation Team at Royal Derby Hospital who actively identify smokers on respiratory wards with the aim of using the admission as a teachable moment to encourage patients to commence a stop smoking programme whilst an inpatient. This is a positive step towards integrating tobacco addiction treatment into care pathways for respiratory patients with benefits that include admission avoidance, reduction in length of stay and reduction in smoking related mortality.

Respiratory Action Plans

Self-management plans are an integral part of patient self-care as they can support patients to recognise when their symptoms are changing and what action to take. All GP practices now have access to Respiratory Action Plans, which can be offered to patients as part of a consultation process and reviewed at least annually.

New Place-based Specialist Respiratory Service

A specialist multi-disciplinary service is due to commence in April 2018 across Southern Derbyshire. The focus of this service is to begin to make the shift from episodic, reactive care to one that is grounded in prevention and proactive care management. The service will support practices and places with their respiratory population of patients through active case finding, education, virtual clinics, specialist holistic patient assessments six-week diagnosis and a respiratory helpline

The Respiratory RightCare programme will continue into 2018/19 and we have already started working on our priorities, which include:

- Working with Primary Care to identify respiratory patients who are most at risk of hospital admission and identifying processes that can be put into place to reduce these risks;

- A targeted flu campaign for patients with respiratory conditions to enable them to stay well next winter and;
- Exploring opportunities to enhance psychological support for the local respiratory population.

Integration Agenda

Personal Health Budgets

In 2017/18 we agreed policies and procedures across all four CCGs to ensure a consistent offer around personal health budgets across the patch. We have continued to speak to health and social care teams about personal health budgets to improve understanding and begin to embed personalised approaches. We worked with Treetops Hospice Care and are one of five pilot sites to develop personal health budgets at end of life. We were nationally recognised for this work, being runners up in the Third Sector Care Awards, CCG staff are pictured with awards host Esther Rantzen.

In Derbyshire we approved 46 personal health budgets for people with a long term condition and 38 for patients with continuing healthcare needs. These were across a number of conditions and offered a wide range of solutions. We continue to look for further opportunities to expand the use of personalised approaches – which may lead to a personal health budget. These include working closely with Derby City Council and NHS England on expanding the use of Shared Lives to prevent readmission; beginning to develop processes around how a PHB may work for someone eligible for section 117 support and how we might support the Transforming Care Cohort out of mental health placements.

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', by:

- 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'.

Read more about how we engage our communities about Place on page 42.

Falls Reduction

Falls involving older people has been identified as one of the main issues for STP Places to focus upon to take a proactive 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 patinets 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 at 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 have been significant pressures across Derbyshire, which has also been seen across the country.

In 2017/18 a Derbyshire-wide Winter Plan was developed, in which additional resource was invested to increase support to deliver the plan. There are schemes that have also been put in place to help support 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 the Performance Analysis section for more detailed information.

Medicines Management

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

Antimicrobial Prescribing

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

Our approach to reducing the unnecessary prescribing of antibiotics is very comprehensive and led by a Lead Antimicrobial Pharmacist who works closely with practices to provide advice and support, and share good practice through education events and sharing handy tips. This approach was successful as the CCG met and exceeded all of its prescribing targets by December 2017. For example, the national target for total antibiotic items prescribed is less than 1,161 items (per STAR PU); we exceeded this target by prescribing 28% below this target as we prescribed 842 items (per STAR PU). Our Lead Antimicrobial Pharmacist has also presented nationally on this topic at various conferences and is the lead for Primary Care, Pharmacy Infection Network at the UK Clinical Pharmacy Association and is also a member of the Expert Advisory Group on Antimicrobials at the Royal Pharmaceutical Society.

Reducing Medicines Wastage

Repeat prescriptions account for around 80% of the money spent on prescribing in primary care each year. Significant amounts of waste medicines are generated due to dispensing of unwanted medication, but much of this waste is preventable.

In December 2017, as part of Southern Derbyshire and Erewash CCGs' joint QIPP programme we launched a new and innovative pilot service which allows patients, or nominated representatives, to order their repeat prescription items using a dedicated telephone line called the Medicines Order Line (MOL), saving visits to the practice to order and collect medication. The service provides an opportunity for repeat medications to be reviewed and quality assured, thus making it possible to better manage the repeat prescribing process and reduce waste.

The pilot initially covered five practices within Derby city and patient feedback reveals:

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

Cost Saving Work

The Medicines Management Team has worked exceptionally hard with support from general practice and other local providers to deliver over £6 million 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 schemes to reduce waste medicines .

Gluten-Free Prescribing Consultation

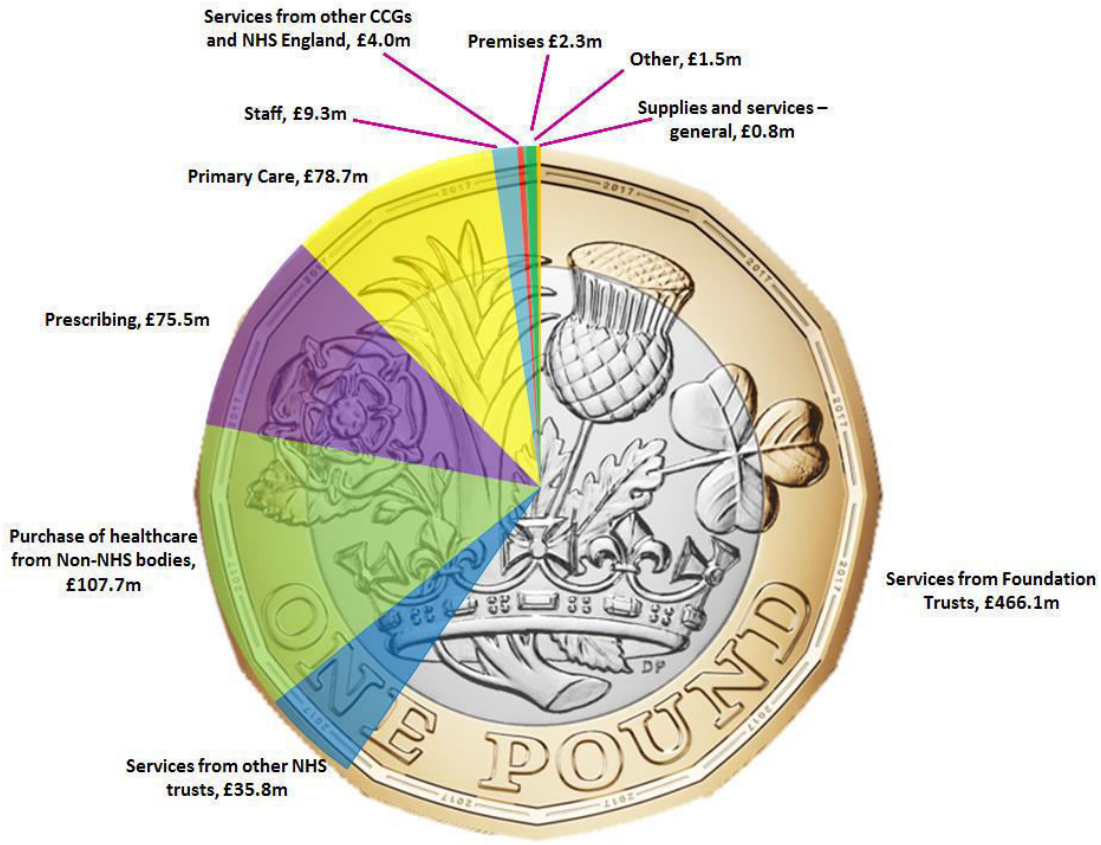
For over 40 years the NHS has prescribed gluten-free foods e.g. bread, flour, cereal and pasta, to patients who have been diagnosed with coeliac disease and therefore need to follow a gluten-free diet. The NHS began prescribing gluten-free foods when products were expensive and difficult to source. Today 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, Southern Derbyshire, North Derbyshire, Erewash and Hardwick CCGs 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 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 to treat short-term, minor self-limiting conditions.

Addressing our Financial Challenge During 2017/18



Financial Position

NHS Southern Derbyshire CCG received two allocations for the financial year 2017/18; the first for the commissioning of healthcare (programme) and the other for their running costs (administration). These allocations came in the form of Parliamentary Funding from NHS England and by March 2018 totalled £746m and £12m respectively.

The CCG has not delivered all financial targets in 2017/18. A significant shortfall against the planned delivery of transformational efficiencies has led to a reported deficit, with programme expenditure exceeding the CCG's programme allocation.

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

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

The financial outlook for future years is an increasingly challenging one. The efficiency requirement for the 2018/19 year is at 3.3% and is a result of both low growth in funding and also the impact of the shortfall in delivering recurrent efficiencies in 2017/18.

Detailed plans for the next year have been submitted to NHS England outlining how we will continue to deliver the financial targets and manage in-year risk. Further development of these plans is ongoing.

Our allocations for the 2018/19 year have been confirmed. These will total £763m for programme costs and £12m for running costs. Our financial target for the 2018/19 year has been confirmed as break-even, keeping expenditure in line with the allocations received. This is based on receipt of £16.9m from the Commissioner Sustainability Fund.

Statement as to the Disclosure to Auditors

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

- So far as the member is aware, there is no relevant audit information of which the NHS body's auditor is unaware, and

- He has taken all the steps that they ought to have taken as a member in order to make himself aware of any relevant audit information and to establish that the entity's auditor is aware of that information.

Performance Analysis

One of the key areas of focus outlined in the CCG's Operational Plan for 2017/18 was to maintain system resilience and performance, and meet all constitutional expectations. The constitutional expectations are those performance standards outlined in the NHS Constitution.These include measures such as Referral to Treatment times, Accident & Emergency (A&E) waiting times and Cancer waiting time standards.

The CCG's Governing Body receives a performance report against these measures on a monthly basis. The Governing Body of the CCG monitors and gains more detailed assurance against the CCG's performance metrics. As part of the development of the 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. The individual projects making up this transformation programme have all identified target measurements that show:

- **Improved quality** – more care available local to home
- **Innovation** – working to a new model of care provision through Advanced Nurse Practitioners to complement GP services and ensuring access 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.

Performance Summary

The overall performance of the CCG in 2017/18 has been strong.

We have delivered 15 of the 22 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.

Performance Analysis

The table below 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%	**92.7%**	**92.8%**
	18 weeks Referral to Treatment - 52+ week wait	0	**47**	**83**
Diagnostic waits	Diagnostic test waiting more than 6 weeks from referral	1%	**0.84%**	**1.11%**
A&E waits	A&E <4 hours	95%	**88.3%**	**89.7%**
Cancer waits - <14 days	Urgent GP referral to 1st outpatient appointment	93%	**96.7%**	**94.4%**
	Urgent GP referral to 1st outpatient appointment. (Breast symptoms)	93%	**95.2%**	**91.1%**
Cancer waits - <31 days	Diagnosis to first definitive treatment for all cancers	96%	**96.6%**	**96.6%**
	Subsequent Surgery within 31 days of Decision to treat.	94%	**96.8%**	**96.8%**
	Subsequent Drugs treatment within 31 days of decision to treat.	98%	**97.5%**	**98.7%**
	Subsequent radiotherapy treatment within 31 days of decision to treat.	94%	**95.8%**	**95.0%**
Cancer waits - <62 days	Urgent GP referral to first definitive treatment for cancer	85%	**79.6%**	**79.5%**
	NHS screening service to first definitive treatment for all cancers	90%	**91.8%**	**91.8%**
	First definitive treatment following a consultant's decision to upgrade (all cancers)	N/A	**88.1%**	**84.9%**
Mental Health	CPA 7 days follow up	95%	**98.1%**	**98.1%**
	IAPT Access	15%	**24.0%**	**24.3%**
	IAPT Recovery	50%	**53.5%**	**54.4%**
	IAPT Waiting times (6 weeks)	75%	**74.3%**	**81.4%**
	IAPT Waiting times (18 weeks)	95%	**99.8%**	**99.8%**
	Early Intervention in Psychosis – Completed	50%	**75.3%**	**89.0%**
	Dementia Diagnosis	67%	**72.3%**	**73.2%**
Infection control	C. Diff	114	**122**	**270**
	MRSA	0	**0**	**3**
Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	**130**	**145**

2017/18 Performance Exceptions

Patients Waiting More than 52 Weeks for Treatment

There were 47 patients who waited for more than 52 weeks for their treatment during 2017/18. Twenty-three of these patients were declared during the last three months of the year. The increase was due mainly as a result of the request from NHS England to cancel all non-urgent elective surgery to support the Emergency Department during winter pressures. The CCG is provided with monthly reports for those patients who have waited for more than 40 weeks for their treatment and breach reports are provided to ensure there is no harm to the patients.

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

The majority of CCG patients attend Derby Teaching Hospital NHS Foundation Trust. Although the trust has been unable to meet the 95% standard this year they compare very favourably with other acute trusts in the country achieving just under 90%. The trust has reported that this is due to the higher acuity of patients being treated and increasing. The Primary Care Streaming service commenced 15 hours each day at the beginning of October 2017 to enable some of the pressure to be taken off the Emergency Department. A refreshed remedial action plan has been developed and the CCG is working closely with the Trust.

Cancer

The CCG has narrowly missed the Cancer 31-day wait – subsequent drug treatment – standard, but work is being undertaken to review this pathway to ensure it is compliant. Failure of this standard was in the first part of the year and unfortunately improvement was too late to affect the year end figure.

Cancer 62 day waits performance for the CCG failed to achieve against the national standard. A contract Performance notice was issued in April 2017. At that time the trust was failing five of the eight standards. A quality visit was undertaken during May 2017 and Cancer Escalation meetings have been taking place weekly since May to go through the actions from the weekly PTL meetings. The trust met the 62 day standard during October 2017 for the first time since April 2016. Recovery is expected for April 2018.

IAPT Recovery Times

The Derbyshire system is on track to deliver against the Five-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 Any Qualified Provider (AQP) system to incentivise achievement of targets. Derbyshire wide employment advisors procurement has started in IAPT. A 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 CCGs as a whole Derbyshire is under objective. The CCG has an annual objective of 122 and at the 2017/18 year end there have been 114 cases.

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

MRSA

There continues to be a zero tolerance approach set by NHS England for MRSA bacteraemia. During 2017/18, across Derbyshire there have been 10 reported cases. Three were SDCCG 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 District General Hospital and two cases were attributed to NHS Hardwick CCG.

Mixed Sex Accommodation

The NHS has a zero target for mixed sex accommodation breaches. The CCG reported 130 breaches up to the end of Q4, 105 of these took place at Derby Teaching Hospitals NHS Foundation Trust.

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

Ambulance Response Times

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

Indicator		Standard	County Wide	EMAS Wide
Ambulance Response times (Aug 17 – Mar 2018)	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 four, which is the highest level. Handover delays at Acute Trusts continue to cause further operational pressures, with work ongoing between Acute Hospitals, Commissioners and Regulators to improve.

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

NHS 111

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

The NHS111 service across Derbyshire is provided by DHU111 (East Midlands) CIC, (DHU111); the contract is regional and also covers four other counties. 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 ais often asked to trial and develop new initiatives. DHU111 has 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 NHS England 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 Interactive Voice Response (IVR) 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 has moved its 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 2017/18 the CCG continued to be monitored through the CCG IAF which was introduced in 2016/17 with the aim of driving improvement in the health and wellbeing of the population, quality improvements for all patients and better value for money.

My NHS is a publicly accessible website which reports on all of the elements of the 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 2017/18 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 either ‘Inadequate’, ‘Requires Improvement’, ‘Good’ or ‘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 Wheelchairs

During 2017/18, the four Derbyshire CCGs completed a review of the Derbyshire Wheelchair Service. We were concerned that waiting times were long, there was a big backlog of patients that had built up, and there was not enough clarity about what type of wheelchairs and associated equipment the service could provide. We established the Derbyshire Wheelchair Service Review Group, which included officers from the four CCGs, managers from Derbyshire Community Health Services, 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 do not 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
- Work with NHS England on the development of personal wheelchair budgets
- Research what works well in other areas, particularly those services who have a 'child in a chair in a day' system

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

Healthcare Acquired Infections

Methicillin-Resistant Straphylococcus Aureus (MRSA)

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

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

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

Clostridium Difficile

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

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

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

Cases of Clostridium Difficile are apportioned to either the acute trust or community. Those patients that develop the infection post 72 hours of admission are classed as attributed to the acute trust. The percentage of acute trust cases differs between the north and south of the county. For Erewash 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 NHS Foundation Trust are below their objectives.

Escherichia Coli (E.coli) Bacteremia

Government expectation and guidance has been issued to address the high national incidence of gram negative bloodstream 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. To date there have been 834 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 the number of cases.

The following table demonstrates each CCG's performance and individual objective to January 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)	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Total cases (Rate per 100,000 Population)
Erewash	74(77.0)	8	10	9	12	7	3	5	6	8	1	2	8	79 (81.06)
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 was pleased to note the action plan and progress that the Derbyshire group had implemented to date.

Serious Incident (SI) Reporting

The quality of the Serious Incident (SI) reports submitted to the CCGs has 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; process is now agreed and in place.

Never Events

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

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

Better Care Fund (BCF) Metrics

In 2017/18, the CCG has pooled £19.2 million of its resources with Derbyshire County Council along with all other Derbyshire CCGs, as part of the nationally mandated Better Care Fund. The intention is that the money be used to reduce non-elective admissions to acute hospitals, reduce delayed transfers of care, reduce admissions to residential and nursing care homes, increase access to reablement/rehabilitation services, increase dementia diagnosis and improve patient experience.

The BCF 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. The 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 **'R**	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 Southern Derbyshire CCG has the following sustainability mission statement located in our sustainable development management plan:

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

Sustainability has become increasingly important as the impact of people's lifestyles and business choices change the world in which we live. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help to achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff and partners.

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

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

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

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

Improving Quality

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 pays great regard to the outcomes of safeguarding adults and children and has 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 has systems and processes in place to measure the quality of services and uses 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 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 has 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 seem 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 has worked with providers to share learning between them in relation to Clostridium Difficile. NHSI was also involved in reviewing every case at DTHFT and was 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 expects to see sustained improvements in 2018/19.

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

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

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

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

NHS Hardwick Clinical Commissioning Group (HCCG) holds the NHS standard contract (AQP) on behalf of all of the four Derbyshire clinical commissioning croups and hosts 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 works 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 use to help improve the care they provide to their residents.

Engaging People & 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:

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

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 has influenced national decision-making at a local level. These include:

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

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

Prescribing Public Consultations
Two countywide prescribing consultations were led by North Derbyshire CCG during 2017.

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

The Gluten-Free Prescribing Public Consultation ran from 27 February - 15 August 2017 on the future of gluten-free foods prescribing. A feedback reports for both are available to view at: 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

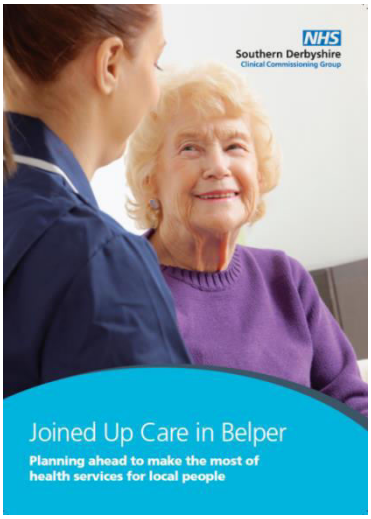
A targeted countywide engagement exercise took place for two weeks in September 2017 to gather the views of service users and staff to inform the writing of the Better Births Derbyshire five-year plan. Engagement took the form of an online survey and a series of outreach events. Details of the engagement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

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

Patient and Public Involvement in Southern Derbyshire

Further information about how the CCG involves patients and the public on an ongoing basis in its commissioning arrangements (planning, decision-making and proposals for change) is available at: www.southernderbyshireccg.nhs.uk/have-your-say/

Joined Up Care in Belper Engagement



The CCG and care organisations in southern Derbyshire came together to plan changes to the way local health services are provided to make them fit for the future. We began the Joined Up Care in Belper review in 2015 to understand what was needed, the review assessed how our health services are being provided in and around Belper to understand how (with the changing health needs of the local population) we may need to alter health service delivery.

Following the review, we undertook an extensive engagement programme from 18 January - 31 March 2018 to talk to local people about a proposal to join Derbyshire County Council in a new facility adjacent to a new centre being developed on Derwent Street in Belper. Gaining the views of local people was important to us, so we notified over 22,000 households about our engagement work in the area through the distribution of leaflets and we spent over 140 hours talking to patients and the public at Belper blood clinic and in Belper town centre.

The Belper engagement closed on 31 March. More information is available at: www.southernderbyshireccg.nhs.uk/have-your-say/engagements/belper-health-services/

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.

Together with Derby and Derbyshire Healthwatch and voluntary organisations, 11 events across Derbyshire have been attended 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 500 people were reached. 120 people have filled out a short and simple questionnaire, whilst 44 people chose to complete it online.

The engagement ran from September to October 2017. In September the focus was on:

- Promoting the questionnaire and working with organisations to involve staff
- Approximately 8 - 10 sessions specifically for carers
- Working on engaging with young people
- Healthwatch Derby focused on reaching specific communities in the city

To 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
b. Working with practices to tackle practice and clinical variation.
c. Focussing on evidence-based and effective delivery.
d. Improving the integration of health and social care.
e. Improving integration of primary and secondary care to improve care for the frail, elderly and those with one or more long-term conditions.
f. Working with partners to improve lifestyle choices of the Derbyshire population in relation to smoking, alcohol, diet and exercise.

Moving forward, one of our main improvement objectives for 2017/18, 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 health inequalities for patients living in specific geographical areas by bringing health and social care organisations together to work collaboratively. We aim for health and social care provision to be thought of in a wider context. We know that only 15% of patient outcomes can be improved by healthcare 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

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 is a regular participant 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 FaceBook 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 ill health. In Derbyshire estimated levels of adult excess weight, the rate of adult alcohol-related harm hospital stays and smoking at time of delivery are worse than the England average. The rate of smoking related deaths is 291*, which represents 1,391 deaths per year.

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

Early intervention and prevention in childhood can avoid expensive and longer term treatments. In Year 6, 17.9% (1,333) of children are classified as obese, better than the average for England, as is the levels of teenage pregnancy. The rate of alcohol-specific hospital stays among those under 18 is 48* 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 Boards and Health Improvement Scrutiny Committee

The four Derbyshire CCGs have contributed greatly to the delivery of the Joint Health and Wellbeing Strategy. The CCGs have been fully engaged with the city and county Health and Wellbeing Boards (H&WBs) 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 CCGs' governing bodies regularly attend the Derbyshire Health Improvement & Scrutiny Committee and the Derby City Protecting Vulnerable Adults Committee to update, present reports and to develop a dialogue and partnership with Derby City and Derbyshire County Council councillors.

Health and Wellbeing Strategy

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

Derbyshire County Council Health & Wellbeing Board weblink:
www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-and-wellbeing-board/health-and-wellbeing-board.aspx

Derby City Council Health & Wellbeing Board weblink:
www.derby.gov.uk/health-and-social-care/health-medical-advice/hwb/

Equality Delivery System (EDS2)

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

Equality Statement

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

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

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

Workforce

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

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

Equality Analysis and 'Due Regard'

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

Due Regard

In applying this policy, NHS Southern Derbyshire 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 Southern Derbyshire CCG

23 May 2018

Corporate Governance Report

Members' Report

The CCG is comprised of the following 55 member practices (including branch surgeries); click the link to connect to the practice website:

Alvaston Medical Centre (Aston Surgery & Appletree Medical Practice Little Eaton - branches)
Appletree Medical Practice
Arthur Medical Centre (The)
Ashbourne Medical Practice
Brailsford & Hulland Medical Practice (Hulland Ward - Branch)
Brook Medical Centre
Brooklyn Medical Practice
Chapel Street Medical Centre (Mayfield Road Medical Centre - Branch)
Charnwood Surgery (Mackworth Surgery - Branch)
Chellaston Medical Centre (Melbourne Medical Centre - Branch)
Crich Medical Practice (Holloway & The Surgery South Wingfield - Branches)
Derby Family Medical Centre
Derwent Medical Centre
Derwent Valley Medical Practice (Derwent Valley Medical Practice (Spondon Branch)
Friar Gate Surgery
Gresleydale Healthcare Centre
Hannage Brook Medical Centre
Haven Medical Centre (Haven Medical Centre - Alvaston Branch)
Heartwood Medical Practice
Hollybrook Medical Centre (Sinfin Health Centre - Branch)
Ivy Grove Surgery
Jessop Medical Practice (Jessop Medical Centre - Ripley branch)
Kelvingrove Medical Centre
Lister House at Chellaston (Lister House Coleman St)
Lister House Surgery (Oakwood Medical Centre - Branch)
Macklin Street Surgery (Park Farm Surgery - Branch)
Mickleover Medical Centre
Mickleover Surgery
Newhall Surgery
Oakwood Surgery
Osmaston Surgery
Overdale Medical Practice (Overdale Medical Practice - Breaston Branch)
Overseal Surgery
Park Farm Medical Centre (Vernon Street Surgery - Branch)
Park Lane Surgery
Park Medical Practice (The)
Parkfields Surgery
Parkside Surgery
Peartree Medical Centre
Ripley Medical Centre
Riversdale Surgery

Somercotes Medical Centre
St Thomas Road Surgery
Surgery (Ashbourne) (The)
Swadlincote Surgery
The Park Surgery (The Park Medical Practice - Borrowash & University of Derby - branches)
Vernon Street The Lanes Medical Centre - Branch)
Village Surgery
Wellbrook Medical Centre
Wellside Medical Centre (Wellside Medical Centre - Mackworth branch)
West Hallam Medical Centre
Whitemoor Medical Centre
Willington Surgery
Wilson Street Surgery (Taddington Road Surgery branch)

Composition of Governing Body

The Governing Body Members for the CCG are:

Governing Body Position	Name
Accountable Officer (Chief Officer)	Dr Chris Clayton
GP Lead – Primary Care and Quality	Dr Buk Dhadda
Health and Well Being Board GP Representative – Derbyshire County Council	Dr Andrew Mott
Health and Well Being Board GP Representative – Derby City Council	Dr Richard Crowson
GP Lead - Place	Dr Andrew Morange
Governing Body Network Lead – Derby City	Dr Merryl Watkins
Governing Body Network Lead – Derbyshire County	Dr Nick Bishop
Chief Finance Officer	Louise Bainbridge
Interim Chief Nurse Officer	Jayne Stringfellow
Lay Member (Audit)	Margaret Amos
Lay Representative (Governance)	Shokat Lal
Lay Member (Patient & Public Involvement)	Martin Whittle
Specialist Care Doctor	(vacant position since 1 April 16)
Local Authority Representative (Derbyshire County Council)	Dean Wallace
Local Authority Representative (Derby City Council)	Perveez Sadiq

http://www.southernderbyshireccg.nhs.uk/about-us/governing-body/

Audit Committee

The Audit Committee is accountable to the Governing Body and provides the Governing Body with an independent and objective view of the Group's financial systems, financial information and compliance with laws, regulations and directions governing the group. The Governing Body has approved and keeps under review the terms of reference for the Audit Committee, which includes membership of the Audit Committee.

Full details of other sub committees can be found in the Annual Governance Statement on page 54.

Audit Committee Membership

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

Audit Committee Member Position	Name
Chair – Governing Body Lay Member for Audit	Margaret Amos
Deputy Chair – Lay Representative	George Tansley
GP Member - Children's Lead for southern Derbyshire and Health & Wellbeing Representative	Dr Andrew Mott

Register of Interests

The CCG holds a register of interest for all individuals who are engaged by the CCG. The register is viewable on the CCGs website http://www.southernderbyshireccg.nhs.uk/about-us/governing-body/register-of-interest/ and http://www.southernderbyshireccg.nhs.uk/publications/ and is available on request at the CCG Headquarters.

Personal data related incidents

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

Statement of Disclosure to Auditors

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

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

Modern Slavery Act Statement

NHS Southern Derbyshire 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.southernderbyshireccg.nhs.uk/about-us/safeguarding/safeguarding-adults/policies/.

The CCG expects commissioned organisations and other companies we engage with to ensure their goods, materials and labour-related supply chains to fully comply with the Modern Slavery Act 2015; and we are transparent, accountable and auditable; and are free from ethnical ambiguities.

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

transfer of its services to another public sector entity.[1]

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

Disclosure: the CCG deficit has been reported by the external auditors under Section 30(b) of The Local Audit and Accountability Act 2014.

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 Southern Derbyshire CCG

23 May 2018

[1] The standard wording of the last bullet is "use the going concern basis of accounting unless they either intend to liquidate the Group or the parent Company or to cease operations, or have no realistic alternative but to do so". The only circumstance under which the Accountable Officer would prepare the accounts on a non-going concern basis is if they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Governance Statement

Introduction and Context

NHS Southern Derbyshire Clinical Commissioing Group ("the CCG") is a corporate body established by NHS England on 1 April 2013 under the National Health Service Act 2006 9as amended).

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

As at 1 April 2017, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

https://www.england.nhs.uk/publication/directions-for-nhs-north-derbyshire-clinical-commissioning-group/

NHS Southern Derbyshire Clinical Commissioning Group brings together local GPs and other healthcare professionals to commission hospital and community NHS services for Southern Derbyshire, comprising of 55 member practices with a registered population of 554,000 patients.

NHS Southern Derbyshire CCG has a revenue income of £758m for 2017/18 and has a workforce of around 206 employees.

Scope of Responsibility

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

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

Governance Arrangements and Effectiveness

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

The role of the Governing Body is corporate responsibility for the CCG's strategies, actions and finances. As a Governing Body of an NHS organisation, it is the custodian of a national asset, provides stewardship and remains publicly accountable.

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

The CCG is a clinically-led organisation and has 55 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 March 2015, and is currently under review to bring consistency across the four Derbyshire CCG's constitutions.

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 the Governance Manager and Governing Body Secretary and its composition is as follows, each with a single non-transferable vote:

NHS Southern Derbyshire CCG Governing Body Membership
Chair (the designated Clinical Leader), elected by members
Chief Executive Officer
Chief Finance Officer
Chief Nurse Officer (Registered Nurse)
Three Lay Members, of whom: • one is Deputy Chair and lead for governance matters • one is Lead for audit • one is Lead for patient and public participation matters
GP Members, which comprise of: • Clinical Lead for Primary Care and Quality • Clinical Lead for Place • Children's Lead for southern Derbyshire and, Health & Wellbeing Representative • County Membership Network Lead • Derby City Council, H&WB Representative • City Network lead for Derby City
A secondary care specialist doctor (vacant position since 1 April 2016)
Officer representative of Derbyshire County Council
Senior representative from Derbyshire County Council, Public Health

The Governing Body met a total of 10 times in public, with 11 confidential meetings during 2017/18 and two extraordinary meetings during 2017/18. The membership and attendance

record for the Governing Body and sub committees can be found in Appendix Two.

Meetings of the Governing Body are held monthly and alternate between matters of business and development. The business meetings are held in in public, and members of the public are welcome to attend to observe these meetings. Papers relating to the meetings are published on the CCG's website a week in advance of the date of the Governing Body meeting, in line with the constitution. Where a member of the public has a question they are invited to submit them in advance of the meeting in order to allow members time to prepare a response.

Meetings of the Governing Body may also be held in a confidential session, where there is confidential business to consider and where publicity regarding that business would be prejudicial to the public interest.

Governing Body Performance

During Q4 of 2016/2017, the CCG instructed Pricewaterhouse Coopers LLP (PwC) to undertake an independent review of the organisation's financial position. The Capacity & Capability review was conducted during Q1 of April 2017/18 and focused on the following themes:

- the proposed year-end financial position for 2016/17;
- the robustness of the financial plan for 2017/18 and 2018/19;
- the current QIPP plan including an independent rating of delivery;
- the proposed year-end position for 2017/18 based on the assessment of the financial plan and QIPP plan;
- the CCG's commissioning and contracting arrangements; and
- Leadership capacity, capability and the robustness of governance arrangements, in the context of the financial challenge facing the CCG.

The main finding was that the CCG had developed a 2017/18 Financial Plan in which NHS England identified a £15m delivery risk. This risk was identified by NHS England (NHSE) as the CCG was late within the planning process and as such the opportunities to identify mitigations had been limited.

During the Q1 and Q2 of 2017/18 the CCG addressed the findings from the Capability & Capacity review, which included:

- Identifying further schemes, which has reduced the £15m gap to £3.7m but with an associated slippage risk of £5.3m;
- Agreeing proposals to strengthen the governance around the management and delivery of the Financial Recovery Plan. This was in the form of a Financial Recovery Group (FRG) in order to accelerate decision making and to put more challenge and rigour into management processes. The FRG was chaired by the Lay Member for Audit & Governance;
- Monthly meetings with NHS England to provide assurance around the delivery of the 2017/18 Financial Plan;
- Appointment of a Senior Manager (Turnaround Director) to work across both North Derbyshire and Southern Derbyshire CCGs to identify further schemes and to support the delivery of 2017/18 plan.

Following a decision by the CCG to appoint a joint Executive Team across the four Derbyshire CCGs, a single Derbyshire Accountable Officer, Dr Chris Clayton was appointed in October and in November 2017, Louise Bainbridge was appointed as a single Derbyshire Chief Finance Officer.

Following a review of the financial position at Month 8, which included forecast outturn, a significant potential adverse variance to the plan was identified as the CCG was forecasting delivery of £25.7m in QIPP against a required £34.7m. In addition further issues were identified in relation to acute contract pricing and performance, continuing healthcare costs, and prescribing. This was alerted to NHSE and highlighted as a material risk to the delivery of its 2017/18 control total. The actual outturn at Month 12 for the year end was a deficit of £18.1m which included £17.8m QIPP delivered against a plan for the year of £34.7m, a shortfall of £16.9m.

In light of the significant deterioration in the CCG's reported position to NHSE the CCG instructed PwC to undertake a further independent review and assessment of risk in relation to matters such as:

- The robustness of the original financial plan for 2017/18 and 2018/19;
- Detailed review of all material spend areas to identify the extent of financial risk against the agree plan;
- Reasons for variance in the plan and financial reporting arrangements;
- Review and assessment of all mitigations;
- Review of the CCGs exit position for 2017/18 and likely forecast outturn based ono assessment of financial and QIPP plans;
- CCG response to recommendations as part of the QIPP Support programme;
- Commissioning and contracting arrangements including adequacy of Business Intelligence arrangements.

The recommendations from the external PwC reports have informed a Derbyshire Organisational Development plan that will provide a process to address issues across all the CCGs. The Organisational Development plan will encompass a Governing Body triumvirate leadership approach comprised of clinical, lay and executive members and is aligned to the outcomes from the NHSE Commission Capability Programme.

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

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

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

NHS Southern Derbyshire CCGs Governing Body, together with Erewash, Hardwick and North 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 in April 2018.

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

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

During 2017/18, Southern Derbyshire CCG Governing Body approved the re-procurement of its Commissioning Support Unit (CSU) services that the four Derbyshire CCGs commission from Arden and GEM CSU. As a result, from 1 April 2017, Continuing Healthcare services are now commissioned from Midlands and Lancashire CSU and 1 October 2017, Corporate IT, GP IT and Business Intelligence services 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 1 February 2018: Communications and Engagement, Information Governance, Human Resources – business partner element, Equality, Inclusion and Human Rights, IFRs, Plastics and Voluntary Sector contracts, Business Continuity, PALS & Complaints, Freedom of Information, Collaborative Contracting. CSU Finance services will transfer to the Derbyshire CCG's from 1 May 2018.

Increased scrutiny has been imposed on the Governing Body during 2017/18 to understand the reasons for the CCG's position, however Governing Body continue to fully discharge their duties and responsibilities as Governing Body members.

Sub Committees of the Governing Body

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

The governance structure of the CCG comprises:

- Governing Body
- Committees of the Governing Body:
  - Audit Committee
  - Remuneration Committee
  - Clinical Commissioning Committee
  - Quality Assurance Committee
  - Governance Committee
  - Lay Reference Group
  - Primary Medical Care Commissioning 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 Southern Derbyshire CCG Audit Committee Membership
Margaret Amos – Audit Chair Governing Body Lay Member for Audit
George Tansley – Deputy Chair – Lay Representative
Dr Andrew Mott – GP Member - Children's Lead for Southern Derbyshire and, Health & Wellbeing Representative

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
Governing Body Assurance Framework 2017/18
High Scoring Risk Reports and Deep Dives
Business of the Quality Assurance Committee
CCG Assurance Framework 2017/18
Financial Control Environment Assessment
Risk Management Strategy and Framework
Service Auditor Reports
Standards of Business Conduct and Compliance
Information Governance Toolkit progress
Operational Scheme of Delegation
Patient & Public Engagement progress
Cyber Security updates
Gifts & Hospitality Register update
Internal Audit
Progress Reports
Budgetary Control and Key Financial Systems 2017/18
Cyber Security Arrangements
Financial Planning and Sustainability
Head of Internal Audit Opinion
Internal Audit Plan
External Audit
Annual Audit Letter
Audit Committee Self-Assessment and Analysis
External Audit Plan
KPMG International Standard on Auditing 360 Report
Counter Fraud
Counter Fraud, Bribery & Corruption Risk Assessment Work Plan
Fraud, Bribery and Corruption Standards for Commissioners – Self-
Self-Assessment Review Tool Process Summary

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

Audit Committee Attendance Record 2017/1					
Member	**July-17**	**Sep-17**	**Nov-17**	**Jan-18**	**Mar-18**
Margaret Amos, Governing Body Lay Member for Audit (Chair)	✓	✓	✓	✓	✓
George Tansley, Lay Representative (Deputy Chair)	✓	✓	✓	✓	✓
Dr Andrew Mott, GP Member	✓	✓	✓	✓	x

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

Clinical Commissioning Committee

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

The composition of the Clinical Commissioning Committee is as follows:

NHS Southern Derbyshire CCG Clinical Committee Membership
Chair - GP Governing Body Member
GP Deputy chair
CCG Chair
GP representing the Membership of SDCCG
Chief Nurse and Director of Quality
Chief Finance Officer or representative
Chief Officer - Assistant Chief Officers as appropriate
Assistant Director Public Health – Clinical Effectiveness
Chairs of sub groups of the Clinical Commissioning Committee
Director of Medicines Management
Director of Planning and Corporate Development or representative
Director of Primary and Community Services or representative
Director of Partnerships and Joint Commissioning or representative
Director of Acute Contracting and Transformation or representative
Lay representative

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

Significant items approved/discussed by Clinical Commissioning Committee 2017/18
Financial Recovery Plan Schemes ad Business Cases, such as: – Personalised Care Review (formerly Prior Approval Process – Fit for Surgery – Respiratory RightCare – First Provider gynaecology service – Primary Care Streaming – Clinical system migration – Ophthalmology Telemedicine – Weight Management – Children and Maternity Transformation Plan – Winter Plan – IAPT extension – Syringe Driver Provision – Derby Urgent Care Centre – Any Qualified Provider (AQP) procurements – Recurrent funding for Derby City Multi Agency Safeguarding Hub (MASH)

Quality Assurance Committee

The purpose of the committee is to provide assurance to the Governing Body of the quality of all CCG commissioned services and to continually develop the CCGs approach to quality improvement and innovation.

It has initiated the development of a quality improvement programme which spans all health services and seeks assurances that we discharge our responsibilities appropriately relating to statutory functions including Safeguarding, Deprivation of Liberty Safeguards and the Duty to Consult.

In addition, the committee seeks assurance on behalf of the Governing Body on the safety and quality of all commissioned and co-commissioned services

The composition of the Quality Assurance Committee is as follows:

NHS Southern Derbyshire CCG Quality Assurance CCG Committee Membership
GP Member for Clinical Lead for Primary Care and Quality (chair)
Chief Nurse and Director of Quality
Deputy Chief Nurse & Deputy Director of Quality
Director of Corporate Development or appointed deputy
Director of Medicines Management or appointed deputy
Director of Acute Commissioning or appointed deputy
Director of Primary & Community Services or appointed deputy
IPC Lead Nurse
General Practice Nursing Representative
Lay Representative

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

Significant items approved/discussed by Quality Assurance Committee 2017/18
Quality Assurance / Exception Reports from Providers
Whistleblowing
CQC Review
Non-Emergency Patient Transport (NEPTS)
Primary Care Performance Report
Safeguarding Children and Adults
Quality Assurance and Quality Improvement in Care Homes
Governing Body Assurance Framework (GBAF) / Risk Register
Quality Accounts
Complaints/Compliance Report

Governance Committee

The Governance Committee has been responsible for receiving assurances that corporate performance issues and associated risks are being effectively managed.

It therefore provides a forum for challenge, verification and validation of detailed action plans and an opportunity to shape future actions to mitigate and manage risk. It has also approved a range of organisational and corporate policies.

The composition of the Governance Committee is as follows:

NHS Southern Derbyshire CCG Governance Committee Membership
Lay member for governance (chair)
Lay member for audit
CCG Chair
Chief Accountable Officer or deputy
Chief Finance Officer
Chief Nursing Officer

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

Significant items approved/discussed by Governance Committee 2017/18
Risks assigned to the Committee
Proposal for Standard Derbyshire Wide HR Policies
Standards of Business Conduct and Conflicts of Interest Policy
Procurement Strategy
Amendments to the Operational Scheme of Delegation
Series of Information Governance Policies
Health and Safety Policy
Gifts and Hospitality Policy
Emergency preparedness, resilience and response (EPRR)

Staffing and Remuneration Committee

The Staffing and Remuneration Committee, which is accountable to the Governing Body, makes recommendations to the Governing Body on decisions about the remuneration, fees and other allowances for employees and for people who provide services to the group.

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

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

The Committee meets as required but as a minimum annually. The Committee met six times during 2017/18. The meeting was quorate and in accordance with its terms of reference.

The composition of the Staffing and Remuneration Committee is as follows:

NHS Southern Derbyshire CCG Staffing and Remuneration Committee Membership
Lay member for governance
Lay member for audit
Chief Accountable Officer
Senior HR Representative, Arden & Greater East midlands CSU (in attendance)
CCG Chair

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

Significant items approved/discussed by Staffing and Remuneration Committee 2017/18
HR Dashboard
Senior Management Team remuneration
Organisational structures and Senior Management Team functions
HR Transition Framework

Lay Reference Group

The purpose of the Group provides the Governing Body with appropriate assurances in respect of ensuring that the voice of patients and the public is heard throughout the CCG. This covers the planning, commissioning and monitoring of services and to provide advice and support on the delivery of appropriate and effective Patient Public Involvement (PPI) methodologies.

The composition of the Lay Reference Group is as follows:

NHS Southern Derbyshire Lay Reference Group Membership
Governing Body Lay Member - PPI Lead (Chair)
CCG Lay Representative
Healthwatch Representative
Voluntary Sector representation City and County
Director of Corporate Development
Deputy Director of Clinical Quality or Deputy or deputy
Head of Communications and Engagement or deputy
Engagement Manager

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

Significant items approved/discussed by Lay Reference Group 2017/18
Provider Quality Intelligence & Monitoring Report
Belper Business Case and Consultation Document
360 Assurance Report – Patient & Public Engagement
GP practice updates
Healthwatch Derby Report on GP Access
Self-Care Consultation
Repeat Medicines Ordering
Healthwatch Derbyshire Report on Mental Health Services
D2A (Discharge to Assess)
STP Communications & Engagement

Primary Medical Care Clinical Commissioning Committee

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

The Committee has been established in accordance with statutory provisions to enable the committee members to make collective decisions on the review, planning and procurement of Primary Care services in southern Derbyshire under delegated authority from NHS England. The functions of the committee are undertaken in the context of a desire to promote increased co-commissioning, to increase quality, efficiency, productivity and value for money. The role of the committee is to carry out the functions relating to the commissioning of Primary Medical Services under Section 83 of the NHS Act. Primary Care Co-Commissioning supports the progression of the CCG objectives as outlined in our five year strategic plan. Conflicts of interest, actual and perceived, are managed robustly and carefully within the Committee and the whole of the CCG.

The Primary Care Co-Commissioning Committee has met five times in public and two as a virtual meeting during 2017/18. All meetings were quorate and in accordance with its terms of reference.

Managing conflicts of interest appropriately is essential to protect the integrity of our decision making processes. We recognise as Commissioners that we need the highest

levels of transparency to demonstrate that conflicts of interest are managed in a way that cannot undermine the probity and accountability of the organisation.

NHS Southern Derbyshire Primary Medical Care Clinical Commissioning Committee Membership
Lay Member for governance (chair)
Lay Representative
Lay Member – Audit and Governance
Lay Member - PPI
Director of Corporate Development
Assistant Director of Primary Care
Governance Manager
Health and Wellbeing Committee Representative (Standing invite as non-voting attendee)
NHS England Representative (Standing invite as non-voting attendee)

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

Significant items approved/discussed by Primary Medical Care Clinical Commissioning Committee 2017/18
Procurement updates
Branch closure applications
Prescribing Quality Scheme
GP Access Fund Pilot
Primary Care Updates
Anticoagulation Service
Direct Access Phlebotomy Services
Diabetes Proof of Concept (Transformation Funding)

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. To support this, the Governing Body considered how the organisation is complying with each principle of the Code at its public meeting in January 2018.

The Governance Statement is intended to demonstrate how the CCG has regard to the principles set out in the Code considered appropriate for CCG's for the financial year ended 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 Southern Derbyshire CCG must reference within this statement are fully compliant.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the Clinical Commissioning Group has reviewed all of the statutory duties and powers conferred on it by the National

Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk Management Arrangements and Effectiveness

The CCG Risk Management Policy & Procedure was reviewed and approved in June 2017. The policy 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 framework that details that 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 Policy highlights that risk management is both a statutory requirement but also an essential element of good governance. It is a fundamental part to the organisation's ability to discharge its functions as a commissioner of services and as an NHS employer.

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 delegated risks at every meeting and the Governing Body receive a monthly high scoring report with details those risks scored at high amber (12) to extreme (15-25) along with been newly identified risk for which the risk rating has increased during the month.

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

Stakeholder Involvement in Managing Risks

Governing Body membership has always been made inclusive to ensure diverse public stakeholders and other stakeholders voices help inform CCG decision-making and can assist in highlighting risks at Governing Body level. The Governing Body has a strong Lay Membership for Audit, Governance, Public and Patient Engagement; other Governing Body members include Public Health and Local Authority representation.

The Governing Body membership is designed to be inclusive to ensure diverse public and other stakeholders voices help inform CCG decision-making and can assist in highlighting risks at Governing Body level. As well as Lay Members for Audit, Governance and Public / Patient Engagement, the Governing Body also includes local authority representation.

Public events including Stakeholder Forums in addition to the Annual General Meeting have taken place throughout the year with population and community groups, which provide the opportunity to highlight risks.

Prevention and Deterrences of Risk

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

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

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

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

Capacity to Handle Risk

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

- **Governing Body** – oversight and holding management to account.
- **Audit Committee** – reviews the effectiveness of the Governing Body 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.
- **Managers and Departments** - responsible for ensuring information on risk is incorporated into the organisation's risk register in line with the policy.
- **Governance Manager** – responsible for the development, implementation and maintenance of the risk management arrangements for the CCG.
- **All staff** – responsible for identifying, reporting and managing risks within their areas.

The Governing Body Assurance Framework has been presented to the Governing Body and Audit Committee during 2017/18 for scrutiny. NHS Southern Derbyshire CCG continue develop and refine its risk management arrangements; however, a challenge is ensuring that risk management systems are effective which is demonstrated through understanding our approach to risk management and in how we respond to potential uncertainty.

Following consultation with the Board, the Governing Body Assurance Framework was refreshed and developed to allow for a more in-depth review of the strategic risks to the CCG, which reflected how the Board now operates with regards to seeking assurances.

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.

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

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

The Governing Body and the Audit Committee fully support the Risk Management Policy 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 Governance Manager 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 Policy 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 Governing Body Assurance Framework sets out the key risks to the achievement of these Objectives.

The design of the annual Internal Audit Plan is linked to the key risks identified within the Governing Body 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.

The following details the most significant risks we have faced during 2017/18 and how we are managing them.

Significant Risks Identified During 2017/18

The significant scoring risks outlined below represent the position at the end of the financial year. The risk register is available in the Governing Body meeting papers, which show how individual risks are managed and mitigated

Risk	Scoring at Q4
Risk 001. The CCG fails to reach agreement on additional activity reductions over and above those contracted.	20
Risk 002. Risk to the CCG if it is unable to produce a (credible) Recovery Plan, which is clinically sustainable and financially viable.	20
Risk 003. The Acute provider contract may over perform against agreed plan and or not deliver A&E standards.	20
Risk 004. The Sustainability & Transformation Plan (STP) and Strategic Outline Case (SOC) are not clearly defined.	16
Risk 005. Risk to the CCG if it does not have sufficient capacity of staff to deliver objectives.	12
Risk 006. There is a risk that the successful delivery of the 'Place' will be delayed.	12
Risk 007. There is a risk that the quality of service is impacted due to financial pressures	12

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. 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 CCG's to undertake an annual internal audit of conflicts of interest management. To support this task, NHS England has published a template audit framework.

The management of conflicts of interest and potential conflicts of interest is a high priority for the CCG to ensure complete transparency in its decision making process. During 2016/17 enhanced systems and process for identifying, recording, reporting and dealing with conflicts of interest were introduced based on the revised guidance from NHS England.

360 Assurance carried out an internal audit of the CCG management of conflicts of interest in November 2017, the outcome of which was an overall significant assurance.

Data Quality

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

Since the Health and Social Care Act 2012 was established on 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 the information provided is fit for purpose. This has involved the delivery of a significantly enhanced monthly Performance Report to Governing Body and Quality Assurance Committee.

Part of the service delivered by AGEM CSU and NECS involves a continuous and regular assessment of the quality of data received from all sources.

Information Governance (IG)

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

On 12 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 & Greater East Midlands Commissioning Support Service – A&GEM) 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 NHS England 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 that there are robust Information Governance systems and processes in place to help protect patient and corporate information. We place high importance on ensuring there are robust IG systems and processes in place to help protect patient and corporate information. Working closely with Arden & Greater East

Midlands CSU and other local CCGs we have developed and established an Information Governance Committee across Derbyshire, with membership from each of the CCG SIROs, Caldicott Guardians and Information Governance Leads. Also in attendance are representatives from Arden & Greater East Midlands CSU IT Services department to advise on data security issues with a particular emphasis on cyber security controls.

The Information Governance Committee supports and drives the broader IG agenda, including ensuring that risks relating to IG including Cyber Risk are identified and managed. The Committee meets monthly. All staff have undertaken annual IG training relevant to their role with more comprehensive training for the SIRO, Deputy SIRO, Caldicott Guardian and Information Asset Owners. The CCG have implemented a staff IG Handbook, a range of staff guidance and briefing documents along with a Code of Conduct on Confidentiality and Information security to ensure staff are aware of their IG roles and responsibilities and how they can access further information and support.

The CCG also appoints a Caldicott Guardian who plays a key role in ensuring that the organisation satisfies the highest practical standards for handling patient identifiable information. 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 Commissioners Office.

The CCG's internal auditors, 360 Assurance, reviewed the Information Governance Toolkit evidence in February 2018 giving '*Full Assurance*' on compliance for the fourth year running 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 IG Toolkit.

Data Security

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

Business Critical Models

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

Third Party Assurances including Service Auditor Reports

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

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

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.

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

Control Issues

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

CCG's Failure to Discharge Statutory Duties

The financial plan agreed at the start of the 2017/18 was for NHS Southern Derbyshire CCG to deliver an in year surplus of £16.8m that was dependent on the organisation delivering £34.7m of QIPP savings, and ensuring that the demand for services remains within contract levels.

At month 9, NHS Southern Derbyshire CCG reported a risk adjusted forecast out-turn variance position of £22.3m against the break-even control total which includes NCSO risk of £4.9m. The actual outturn at Month 12 for the year end was a deficit of £18.1m.

The external auditor is to write to the Secretary of State to confirm the CCG has breached it's revenue resource limit for the 2017/18 financial year, as required under the NHS Act 2006.

The QIPP programme faced a £15.6m of risk against plan. The causes of these variances include demand management schemes that have not been accepted by DTHFT as 'contracted QIPP'; a failure to agree a resolution with DTHFT on specific contract issues; national cost pressures associated with medicines management stock, and a regional pricing issue with HRG4+ where activity is broadly on plan yet the cost is significantly higher than contractually agreed.

All the above financial risks are being addressed with NHS England support and managed formally through the monthly escalation meetings.

A&E Waiting Times

Derbyshire failed to deliver against the national 95% standard during December (86.7%). Underperformance has been attributed predominantly to underperformance at Derby Teaching Hospital (DTHFT) and Chesterfield Hospital (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 YTD (87.2%). 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 RAP which was presented to the CMDG 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 one 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 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 Patient > 52 week waits

Derbyshire reported four patients waiting over 52 weeks for treatment during November, three attributed to Southern Derbyshire CCG and one to North Derbyshire CCG. The North Derbyshire patient related to an Orthopaedic wait at Chesterfield Hospital, the delay was identified as a combination of patient choice and capacity and demand issues at the trust. The patient received treatment on the 20 December. There is a recovery action plan in place with the trust which identifies no further 52 week breaches from February 18 onwards.

The Southern Derbyshire patients relate to one wait at Chesterfield Hospital, the delay was identified as a combination of patient choice and capacity and demand issues at the trust. The patient received treatment on the 20 December. An RCA has been requested. There is a recovery action plan in place with the trust which identifies no further 52 week breaches from February 18 onwards.

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 (STHFT) reporting (7.5 %) - 42 breaches and East Cheshire Hospital (ECT) reporting (12%)- 27 breaches 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 Q4.

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%) with performance in December (88%). Underperformance has been attributed predominantly to underperformance at Derby Teaching Hospital (DTHFT) and Chesterfield Hospital (CRHFT) for the 62 day standard and Sheffield Teaching Hospital (STHFT) for the 62 day screening target.

62 day Standard

Derby (DTHFT) - Although the trust had failed to deliver against the national 62 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 Chesterfield Hospital (CRH) where historically the patients have remained on the CRH waiting list. However this clinic is prone to cancellation by STHFT resulting in waiting list breaches for CRH. Discussions between Medical Directors at both trusts have resulted in an agreement to withdraw the current service from 1/2/18 and treat patient's onsite at STHFT. The CCG is raising 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.

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 Governing Body 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 and Audit Committee regularly review the Governing Body Assurance Framework, advising on the effectiveness of the system of internal control; plans to address weaknesses and ensuring continuous improvement of the system are in place.

The CCG's rating for the Improvement and Assessment Framework (IAF) for 2016/17 was rated as 'Amber' due to the organisation's financial position, and the pace required to deliver the 2017/18 Financial Recover Plan. The CCG has yet to receive the final 2017/18 IAF rating.

Delegation of Functions

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

The CCG has two external delegation chains:

- Delegated responsibility for Primary Medical Care from NHS England (NHSE). This responsibility is led by the Primary Care Co Commissioning Committee under specific Terms of Reference common to all CCGs who have taken full delegated powers; and

- The Derbyshire Better Care Fund (BCF) under the authority of the Health and Well-Being Board.

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

Counter Fraud Arrangements

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

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

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

Head of Internal Audit Opinion

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

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

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

It should be noted however that the breadth of the actual work undertaken to date is not as extensive as that originally anticipated on the agreement of the 2017/18 internal audit plan and updates to the plan during the course of the year. Changes to the plan have been bought 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 the significant challenges currently facing many organisations operating in the NHS, and my opinion recognises that the system of internal control is designed to manage risk to a reasonable level, rather than eliminate all risk of failure to the achievement of strategic objectives.

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

Area of Audit	Level of Assurance Given
Budgetary Control & Key Financial Systems	Limited
Conflicts of Interest	Significant
Information Governance Toolkit	Full
Governance and Risk Management	Significant
Public Sector Equality Duty	Significant (indicative to be agreed)
GDPR Readiness Assessment	Fieldwork commenced
General Data Protection Regulations	Fieldwork commenced
Derbyshire-wide Quality Innovation, Productivity and Prevent (QIPP) Programme	Fieldwork commenced
Procurement of Healthcare Contracts	Significant

Limited assurance was received for the Budgetary Control & Key Financial Systems audit. The main finding was the identification of one high risk issue relating to the regularity of budget holder meetings. The findings were considered by the CCG's Audit Committee on the 30 April 2018.

Follow-Up Reports

One further Follow Up Report was published during 2017/18 around Primary Care Commissioning. Internal Audit liaises with the Governance Manager to ensure that agreed actions from previous audit reports are implemented in a timely fashion.

Review of the Effectiveness of Governance, Risk Management & Internal Control

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

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

I have been advised on the implications of the result of this review by the Governing Body and the committees of the Governing Body such as the Audit Committee, and have addressed weaknesses during the year and ensure continuous improvement of the system are in place.

The effectiveness of the governance, risk management and internal control is reviewed by the Audit Committee which scrutinises and challenges the reports provided by the CCG. In addition, the reports in relation to the programme of work in the Internal Audit Plan are presented to the Audit Committee. 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:

- The Governing Body
- The Audit Committee
- NHS England - Improvement and Assessment Framework (IAF), MyNHS. MyNHS is a website which reports on all elements of the CCG IAF and allows users to compare the CCG position against other CCGs
- 360 Assurance - Internal Audit reviews and Head of Internal Audit Opinion
- KPMG - External Audit
- Arden & GEM CSU - Monthly contract monitoring meetings
- North of England Commissioning Services - Monthly contract monitoring meetings
- Sub Committees of the Governing Body
- Executive Team
- Collaborative and joint working with associate CCGs

Conclusion

Significant deterioration in the CCG's financial position have been identified and reported to NHSE during the year. Further to the Capacity and Capability reviews undertaken by PwC on behalf of NHSE, the CCG has identified additional measures and organisational development necessary to secure the internal systems of control to deliver successful organisation and financial turnaround.

The Capacity & Capability Plan has been fully implemented and approved by the CCG Governing Body with on-going monitoring to ensure the changes become embedded as business as usual and are embedded as part of the Derbyshire Organsiational Development Plan.

Dr Chris Clayton

Accountable Officer

NHS Southern Derbyshire CCG

23 May 2018

Remuneration and Staff Report

Remuneration Report

Staffing and 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 and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme. The committee is chaired by a lay member.

The Staffing and Remuneration Committee is comprised of the following members:

Member	Name
Lay Member for Governance	Shokat Lal (Chair)
Lay Member for Audit	Margaret Amos
Accountable Officer	Dr Chris Clayton
CCG Chair	Dr Paul Wood

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 (including salary and pension entitlements)

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

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

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

Remuneration Report Tables

Salaries and Allowances 2017/18

Name	Title	Note	2017-18 (a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 * £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Margaret Amos	Lay Governing Body Member-Audit/Governance		20-25	0	0	0	0	20-25
Louise Bainbridge	Chief Financial Officer		25-30	0	0	0	15-17.5	15-20
Cumba Balding	Director of Contracting & Acute Transformation		35-40	0	0	0	7.5-10	45-50
Nicolas Bishop	GP Governing Body Member		20-25	0	0	0	0	20-25
Kathryn Brown	Director of Primary Care Development		90-95	600	0	0	67.5-70	160-165
Christopher Clayton	Accountable Officer		35-40	0	0	0	12.5-15	85-90
Phillip Cowley	Chief Financial Officer		195-200	200	0	0	12.5-15	210-215
Richard Crowson	GP Governing Body Member-H&WBBR Representative		15-20	0	0	0	0	15-20
Bukhtawar Dhadda	Governing Body GP		65-70	0	0	0	0	65-70
Helen Dillistone	Deputy Chief Officer & Director of Corporate Dev-Planning		110-115	0	0	0	32.5-35	140-145
Richard Guest	Governing Body GP		0-5	0	0	0	0	0-5
Joy Hollister	Council		N/A	0	0	0	0	N/A
Steven Hulme	Director of Medicines Management		90-95	0	0	0	22.5-25	110-115
Shokat Lal	Board Member SDCCG		5-10	0	0	0	0	5-10
Andrew Maronge	Governing Body GP		10-15	0	0	0	0	10-15
Peter Moore	Director of Acute Commissioning		45-50	0	0	0	20-22.5	65-70
Andrew Mott	GP Governing Body Member-H&WBBR Representative		65-70	0	0	0	32.5-35	95-100
Kevin Orford	Lay Governing Body Member-Audit/Governance		0-5	0	0	0	0	0-5
Pervez Sadiq	Council		N/A	0	0	0	0	N/A
Joanna Smith	Lay Governing Body Member-Government & Public Involvement		0-5	0	0	0	0	0-5
Jayne Stringfellow	Chief Nurse & Director of Quality		50-5	0	0	0	122.5-125	120-125
Jennifer Swatton	Director of Joint Commissioning		90-95	0	0	0	12.5-15	105-110
Peter George Tansley	Lay Governing Body Member-Audit/Governance		5-10	0	0	0	0	5-10
Gary Thompson	Chief Officer		90-95	0	0	0	42.5-45	135-140
Dean Wallace	Council		N/A	0	0	0	0	N/A
Merryl Watkins	Governing Body GP		10-15	0	0	0	0	10-15
Martin Whittle	Lay Governing Body Member-Government & Public Involvement		10-15	0	0	0	0	10-15
Paul Wood	Chair		75-80	0	0	0	0	75-80

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

Notes to Salaries and Allowance - 2017/18

The Chief Officer has confirmed that the above table includes all those deemed to be 'senior managers', i.e. those deemed to have authority or responsibility for directing or controlling the major activities of the CCG
Remuneration shown here is that which is in respect of the period the senior manager held office.

Note 1. Margaret Amos took up her post on 1st June 2017 and replaced Kevin Orford who left on the 31st May 2017
Note 2. Louise Bainbridge took up her post on 1st November 2017
Note 3.Cumba Balding left her post on 31st August 2017 leaving her post for Peter Moore who returned from secondment on 1st October 1017
Note 4. Christopher Clayton took up his post on 1st October 2017
Note 5. Philip Cowley left his post on 17th March 2018, the amount shown includes a payment of £100k for loss of office, which was approved by the remuneration committee
Note 6. Richard Guest left his post on 2nd April 2017
Note 7. Joanna Smith left her post on 21st July 2017
Note 8. Gary Thompson left his post on 31st December 2017
Note 9. For Christopher Clayton, Louise Bainbridge and Jayne Stringfellow Pension related benefits are total benefits less individuals contributions, salary figures are SDCCG's share of the senior managers pay.
Total salary payable to shared managers across the four Derbyshire CCG's in bands of £5,000's were, Christopher Clayton £70-75k for the period 1st October 2017 to 31st March 2018
Louise Bainbridge £50-55k for the period 1st November 2017 to 31st March 2018 and Jayne Stringfellow £105-110k for the full year to 31st March 2018
Note 10. In the absence of P11D information, the figures shown in taxable benefits are an estimate based on prior year information. They relate to the provision of a lease car.

Salaries and Allowances 2016/17

Salaries and Allowances 2016/17

Name	Title	Note	2016-17 (a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 * £00	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a to e) (bands of £5,000) £000
Cumba Balding	Director of Contracting & Acute		70-75	0	0	0	102.5-105	175-180
Nicolas Bishop	GP Governing Body Member AV/SDD		15-20	0	0	0	0	15-20
Kathryn Brown	Director of Primary Care Development		90-95	0	0	0	25-27.5	115-120
Phillip Cowley	Chief Financial Officer		100-105	200	0	0	17.5-20	120-125
Richard Crowson	GP Governing Body Member-H&WBBR		15-20	0	0	0	0	15-20
Bukhtawar Dhadda	Governing Body GP		65-70	0	0	0	17.5-20	80.85
Helen Dillistone	Deputy Chief Officer & Director of		95-100	0	0	0	50-52.5	145-150
Richard Guest	Governing Body GP		15-20	0	0	0	5-7.5	20-25
Joy Hollister	Council		0	0	0	0	0	0
Steven Hulme	Director of Medicines Management		90-95	0	0	0	25-27.5	115-120
Shokat Lal	Board Member SDCCG		5-10	0	0	0	0	5-10
Andrew Mott	GP Governing Body Member-H&WBBR		65-70	0	0	0	22.5-25	90-95
Kevin Orford	Lay Governing Body Member-		10-15	0	0	0	0	10-15
Pervez Sadiq	Council		0	0	0	0	0	0
Joanna Smith	Lay Governing Body Member-Government		5-10	0	0	0	0	5-10
Jayne Stringfellow	Chief Nurse & Director of Quality		10-15	0	0	0	5-7.5	15-20
Jennifer Swatton	Director of Joint Commissioning		90-95	0	0	0	20-22.5	110-115
Peter George Tansley	Lay Governing Body Member-		5-10	0	0	0	0	5-10
Gary Thompson	Chief Officer		120-125	0	0	0	67.5-70	185-190
Martin Whittle	Lay Governing Body Member-Government		5-10	0	0	0	0	5-10
Paul Wood	Chair		40-45	0	0	0	0-2.5	45-50

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

Notes to Salaries and Allowance - 2016/17

Joanna Smith replaced Suzanne McKeown in April 2015

In addition to the above Perveez Sadiq and Joy Hollister also sat on the CCG's Governing Body as representatives of Derby City Council and Derbyshire County Council respectively, neither received a salary from the CCG.

In the absence of P11D information, the figures shown in taxable benefits are an estimate based on prior year information. They relate to the provision of a lease car.

Pension Benefits as at 31 March 2018

Name	Title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2018 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2017 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employers contribution to stakeholder pension £000
Louise Bainbridge	Chief Financial Officer	0-2.5	0-2.5	15-20	40-45	229	19	278	N/A
Cumba Balding	Director of Contracting & Acute Transformation	0-2.5	0-2.5	15-20	55-60	373	0	373	N/A
Kathryn Brown	Director of Primary Care Development	2.5-5	5-7.5	30-35	85-90	501	86	592	N/A
Christopher Clayton	Accountable Officer	0-2.5	-2.5-0	15-20	35-40	211	13	239	N/A
Phillip Cowley	Chief Financial Officer	0-2.5	2.5-5	15-20	55-60	381	0	381	N/A
Helen Dillistone	Deputy Chief Officer & Director of Corporate Dev-Planning	0-2.5	0-2.5	20-25	50-55	275	43	320	N/A
Steven Hulme	Director of Medicines Management	0-2.5	0-2.5	20-25	50-55	304	37	344	
Peter Moore	Director of Acute Commissioning	0-2.5	0-2.5	10-15	0-5	126	24	151	N/A
Andrew Mott	GP Governing Body Member-H&WBBR Representative	0-2.5	0-2.5	10-15	20-25	122	24	147	N/A
Jayne Stringfellow	Chief Nurse & Director of Quality	5-7.5	17.5-20	45-50	140-145	838	176	1023	N/A
Jennifer Swatton	Director of Joint Commissioning	0-2.5	2.5-5	35-40	110-115	721	64	792	N/A
Gary Thompson	Chief Officer	2.5-5	-2.5-0	40-45	95-100	625	58	709	N/A

Notes

This disclosure is only for senior managers disclosed in the Salaries and Allowances table, where the Clinical Commissioning group makes contributions direct to a pension scheme (i.e. as an employer) or a sharing arrangement is in place which is being disclosed as if the person were employed. Other persons paid via an invoice to their employer and those where no pension contributions are being made will not be included in the table.

Where NHS Pension have provided the pension values relating to GP's membership of the Practitioner Pension scheme this is not relevant to the CCG role of that GP - only pension entitlements built up as part of contributions paid on the income from the CCG would be relevant.

Note 1. Louise Bainbridge took up her post on 1st November 2017

Note 2. Cumba Balding left her post on 31st August 2017 leaving her post for Peter Moore who returned from secondment on 1st October 1017

Note 3. Christopher Clayton took up his post on 1st October 2017

Note 4. Philip Crowley left his post on 17th March 2018

Note 5. Gary Thompson left his post on 31st December 2017

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 spouse's (or other allowable beneficiary's) pension payable from the scheme.

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

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. 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

One payment was made during the year in respect of early retirement or loss of office.

Payments to Past Members

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

Fair Pay Disclosure

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

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

The banded remuneration of the highest paid director/Member in NHS Southern Derbyshire CCG in the financial year 2017/18 was £143k (2016/17 £157k). This was 3.5 times (2016/17 3.9) the median remuneration of the workforce, which was £41k (2016/17 - £40k). The fall in the ratio is due to the reduction in remuneration of the highest paid director/member.

In 2017/18, one employee received remuneration in excess of the highest paid director/Member. Remuneration ranged from £16k to £157k (2016/17: £16 k to £158k).

The banded remuneration of the highest paid employee in NHS Southern Derbyshire CCG in the financial year 2017/18 was £157k (2016/17 £158k) this was 3.9 times (2016/17 3.9), the median remuneration of the workforce, which was £41k (2016/17 - £40 k).

There are a number of staff, including three executive directors, that are shared across the Derbyshire Clinical Commissioning Groups (Erewash Clinical Commissioning Group receives an apportioned charge for its share of the costs). However for the purpose of pay multiple calculations, the annual full-time equivalent salaries have been used, rather than the apportioned shares (this methodology has been applied to all shared staff).

Staff Report

Number of Senior Managers and staff composition

The table below shows the gender and pay band of the Very Senior Managers and gender of the other CCG Employees for 2017/18.

	Male	Female	Total
Executive Members	3	3	6
Band 8d	0	2	2
Band 8c	5	10	15
Band 8b	6	14	20
Band 8a	12	25	37
Other Banded CCG Employees	9	100	109
Total CCG Employees	35	154	189
Other Non Permanent Engagements including non-executive directors and lay members	13	4	17
Total	**48**	**158**	**206**

Staff Numbers and Costs

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

2017/18	2017/18	2017/18	2016/17
Total Number	Permanently Employed	Other Number	Total Number
161	154	7	168

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	1,608	1,340
Average number of permanent employees for the year	154	156
Average working days lost *	10	9

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

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires public sector organisations to report on trade union time in their organisation. The CCG has a Trade Union Official however their contribution is negligible. The CCG is required to publish the relevant information on their website by 31 July 2018.

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

Expenditure on Consultancy

The expenditure on consultancy for 2017/18 for the CCG was £144,000.

Off-payroll Engagements

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

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

Table 1: Off-payroll engagements longer than 6 months

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

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

Table 2: New off-payroll engagements

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

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
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	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 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. (1)	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. (2)	11

Note
(1) There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances
(2) As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero

Exit packages, Including Special (non-contractual) Payments or Any Other Departures

The CCG has agreed one exit packages or severance payments in the financial year 2017/18.

Parliamentary Accountability and Audit Report

NHS Southern Derbyshire 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.

KPMG

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Southern Derbyshire 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 53, 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.

Qualified opinion

In our opinion, except for the matters outlined in the basis for qualified opinion paragraph below 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.

Basis for qualified opinion

The CCG has a statutory duty under Section 223H of the National Health Service Act 2006 to ensure that its expenditure which is attributable to the performance by it of its functions in the financial year does not exceed the Revenue Resource Limit specified by the NHS Commissioning Board. In 2017/18 the net operating expenditure of the CCG was £776.3 million, which was £18.1 million in excess of its Revenue Resource Limit of £758.2 million.

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.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects NHS Southern Derbyshire CCG put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

The CCG had a savings target which it failed to meet resulting in it breaching its Revenue Resource Limit. This indicates weaknesses in the CCG's arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and the maintenance of statutory functions. Of the overall Quality, Innovation, Productivity and Prevention savings target for 2017/18 of £35m only £18m was delivered by the CCG. The CCG is reporting a deficit of £18.1m (a £1.3m cumulative deficit after allowing for prior year surpluses brought forward of £16.8m). Steps were taken by the CCG to limit the extent of overspending against the revenue resource limit in 2017/18, but these did not avoid the breach reported.

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 53, 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 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.

We are required to report to you if we refer a matter to the Secretary of State and the NHS Commissioning Board 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:

On 21 May 2018 we made a referral to the Secretary of State and the NHS Commissioning Board under Section 30(1)(b) of the Local Audit and Accountability Act 2014 as a consequence of the CCG breaching its 2017/18 Revenue Resource Limit.

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 Southern Derbyshire 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 Southern Derbyshire 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
25 May 2018

NHS SOUTHERN DERBYSHIRE CCG
FINANCIAL STATEMENTS
2017/18

Dr Chris Clayton

Accountable Officer

NHS Southern Derbyshire CCG

23 May 2018

NHS Southern Derbyshire CCG - Annual Accounts 2017-18

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	(5,039)	(3,004)
Other operating income	2	(445)	(186)
Total operating income		**(5,484)**	**(3,190)**
Staff costs	4	9,339	8,586
Purchase of goods and services	5	771,865	733,305
Depreciation and impairment charges	5	0	0
Provision expense	5 & 30	237	0
Other Operating Expenditure	5	360	465
Total operating expenditure		**781,801**	**742,356**
Net Operating Expenditure		**776,317**	**739,166**
Finance income		0	0
Finance expense	10	0	0
Net expenditure for the year		**776,317**	**739,166**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**776,317**	**739,166**
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		**776,317**	**739,166**

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	5,836	4,436
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	39	98
Total current assets		**5,875**	4,534
Non-current assets held for sale	21	0	0
Total current assets		**5,875**	4,534
Total assets		**5,875**	4,534
Current liabilities			
Trade and other payables	23	(43,757)	(43,929)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(237)	0
Total current liabilities		**(43,994)**	(43,929)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(38,119)**	(39,395)
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		**(38,119)**	(39,395)
Financed by Taxpayers' Equity			
General fund		(38,119)	(39,395)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(38,119)**	(39,395)

The notes on pages 100 to 130 form part of this statement

The financial statements on pages 96 to 130 were approved by the Audit Committee under delegated powers from the Governing Body on 23 May 2018 and are signed on its behalf by:

Dr Chris Clayton
Accountable Officer

Louise Bainbridge
Chief Finance Officer

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(39,395)	0	0	**(39,395)**
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	**(39,395)**	**0**	**0**	**(39,395)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(776,317)			(776,317)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(776,317)**	**0**	**0**	**(776,317)**
Net funding	777,593	0	0	777,593
Balance at 31 March 2018	**(38,119)**	**0**	**0**	**(38,119)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	**(48,148)**	**0**	**0**	**(48,148)**
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	**(48,148)**	**0**	**0**	**(48,148)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(739,166)			(739,166)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(739,166)**	**0**	**0**	**(739,166)**
Net funding	747,919	0	0	747,919
Balance at 31 March 2017	**(39,395)**	**0**	**0**	**(39,395)**

The notes on pages 100 to 130 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		(776,317)	(739,166)
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	(1,400)	118
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(172)	(9,004)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	237	0
Net Cash Inflow (Outflow) from Operating Activities		**(777,652)**	(748,052)
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		**(777,652)**	(748,052)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		777,593	747,919
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		**777,593**	747,919
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(59)**	(133)
Cash & Cash Equivalents at the Beginning of the Financial Year		**98**	231
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		**38**	98

The notes on pages 100 to 130 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.

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**

Management has not made any material estimates in the process of applying the clinical commissioning group's accounting policies. Income and expenditure accrual estimates have the most significant effect on the amounts recognised in the financial statements. The relevant notes to the accounts are notes 17 and 23.

The clinical commissioning group has mitigated the risks resulting from this estimation uncertainty by using previous knowledge and experience and also seeking professional advice as appropriate. On this basis there are no key sources of estimation uncertainty at the Statement of Financial Position date that have a significant risk of causing material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.8 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.9.2 **Retirement Benefit Costs**

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

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

1.10 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the Clinical Commissioning Group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Valuation**

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the Clinical Commissioning Group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

· Land and non-specialised buildings – market value for existing use; and,

· Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

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

1.11.3 **Subsequent Expenditure**

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

1.12 **Intangible Assets**

The Clinical Commissioning Group owns no intangible assets

1.13 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.14 **Donated Assets**

The Clinical Commissioning Group has no donated assets.

1.15 **Government Grants**

The Clinical Commissioning Group has received no government grants.

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

The Clinical Commissioning Group has no assets held for sale.

1.17 **Leases**

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

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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.

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

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

1.27 **Financial Assets**

Financial assets are recognised when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

· Financial assets at fair value through profit and loss;
· Held to maturity investments;
· Available for sale financial assets; and,
· Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

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

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

The Clinical Commissioning Group does not have any financial assets at fair value through profit and loss.

1.27.2 **Held to Maturity Assets**

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

1.27.3 **Available For Sale Financial Assets**

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

The Clinical Commissioning Group does not have any financial assets available for sale.

1.27.4 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Clinical Commissioning Group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

1.27.5 **Impairment**

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

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

1.28 **Financial Liabilities**

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

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

1.28.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

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

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

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

The Clinical Commissioning Group does not have any financial liabilities at fair value through profit and loss.

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

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

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

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

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

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

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

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

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

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

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

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	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	£'000	£'000	£'000
Recoveries in respect of employee benefits	264	264	0	0
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	4	4	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	5,035	200	4,835	3,004
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	181	86	95	186
Total other operating revenue	**5,484**	**554**	**4,930**	**3,190**

Admin revenue received is not directly attributable to the provision of healthcare or healthcare services.
Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

3 Revenue

	2017-18 Total	2017-18 Admin	2017-18 Programme	2016-17 Total
	£'000	£'000	£'000	£'000
From rendering of services	5,484	555	4,930	3,190
From sale of goods	0	0	0	0
Total	**5,484**	**555**	**4,930**	**3,190**

Revenue is wholly from the supply of services. The CCG receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2017-18	Total	Permanent Employees	Other
	Total £'000	**£'000**	**£'000**
Employee Benefits			
Salaries and wages	7,582	6,742	840
Social security costs	735	735	0
Employer Contributions to NHS Pension scheme	902	902	0
Other pension costs	0	0	0
Apprenticeship Levy	20	20	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	100	100	0
Gross employee benefits expenditure	**9,339**	**8,499**	**840**
Less recoveries in respect of employee benefits (note 4.1.2)	(265)	(265)	0
Total - Net admin employee benefits including capitalised costs	**9,074**	**8,234**	**840**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**9,074**	**8,234**	**840**

4.1.1 Employee benefits

2016-17	Total	Permanent Employees	Other
	Total £'000	**£'000**	**£'000**
Employee Benefits			
Salaries and wages	7,004	6,270	734
Social security costs	703	703	0
Employer Contributions to NHS Pension scheme	879	879	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	**8,586**	**7,852**	**734**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**8,586**	**7,852**	**734**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**8,586**	**7,852**	**734**

4.1.2 Recoveries in respect of employee benefits

2017-18	Total	Permanent Employees	Other	2016-17 Total
	Total £'000	**£'000**	**£'000**	£'000
Employee Benefits - Revenue				
Salaries and wages	(228)	(228)	0	0
Social security costs	(16)	(16)	0	0
Employer contributions to the NHS Pension Scheme	(20)	(20)	0	0
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**(265)**	**(265)**	**0**	**0**

Recoveries represent charges to other organisations in respect of staff employed by the CCG & providing services to the other body. (their gross costs are included in note 4.1.1).

4.2 Average number of people employed

	2017-18 Total Number	2017-18 Permanently employed Number	2017-18 Other Number	2016-17 Total Number
Total	**161**	**154**	**7**	168
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

	2017-18 Number	2016-17 Number
Number of persons retired early on ill health grounds	0	0
	£'000	**£'000**
Total additional Pensions liabilities accrued in the year	0	0

4.4 Exit packages agreed in the financial year

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	1	100,000	0	0	1	100,000
£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	**1**	**100,000**	**0**	**0**	**1**	**100,000**

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

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

Analysis of Other Agreed Departures

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

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

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

Redundancy and other departure costs 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 at the latest 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 £893,327 were payable by the CCG to the NHS Pensions Scheme (2016-17: £878,537) 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. (the values in note 4.1.1 are slightly higher than reported here as these will include staff seconded into the CCG whose pension contributions have been paid over by the other organisation).

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	8,209	5,557	2,652	7,581
Executive governing body members	1,130	1,078	52	1,005
Total gross employee benefits	**9,339**	**6,635**	**2,704**	**8,586**
Other costs				
Services from other CCGs and NHS England	4,006	1,489	2,517	3,568
Services from foundation trusts	466,116	0	466,116	450,782
Services from other NHS trusts	35,767	0	35,767	32,688
Sustainability Transformation Fund	0	0	0	0
Services from other WGA bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	107,702	0	107,702	92,256
Purchase of social care	0	0	0	0
Chair and Non Executive Members	289	289	0	453
Supplies and services – clinical	0	0	0	0
Supplies and services – general	835	697	138	763
Consultancy services	152	152	0	175
Establishment	386	340	46	105
Transport	9	5	4	9
Premises	2,334	220	2,114	2,826
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	44	44	0	88
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	75,473	0	75,473	74,697
Pharmaceutical services	479	0	479	448
General ophthalmic services	282	0	282	305
GPMS/APMS and PCTMS	77,957	0	77,957	73,808
Other professional fees excl. audit	5	0	5	173
Legal fees	185	181	4	0
Grants to Other bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	71	71	0	12
Education and training	133	29	104	69
Change in discount rate	0	0	0	0
Provisions	237	237	0	0
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions	0	0	0	544
Non cash apprenticeship training grants	0	0	0	0
Other expenditure	0	0	0	1
Total other costs	**772,462**	**3,754**	**768,708**	**733,770**
Total operating expenses	**781,801**	**10,389**	**771,412**	**742,356**

Admin expenditure is expenditure that is not directly incurred for the provision of healthcare or healthcare services.
The executive governing body members gross employee benefits include a one-off redundancy payment made by the CCG to the CFO but exclude charges made by other Derbyshire CCGs in respect of redundancy risk-sharing (these are included in other employee benefit costs).

The external audit of the 2017/18 accounts of the CCG was undertaken by KPMG LLP. The audit fee amounted to £35,000 (2016/17 £71,250) exclusive of VAT.
An additional fee was paid to KPMG LLP. of £2,000 exclusive of VAT in respect of the 2016/17 statutory audit (£2,300 in 2016/17 in respect of the previous year audit).

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	16,475	109,327	15,553	103,567
Total Non-NHS Trade Invoices paid within target	16,475	109,327	15,551	103,566
Percentage of Non-NHS Trade invoices paid within target	**100.00%**	**100.00%**	99.99%	100.00%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,740	504,428	4,065	487,225
Total NHS Trade Invoices Paid within target	3,740	504,428	4,065	487,225
Percentage of NHS Trade Invoices paid within target	**100.00%**	**100.00%**	100.00%	100.00%

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

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 CCG had no income generation activities whose full cost exceeded £1m or was otherwise material (2016-17 £nil).

8. Investment revenue

During the year the CCG received no investment revenue (2016-17: £nil).

9. Other gains and losses

During the year the CCG incurred no other gains and losses (2016-17: £nil).

10. Finance costs

During the year the CCG incurred no finance costs (2016-17: £nil).

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

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

During the year the CCG incurred no gains/(losses) on transfer by absorption (2016-17: £nil).

12. Operating Leases

12.1 As lessee

The CCG has no formal lease in place with NHS Property Services for the rental of the CCG's main office.

Even though there is no contract in place (lease or Memorandum of Terms of Occupation), the transactions involved do convey the right of the clinical commissioning group to use such property assets. This suggests that (under paragraph 9 of IFRIC 4), this arrangement is (or contains) a lease and as such is to be accounted for in accordance with IAS 17.
Therefore, the 2017-18 expenditure in relation to the property are disclosed as minimum lease payments under the buildings column of Note 12.1.1. below.

The CCG has also entered into leases in respect of lease cars for use by employees. Lease costs for these cars are shared between the CCG and employee. Terms and conditions of these leases are agreed prior to commencement of the lease and fixed for the whole term. The CCG's contribution to such leases is fixed according to certain pre-determined criteria linked to the role of the employee.

12.1.1 Payments recognised as an Expense

	2017-18				2016-17			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payments recognised as an expense								
Minimum lease payments	0	2,292	9	**2,301**	0	2,727	(7)	**2,720**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**2,292**	**9**	**2,301**	**0**	**2,727**	**(7)**	**2,720**

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

12.1.2 Future minimum lease payments

	2017-18				2016-17			
	Land	**Buildings**	**Other**	**Total**	Land	Buildings	Other	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000	£'000	£'000	£'000
Payable:								
No later than one year	0	0	4	**4**	0	0	6	**6**
Between one and five years	0	0	1	**1**	0	0	6	**6**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**12**	**12**

12.2 As lessor

The CCG was not a lessor during the year ended 31st March 2018, nor during the previous year.

13 Property, plant and equipment

During the year the CCG held no property, plant and equipment (2016-17: £nil).

14 Intangible non-current assets

During the year the CCG held no intangible non-current assets (2016-17: £nil).

15 Investment property

As at 31st March 2018 the CCG held no investment properties (2016-17: £nil).

16 Inventories

As at 31st March 2018 the CCG held no inventories (2016-17: £nil).

17 Trade and other receivables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	1,454	0	917	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	2,426	0	2,574	0
NHS accrued income	31	0	197	0
Non-NHS and Other WGA receivables: Revenue	570	0	175	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	905	0	520	0
Non-NHS and Other WGA accrued income	403	0	0	0
Provision for the impairment of receivables	0	0	0	0
VAT	46	0	53	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	1	0	0	0
Total Trade & other receivables	**5,836**	**0**	**4,436**	**0**
Total current and non current	**5,836**		**4,436**	
Included above:				
Prepaid pensions contributions	0		0	

The majority of the CCG's revenue is with NHS England. NHS England is funded by Government to provide funding to CCGs to commission services, therefore no credit scoring of them is considered necessary.
Other major revenue is with other NHS organisations, local authorities, HMRC and GPs whose credit rating is deemed secure.

17.1 Receivables past their due date but not impaired	2017-18 £'000	2017-18 £'000	2016-17 £'000
	DH Group Bodies	Non DH Group Bodies	All receivables prior years
By up to three months	675	420	613
By three to six months	0	91	128
By more than six months	0	57	0
Total	**675**	**568**	**741**

The prior year values have been restated to include all overdue debt not just non-NHS receivables as previously reported.
£580k of the DH Group outstanding debt relates to an invoice for penalty notices to Derby Hospitals Teaching Hospital raised in March.
£306k of the amount above has subsequently been recovered post the statement of financial position date.

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

The CCG has undertaken an impairment review of its non-NHS receivables and considers that no general provision for impairment is deemed to be necessary. The CCG has made a specific adjustment for two invoices that were overcharged (total £13k).

18 Other financial assets

As at 31st March 2018 the CCG had no other financial assets (2016-17: £nil).

19 Other current assets

As at 31st March 2018 the CCG had no other current assets (2016-17: £nil).

20 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	98	231
Net change in year	(59)	(133)
Balance at 31 March 2018	**39**	**98**
Made up of:		
Cash with the Government Banking Service	38	97
Cash with Commercial banks	0	0
Cash in hand	1	1
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**39**	**98**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**39**	**98**

No patient monies are held by the CCG.
The £38k cash balance with GBS is represented by £82k cleared bank balance less unpresented payable orders of £44k.
The CCG's target of a £831k maximum cash balance as at 31st March 2018 was achieved (1.25% of March drawdown £66.5m).
During 2017-18 cash was managed within the CCG's notified Maximum Cash Drawdown Limit of £778,185k.

21 Non-current assets held for sale

As at 31st March 2018 the CCG had no non-current assets held for sale (2016-17: £nil).

22 Analysis of impairments and reversals

Southern Derbyshire CCG had no impairments or reversals in the year 2017/18 (2016/17: £nil).

23 Trade and other payables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	4,544	0	4,809	0
NHS payables: capital	0	0	0	0
NHS accruals	5,205	0	4,385	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	1,996	0	4,207	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	24,782	0	23,255	0
Non-NHS and Other WGA deferred income	0	0	202	0
Social security costs	111	0	106	0
VAT	0	0	0	0
Tax	116	0	87	0
Payments received on account	0	0	0	0
Other payables and accruals	7,003	0	6,878	0
Total Trade & Other Payables	**43,757**	**0**	**43,929**	**0**
Total current and non-current	**43,757**		**43,929**	

Other payables include £583k (2016-17: £841k) outstanding pension contributions at 31st March 2018 (GPs and CCG Staff).

24 Other financial liabilities

As at 31st March 2018 the CCG had no other financial liabilities (2016-17: £nil).

25 Other liabilities

As at 31st March 2018 the CCG had no other liabilities (2016-17: £nil).

26 Borrowings

As at 31st March 2018 the CCG had no borrowings (2016-17: £nil).

27 Private finance initiative, LIFT and other service concession arrangements

As at 31st March 2018 the CCG had no PFI, LIFT or other service concession arrangements (2016-17: £nil).

28 Finance lease obligations

As at 31st March 2018 the CCG had no finance lease obligations as a lessee (2016-17: £nil).

29 Finance lease receivables

As at 31st March 2018 the CCG had no finance lease obligations as a lessor (2016-17: £nil).

30 Provisions

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0		
Restructuring	237	0		
Redundancy	0	0		
Agenda for change	0	0		
Equal pay	0	0		
Legal claims	0	0		
Continuing care	0	0		
Other	0	0		
Total	**237**	**0**	**0**	**0**
Total current and non-current	**237**		**0**	

	Pensions Relating to Former Directors £'000	Pensions Relating to Other Staff £'000	Restructuring £'000	Redundancy £'000	Agenda for Change £'000	Equal Pay £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Arising during the year	0	0	237	0	0	0	0	0	0	237
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**	**237**	**0**	**0**	**0**	**0**	**0**	**0**	**237**
Expected timing of cash flows:										
Within one year	0	0	237	0	0	0	0	0	0	237
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**	**237**	**0**	**0**	**0**	**0**	**0**	**0**	**237**

A value of £237k has been set aside in 2017/18 for costs resulting from the re-organisation of the shared Derbyshire Clinical Commissioning Group executive management structure, with costs likely to materialise in the early part of 2018/19. The other Derbyshire Clinical Commissioning Groups have likewise set up a provision for their share of the costs.

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them.
As at 31st March 2018 there are no claims currently being handled by NHS Resolution on behalf of NHS Southern Derbyshire CCG.
As at March 2018 there was £nil included in the provisions of NHS Resolution in respect of clinical negligence liabilities of the clinical commissioning group.

Under the Annual Accounts Directions issued by NHS England on 22 February 2016, NHS England is responsible for accounting for liabilities relating to NHS continuing healthcare claims relating to periods of care before the establishment of the CCG. However, the legal liability remains with the CCG.
The total value of legacy continuing healthcare provisions accounted for by NHS England on behalf of this CCG at 31st March 2018 is £0.318m (2016-17: £0.447m).

31 Contingencies

The CCG has no contingent liabilities (2016-17: £nil) and no contingent assets (2016-17: £nil)

32 Commitments

As at 31st March 2018 the CCG had no capital commitments (2016-17: £nil) and no other financial commitments (2016-17: £nil).

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

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

33.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2017-18 £'000	Loans and Receivables 2017-18 £'000	Available for Sale 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,485	0	1,485
· Non-NHS	0	974	0	974
Cash at bank and in hand	0	39	0	39
Other financial assets	0	0	0	0
Total at 31 March 2018	**0**	**2,498**	**0**	**2,498**

	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	1,114	0	1,114
· Non-NHS	0	175	0	175
Cash at bank and in hand	0	98	0	98
Other financial assets	0	2	0	2
Total at 31 March 2018	**0**	**1,389**	**0**	**1,389**

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	9,749	9,749
· Non-NHS	0	33,782	33,782
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**	**43,531**	**43,530**

	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	9,194	9,194
· Non-NHS	0	34,339	34,339
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**	**43,533**	**43,533**

34 Operating segments

The CCG considers it to have only one operating segment, namely the commissioning of healthcare services as follows:

	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Commissioning of Healthcare Services	781,801	(5,484)	**776,317**	5,875	(43,994)	**(38,119)**

35 Pooled budgets

Derbyshire

On 1st of April 2015, the Derbyshire Better Care Fund (BCF) became operational. The clinical commissioning group is a partner to this fund along with NHS North Derbyshire, NHS Hardwick, NHS Erewash, NHS Tameside & Glossop Clinical Commissioning Groups and 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 aim of the fund is 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 £19,170, 000 (£18,809,000 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 by Derbyshire County Council who are host and lead commissioner
- Commissioning of existing funded schemes directly by each partner

The clinical commissioning group also has a separate pooled budget arrangement for the provision and commissioning of services for Children and Young People with Complex Needs (Complex Cases). This pool is also hosted by Derbyshire County Council and is partnered with NHS North Derbyshire Clinical Commissioning Group, NHS Hardwick Clinical Commissioning Group and NHS Erewash Clinical Commissioning Group.

Derby City

On 1st of April 2015, the Derby City Better Care Fund (BCF) became operational. The clinical commissioning group is a partner to this fund along with Derby City 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 £29,187,649 including iBCF funding (£23,090,543 excluding iBCF).

The aim of the fund is to improve the provision of health and social care. Both 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. Derby City Council received an additional £6,097,106 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 £21,078, 000 (£19,249,000 in 2016-17).
Under the agreement, the BCF Plan for Derby City is split into 2 areas:
- Contributions to a pooled fund by all partners and commissioned by Derby City Council who are host and lead commissioner
- Commissioning of existing funded schemes directly by each partner

The clinical commissioning group also has a separate pooled budget arrangement for the provision of an Integrated Disabled Children's Centre and Services in Derby (IDCS). This pooled budget is hosted by Derby City Council.

Pooled Budget Performances

The CCG's share of the income and expenditure handled by the pooled budgets in the financial year were:

	2017/18 Total Pooled Budget £000s	2017/18 NHS Southern Derbyshire Share £000s	2016/17 Total Pooled Budget £000s	2016/17 NHS Southern Derbyshire Share £000s
Income	125,860	41,822	93,476	39,582
Expenditure	(125,981)	(41,835)	(93,443)	(39,610)
Surplus for 2017/18	(121)	(13)	33	(28)
Balance brought forward	132	18	99	46
Balance carried forward	11	5	132	18

The CCG's share of expenditure for all pooled budgets is included in the income and expenditure account of the CCG.

35 Pooled budgets

Memorandum Account for the Derbyshire County Council Better Care Fund

Income	2017/18 £000s	2017/18 %	2016/17 £000s	2016/17 %
NHS Southern Derbyshire CCG	19,170	21.6%	18,809	28.9%
NHS North Derbyshire CCG	21,289	24.0%	21,324	32.8%
NHS Hardwick CCG	12,447	14.0%	8,179	12.6%
NHS Erewash CCG	7,199	8.1%	7,129	11.0%
NHS Tameside & Glossop CCG	2,252	2.5%	2,212	3.4%
Derbyshire County Council	26,419	29.8%	7,338	11.3%
Total Income	**88,776**	**100.0%**	64,991	100.0%
Expenditure				
CCG schemes aimed at reducing non elective activity	31,869		24,739	
Derbyshire County Council schemes	5,966		5,481	
Community Health Services	25,682		24,920	
Social Care	3,404		6,917	
Mental Health	3,147		2,443	
Administration, Performance & Information Sharing	490		491	
iBCF	18,218		-	
Total Expenditure	**88,776**		64,991	
Net Position for the Pool	-		-	
Balance brought forward at 1 April	-		-	
Balance carried forward at 31 March	-		-	

Memorandum Account for the Derby City Council Better Care Fund

Income	2017/18 £000s	2017/18 %	2016/17 £000s	2016/17 %
NHS Southern Derbyshire CCG	21,078	72.2%	19,249	91.2%
Derby City Council	8,110	27.8%	1,859	8.8%
Total Income	**29,188**	**100.0%**	21,108	100.0%
Expenditure				
CCG schemes aimed at reducing non elective activity	3,347		5,633	
Derby City Council schemes	1,748		2,499	
Community Health Services	9,818		6,524	
Social Care	7,557		4,505	
Mental Health	468		1,797	
Accident & Emergency	153		150	
iBCF	6,097			
Total Expenditure	**29,188**		21,108	
Net Position for the Pool	-		-	
Balance brought forward at 1 April	-		-	
Balance carried forward at 31 March	-		-	

35 Pooled budgets

Memorandum Account for Children and Young People with Complex Needs Arrangement

Income	2017/18 £000s	2017/18 %	2016/17 £000s	2016/17 %
NHS Southern Derbyshire CCG	563	9.9%	513	9.9%
NHS North Derbyshire CCG	755	13.2%	687	13.2%
NHS Hardwick CCG	305	5.3%	278	5.3%
NHS Erewash CCG	261	4.6%	238	4.6%
Derbyshire County Council	3,824	67.0%	3,484	67.0%
Total Income	**5,708**	**100.0%**	5,200	**100.0%**
Expenditure				
Placements	5,827		5,081	
Total Expenditure	**5,827**		5,081	
Net Position for the Pool	119		119	
Balance brought forward at 1 April	119		-	
Balance carried forward at 31 March	-		119	

Memorandum Account for the Integrated Disabled Children's Centre and Services in Derby Arrangement

Income	2017/18 £000s	2017/18 %	2016/17 £000s	2016/17 %
NHS Southern Derbyshire CCG	1,011	46.2%	1,011	46.4%
Derby City Council	1,177	53.8%	1,166	53.6%
Total Income	**2,188**	**100.0%**	2,177	100.0%
Expenditure				
Residential Services	1,213		1,280	
Community Support Teams	302		366	
Children's Disability Team	3		-	
Management and Administration	672		617	
Total Expenditure	**2,190**		2,263	
Net Position for the Pool	2		86	
Balance brought forward at 1 April	13		99	
Balance carried forward at 31 March	11		13	

The Integrated Disabled Children's Centre and Services in Derby pooled budget reported an overspend of £2k for the year, with a total accumulated underspend of £11k at 31 March 2018.
The clinical commissioning group's share of the accumulated underspend was £5k. This amount has been carried forward in the pool.
During the year the council updated the final 2016/17 pooled budget figures and these have now been restated in these accounts.

36 NHS Lift investments

	Loan 2017-18 £'000	Share Capital 2017-18 £'000	Total 2017-18 £'000
Balance at 01 April 2017	0	0	**0**
Additions	0	0	**0**
Disposals	0	0	**0**
Loan repayments	0	0	**0**
Revaluations	0	0	**0**
Loans repayable within 12 months	0	0	**0**
Balance at 31 March 2018	**0**	**0**	**0**

	Loan 2016-17 £'000	Share Capital 2016-17 £'000	Total 2016-17 £'000
Balance at 01 April 2016	0	0	0
Transfer of investments from closed NHS bodies as a result of the 01 April 2016 transition	0	0	0
Adjusted Balance at 01 April 2016	**0**	**0**	0
Additions	0	0	0
Disposals	0	0	0
Loan repayments	0	0	0
Revaluations	0	0	0
Loans repayable within 12 months	0	0	0
Balance at 31 March 2017	**0**	**0**	0

37 Related party transactions

Details of related party transactions with individuals for financial year 2017/18 are as follows:

Name	Position	Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
			£'000	£'000	£'000	£'000
Louise Bainbridge	Chief Finance Officer	NHS NORTH DERBYSHIRE CCG	436	(137)	69	(34)
Louise Bainbridge	Chief Finance Officer	NHS HARDWICK CCG	768	(122)	187	(22)
Louise Bainbridge	Chief Finance Officer	NHS EREWASH CCG	172	(619)	0	(11)
Dr Nick Bishop	GP Governing Body Member	WHITEMOOR MEDICAL CENTRE	3,455	0	0	0
Dr Nick Bishop	GP Governing Body Member	DERBYSHIRE COMM HLTH SERV NHS FT	54,245	0	295	0
Dr Christopher Clayton	Accountable Officer	NHS NORTH DERBYSHIRE CCG	436	(137)	69	(34)
Dr Christopher Clayton	Accountable Officer	NHS HARDWICK CCG	768	(122)	187	(22)
Dr Christopher Clayton	Accountable Officer	NHS EREWASH CCG	172	(619)	0	(11)
Dr Christopher Clayton	Accountable Officer	PRICE WATERHOUSE COOPERS LLP	173	0	0	0
Dr Richard Crowson	GP Governing Body Member	MACKLIN STREET SURGERY	3,258	0	0	0
Dr Richard Crowson	GP Governing Body Member	DERBY HOSPITALS NHS FT	309,288	(1,969)	92	(596)
Dr Buk Dhadda	GP Governing Body Member	SWADLINCOTE SURGERY	3,856	0	0	0
Steve Hulme	Director of Medicines Management	ARTHUR MEDICAL CENTRE	2,306	0	0	0
Steve Hulme	Director of Medicines Management	PRESCQIPP CIC	8	0	0	0
Shokat Lal	Vice Chair & Lay Representative	PEARTREE MEDICAL CENTRE	1,336	0	0	0
Shokat Lal	Vice Chair & Lay Representative	SAHARA CARE AGENCY	123	0	0	0
Dr Andrew Maronge	GP Governing Body Member	RIVERSDALE SURGERY DE56 1AY	3,443	0	3	0
Dr Andrew Maronge	GP Governing Body Member	WILLINGTON SURGERY	2,341	0	0	0
Dr Andrew Mott	GP Governing Body Member	JESSOP MEDICAL PRACTICE	4,963	0	0	0
Dr Andrew Mott	GP Governing Body Member	DERBY HOSPITALS NHS FT	309,288	(1,969)	92	(596)
Kevin Orford	Lay Representative	KEVIN ORFORD & ASSOCIATES	2	0	2	0
Kevin Orford	Lay Representative	NHS W LEICESTERSHIRE CCG	0	(20)	0	0
Kevin Orford	Lay Representative	NHS WALSALL CCG	0	(1)	0	0
Kevin Orford	Lay Representative	NHS NENE CCG	0	2	0	0
Kevin Orford	Lay Representative	NHS SHEFFIELD CCG	1	(5)	0	0
Kevin Orford	Lay Representative	STAFFS & STOKE PART NHST	156	0	4	0
Kevin Orford	Lay Representative	NHS BHAM CROSS CITY CCG	0	(3)	0	0
Kevin Orford	Lay Representative	NHS NOTTINGHAM CITY CCG	1	(65)	0	(48)
Kevin Orford	Lay Representative	NHS ARDEN AND GEM CSU	2,056	0	0	0
Kevin Orford	Lay Representative	NHS NORTH DERBYSHIRE CCG	436	(137)	69	(34)
Kevin Orford	Lay Representative	CHESTFIELD R HOSP NHSFT	4,003	0	156	0
Kevin Orford	Lay Representative	NHS SOLIHULL CCG	0	(1)	0	0
Perveez Sadiq	Council Representative	DERBY CITY COUNCIL	14,577	(242)	151	(134)
Jayne Stringfellow	Chief Nurse	NHS NORTH DERBYSHIRE CCG	436	(137)	69	(34)
Jayne Stringfellow	Chief Nurse	NHS HARDWICK CCG	768	(122)	187	(22)
Jayne Stringfellow	Chief Nurse	NHS EREWASH CCG	172	(619)	0	(11)
Jayne Stringfellow	Chief Nurse	CHESTFIELD R HOSP NHSFT	4,003	0	156	0
Jayne Stringfellow	Chief Nurse	CARERS TRUST EAST MIDLANDS	10	0	0	0
Jayne Stringfellow	Chief Nurse	NHS MANSFIELD & ASHFIELD CCG	0	(4)	0	(1)
Dean Wallace	Council Representative	DERBYSHIRE COUNTY COUNCIL	21,893	(447)	60	(50)
Dr Merryl Watkins	GP Governing Body Member	VERNON STREET MEDICAL CTR	2,272	0	0	0
Dr Merryl Watkins	GP Governing Body Member	DERBY HOSPITALS NHS FT	309,288	(1,969)	92	(596)
Dr Paul Wood	Chair	IVY GROVE SURGERY	3,147	0	0	0
Dr Paul Wood	Chair	DERBY HOSPITALS NHS FT	309,288	(1,969)	92	(596)

38 Events after the end of the reporting period

There are no events after the reporting period which have a material effect on the financial statements of the CCG.

39 Losses and special payments

39.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Administrative write-offs	0	0	0	0
Fruitless payments	0	0	3	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**0**	**0**	**3**	**0**

39.2 Special payments

	Total Number of Cases 2017-18 Number	**Total Value of Cases 2017-18 £'000**	Total Number of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	0	0	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**0**	**0**	**0**	**0**

40 Third party assets

During the year the CCG held no third party assets (2016-17: £nil).

41 Financial performance targets

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

	2017-18 Target	**2017-18 Performance**	2016-17 Target	2016-17 Performance
Expenditure not to exceed income	763,714	781,801	750,689	742,356
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	758,230	776,317	747,499	739,166
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	69,244	68,843	68,285	67,535
Revenue administration resource use does not exceed the amount specified in Directions	11,727	9,835	11,713	9,992

The revenue resource use on specified matter(s) relates to the commissioning of general practice services which became the responsibility of NHS Southern Derbyshire CCG on 1 April 2015.

For the purposes of 'Expenditure not to exceed income' expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

Each clinical commissioning group must, in respect of each financial year, perform its functions so as to ensure that its expenditure which is attributable to the performance by it of its functions in that year does not exceed the aggregate of;

i. the amount allotted to it for that year under section 223G;
ii. any sums received by it in that year under any provision of this Act (other than sums received by it under section 223G), and
iii. any sums received by it in that year otherwise than under this Act for the purpose of enabling it to defray such expenditure.

The CCG had a notified resource limit of £758,230k for financial year (2016-17: £747,499k). Following a change in criteria these figures reflect the in year position and no longer include any surplus/deficit carried forward.

The CCG had an administration resource limit of £11,727k (2016-17: £11,713k).

The CCG has not delivered all financial targets in 2017/18. A significant shortfall against the planned delivery of transformational efficiencies has led to a reported deficit, with programme expenditure exceeding the CCGs programme allocation.

The Medium Term Financial Strategy (MTFS) will be developed over the coming months and aims to bring the CCG back into a breakeven position. The MTFS will provide clarity on the financial position over the medium term and inform future savings and investment and commissioning and move the CCG to a balanced financial position.

42 Impact of IFRS

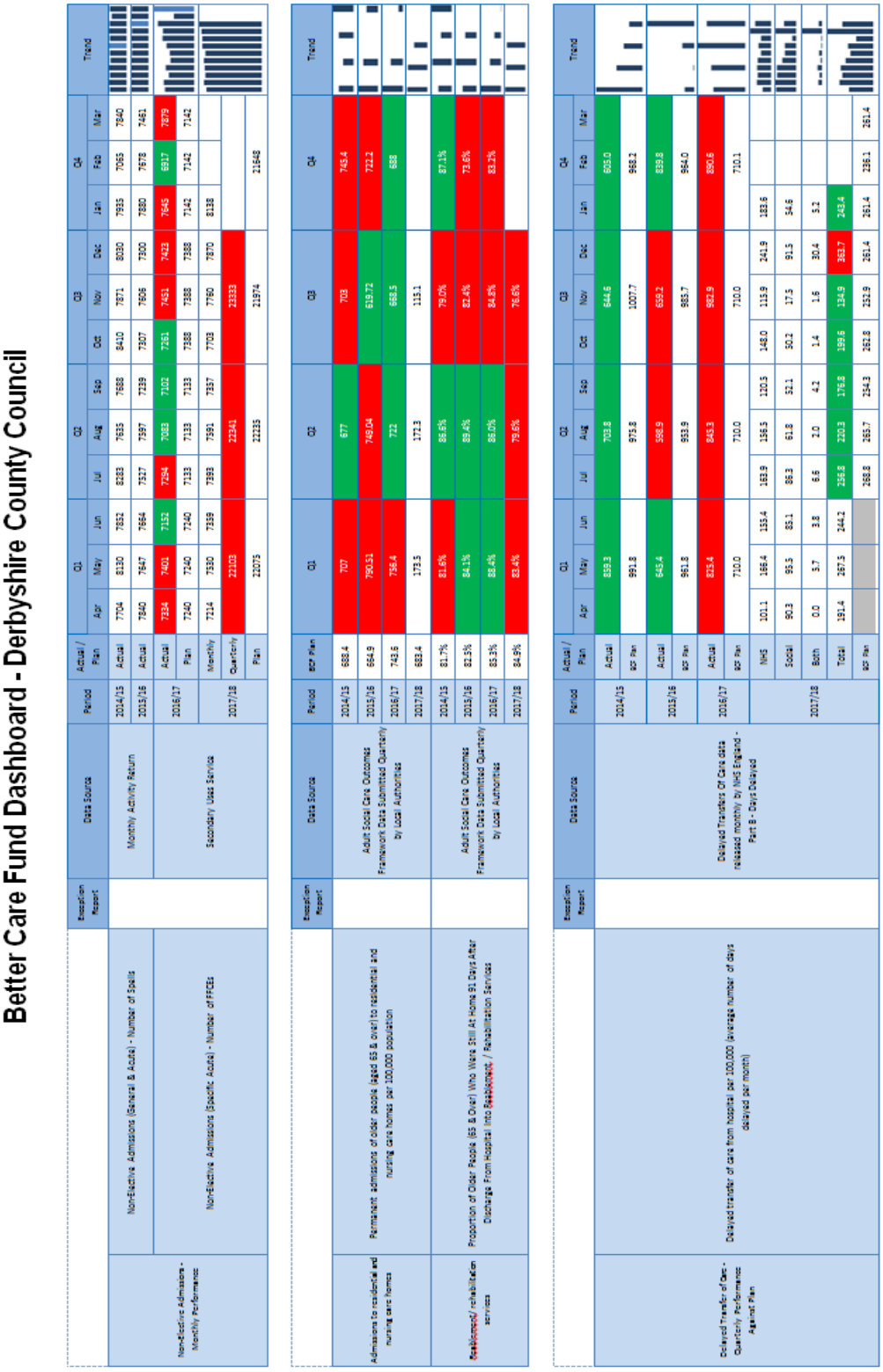
There has been no impact on the CCG when preparing the financial statements under IFRS.

43 Analysis of charitable reserves

Southern Derbyshire CCG holds no material charitable funds.
Where charitable funds are in existence the Derbyshire Community Health Services Charitable Trust has responsibility for the administration of any such Charitable Funds.
Derbyshire Community Health Services NHS Foundation Trust is the Corporate Trustee and holds assets belonging to the charity.
The CCG has not consolidated any charitable funds on the basis of immateriality and not having controlling power over any charitable funds as determined by IAS 27.

Appendices

Appendix One



Appendix Two

NHS Southern Derbyshire CCG Attendance at Meetings 2017/18

	Governing Body	Clinical Commissioning Committee (incl. virtual meetings)	Audit Committee	Remuneration & Staffing Committee	Lay Reference Group	Quality Assurance Committee	Governance Committee	Primary Medical Care Co-Commissioning Committee (incl. virtual meetings)
Dr Paul Wood	10	18					5	
Dr Chris Clayton (Commenced 1 October 2017)	6	0		2			0	
Ms Louise Bainbridge (commenced November 2017)	4	5	1				0	
Mr Philip Cowley (left March 2018)	7	20	4	5			3	
Dr Buk Dhadda	10	19				8		
Dr Nick Bishop	7	20						
Mr Shokat Lal	10			6			5	7
Dr Andrew Mott	8	21	4					
Dr Richard Crowson	7							
Dr Merryl Watkins	7							
Dr Andrew Maronge	8							
Ms Margaret Amos (commenced June 2017)	6		5	4			3	4
Mr Kevin Orford (left May 2017)	0	0	0	2			1	0
Mr Martin Whittle	8	21			6	5	4	5
Mrs Joanne Smith (left July 2017)	1				3	2		
Mr George Tansley	7		5		10	8	3	7
Mrs Jayne Stringfellow (shared post with North Derbyshire CCG)	7	19					3	5

Glossary

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
PHBs	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

About NHS Southern Derbyshire Clinical Commissioning Group (CCG)

NHS Southern Derbyshire Clinical Commissioning Group brings together the combined expertise of 55 local GP practices to commission health services on behalf of over 554,000 patients in southern Derbyshire. Our vision is to continuously improve the health and wellbeing of the people of southern Derbyshire, using all resources as fairly as possible.

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