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Performance Overview

Welcome to the first annual report for NHS North Cumbria Clinical Commissioning Group (CCG).

NHS North Cumbria CCG came into being on 1 April 2017 following a boundary change which saw the southern part of the previous ‘NHS Cumbria CCG’ organisation join with North Lancashire CCG to create NHS Morecambe Bay CCG. NHS North Cumbria CCG covers the areas of Allerdale, Eden, Carlisle and the majority of Copeland. These changes make local commissioning arrangements simpler and more efficient, paving the way toward greater integration of health and social care services for both north Cumbria and Morecambe Bay.

It has been a successful, but incredibly challenging first year for the organisation. There is a significant recruitment issue for General Practice (GP) in England, and this is particularly true of North Cumbria where there is a vacancy rate of up to 20% (with urban areas experiencing the most significant difficulty). We continue to make patient care our priority and it is at the heart of everything we do. We have recently come out of ‘directions’ which had been put in place by NHS England (NHSE) and are delighted that both the hard work and improvements that were implemented by staff, and our ongoing commitment to the care needs of our community has been recognised.

It is hard to tell our current story and update on the progress we’ve made without first setting the scene for our health system in North Cumbria. The system was part of a Success Regime from June 2015 to March 2017, which saw providers and commissioners of health and care services working more closely than ever. Since then this way of working became embedded across our North Cumbria Health and Care System, with us working towards being recognised as an Integrated Care System (ICS). Our ambition is to ensure a more ‘joined up’ system for health and social care across North Cumbria and beyond.

We face significant challenges in our system particularly in the areas of recruitment and finance, but we are working hard to address these issues with sustainable solutions, especially for some of our vulnerable services which were considered as part of the Healthcare for the Future consultation.

The full journey through the consultation process can be found at:
www.wnecumbria.nhs.uk or
www.northcumbriaccg.nhs.uk

There is a significant GP recruitment problem across England. In North Cumbria this is particularly the case with an average vacancy rate of 20% with many urban areas experiencing more difficulties than rural areas. GP practices continue to work hard to attract and retain both GPs and other members of the primary care team. The CCG continues to focus on this very important issue, attracting national funding for an overseas GP recruitment programme as well as working with Health Education England (HEE) and other local partners to offer flexible, supportive working environments, which we hope will attract GPs to our area. In the meantime, our existing GP practices continue in their efforts to ensure that patients continue to receive high quality care.

The service changes consulted on were maternity, paediatrics, community hospitals, stroke services, accident and emergency, emergency surgery, trauma and orthopaedics. Since the consultation there has been considerable work carried out in order to ensure the transition of services are made in a safe and sustainable way.

The maternity decision was referred to the Secretary of State by Cumbria County Council’s Health Scrutiny Committee. It was considered by the Independent Reconfiguration Panel (IRP) which gave careful consideration to our decisions around maternity challenges in West Cumbria. Their review endorses the work we are undertaking as a result of the consultation decisions. The CCG has always been – and remains – committed to commissioning consultant-led maternity care if it can be delivered safely and sustainably. The 12 month period for testing the ability to deliver consultant-led maternity services at the West Cumberland Hospital, Whitehaven started in April 2018.
We have also started a new way of working with our community called ‘co-production’ and several working groups have been established. These groups are now working actively to look at the opportunities offered in areas, such as telemedicine, as well as for fresh answers to difficulties in recruiting health care professionals, particularly specialists. Co-production is a valuable way of us tackling our challenges by working together with the community, patients, health professionals, third sector organisations as well as leaders from across the health and social care system. The Working Together Steering Group is focusing on maternity and paediatric services and sits across five smaller working groups, which have been set up around recruitment and retention, children, maternity, community hospitals, stroke services, telemedicine and experience of care at distance. There are three community alliances in areas where inpatient beds are being removed from community hospitals in Alston, Maryport and Wigton. We are working with the Stroke Association and the community as we develop stroke services. We have made good progress so far, however this is an ongoing process and we are really keen to involve more people.

It is clear now more than ever that the NHS is loved and valued by those it serves, and that the future will see greater integration from those organisations within it, a relationship with patients where we all take more responsibility for our health and wellbeing, and one where we work together to ensure our precious resources are used to best effect. A constructive and positive approach towards developing our services sustainably will help ensure that we can encourage more clinical experts to live and work here and we need our community to continue to support us in painting this picture.

In July 2017 it was confirmed that more than £65 million has been awarded to support the development of health facilities in the area meaning we can now pursue plans to develop a cancer centre in Carlisle, the next phase of development at the West Cumberland Hospital and support the development of community services. In January 2018 a new LINAC machine funded by NHS England was formally opened at the Cumberland infirmary. The state of the art technology has been welcomed by the radiotherapy team which will improve patient and staff experience. Our integrated way of working has also been rated as ‘good’ by NHS England.

We are now looking forward to celebrating the 70th birthday of the NHS in July 2018 and celebrating the achievements of our staff and teams who consistently go above and beyond to deliver care and compassion to our patients.

We are in challenging times and there is much more to be done, but work to integrate our health and care services across North Cumbria is developing, and there is national confidence in our plans and our ability to deliver them.

Our focus remains – to commission the best possible healthcare and outcomes for the population of North Cumbria.

David Rogers
Interim Accountable Officer/Medical Director
Who are we?

NHS North Cumbria Clinical Commissioning Group (CCG) has a registered population of 323,000 and this includes patients who are resident in Scotland and Northumberland but are registered with a North Cumbria GP Practice. The CCG is characterised by a higher than average proportion of the population living in rural communities. Population density is therefore very low. The Eden Valley has the lowest population density of any Local Authority in England, with just 24 people per square km. (This compares, for example, to Islington with 13,875 people per square km.). Our west coast communities are geographically relatively isolated, and there are significant pockets of economic deprivation. These issues present major challenges for our health services in terms of delivery and recruitment/retention of staff.

The CCG has a total of 40 member Practices, serving populations between just 800, to over 36,000 registered patients.

Out of hours primary care is provided by Cumbria Health on Call (CHOC).

North Cumbria is served by three main NHS Trusts:

- **Cumbria Partnership NHS Foundation Trust (CPFT)** delivers community services, including community hospitals, mental health and learning disability services, and some specialist services including neurology and diabetes

- **North Cumbria University Hospitals NHS Trust (NCUHT)** provides secondary care services from Cumberland Infirmary Carlisle and the West Cumberland Hospital, as well as some outpatient services delivered in community hospitals and the birthing unit at Penrith Community Hospital

- **North West Ambulance Service NHS Trust (NWAS)** delivers Paramedic Emergency Services, Patient Transport Services, and NHS 111.

For the North Cumbria population there are significant patient flows to a number of Trusts in the North East, particularly Newcastle Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust, Gateshead Health NHS Foundation Trust and South Tees Hospitals NHS Foundation Trust.
What we want to achieve and the risks that could affect it

The CCG’s vision, purpose and objectives (below) have now been refreshed to better reflect the CCG’s position within the wider system.

They reflect the continuing significant change and challenge the CCG faces in line with other CCGs and NHS bodies.

Our Vision
Better Health and best Care for the people of North Cumbria – Delivered Safely and Sustainably

Our Purpose
We work to understand health care needs; we work with local people, communities and partners to improve health, to commission appropriate services and to develop general practice; we monitor the quality of services as provided and foster their improvement; we play our part as a local NHS leader.

Our Four Objectives

1. Support continuous quality improvement within existing services including General Practice
   Quality = experience, effectiveness, safety

2. Commission a range of health services, including an increasing range of integrated services, appropriate to our population’s needs
   Including a clear system financial and performance plan

3. Develop our system leadership role (in the context of an integrated health and care system) and our effectiveness as a partner
   Working with our partners including Morecambe Bay CCG, Cumbria County Council, NHS England and our STP partners in North Cumbria and the North East

4. Continuously improve our organisation and support our staff to excel

We are here to make a real difference to people’s lives. Firstly this is about making a difference by improving the health and wellbeing of individuals and their families. In particular it is about taking serious action to reduce the inequalities in health that exist between different communities across north Cumbria.

We want to add years to peoples’ lives, and quality of life to these extra years.

Making a difference to people’s lives also includes improving the day to day experience of patients and those working to deliver better healthcare. Working for the health service in north Cumbria should be a privilege and a source of pride. We want this to be true for all our colleagues, as we recognise that quite simply people who are happy in their jobs provide better care.
Our most important NHS resource is our staff who, despite recruitment difficulties and increasing demand, have been able to continue to improve services through their hard work and diligence.

As part of our organisation’s commitment to continuous improvement we have agreed values and behaviours across the organisation covering how we act towards each other, our colleagues and the wider community. The values are as follows and are embedded as part of our organisation behaviours:

Our Values

Kindness: we always remember we are here for our community

Fairness: we are accountable, honest and inclusive

Ambition: we never stop improving

Spirit: we are energetic, resourceful and determined

Colleagues from CPFT initially developed the values and Behaviours. Following staff engagement across the CCG, we as an organisation have adopted them (with some amendments and the permission of CPFT).

North Cumbria Health & Care System

In 2017/18 we saw the continued development of The North Cumbria Integrated Health and Care System. This system is made up of health and care commissioners and providers – Cumbria Partnership NHS Foundation Trust, NHS England, North Cumbria Clinical Commissioning Group, North Cumbria University Hospitals NHS Trust, NHS Improvement, North West Ambulance Service, primary care – working in partnership with Cumbria County Council and third sector organisations.

This integrated approach to health and care will see much closer working between organisations for the benefit of the local communities we collectively serve.

How will integrated systems improve care?

Integrated Care Systems are key to achieving sustainable improvements in health and care by:

- creating more robust cross-organisational arrangements to tackle the systemic challenges facing the NHS;
- supporting population health management approaches that facilitate the integration of services focused on populations that are at risk of developing acute illness and hospitalisation;
- delivering more care through re-designed community-based and homebased services, including in partnership with social care, the voluntary and community sector; and
- allowing systems to take collective responsibility for financial and operational performance and health outcomes.
What does that mean in practice?

Patients should see more joined up care, and staff should find it easier to work with colleagues from other organisations to deliver the best outcomes for patients and local communities. By working alongside councils, and drawing on the expertise of others such as our third sector organisations, local charities and community groups, the NHS can help people to live healthier lives for longer, tackle variations in outcomes and support people who are at greatest risk of admission to hospital.

Integrated care system leaders gain greater freedoms to manage the operational and financial performance of services in their area.

It moves the focus from individual organisations to the wider system – working for the best health and wellbeing outcomes for our local communities. Work will continue throughout 2018/19.

Performance Analysis

Measuring our performance against national and local priorities helps ensure our services are being delivered to a high quality standard and provide value for money.

NHS North Cumbria CCG monitors the performance of its local healthcare providers to ensure that:

- Local people receive good quality care. There are processes in place to measure quality of care under three domains: Patient Safety (including infection prevention and control and clinical incident reporting), Patient Experience and Clinical Effectiveness (including how providers of care ensure they are providing the most clinically effective care).

- Patient rights under the NHS constitution are being promoted. These include: waiting times for A&E, cancer treatment, elective surgery and ambulance calls; mixed-sex accommodation breaches and the mental health care programme approach.

We also work with partners in Cumbria County Council to promote good quality Social Care.

Performance Measures

One of the primary aims of the NHS Constitution, and the associated service standards, is to set out clearly what patients, the public and staff can expect from the NHS. The CCG aims to ensure compliance with the constitution and its standards in the services it commissions from providers such as hospitals, community services and ambulance services.

At the end of March 2018 the CCG had achieved the standards in ten of the key national measures. Although many of the pressures experienced nationally have also impacted in North Cumbria, there has been an improvement in delivery of the standards which places the CCG in a stronger position at the end of the year than it was a year ago.

Diagrams 1 and 2, over the page, indicate how well the CCG is achieving the national standards.
Diagram 1. Referral to Treatment Time (RTT) standards for elective care, and Cancer waiting times.

NHS Constitution Rights and Pledges 2017 – 18 CCG Aggregate Performance
Referral to Treatment Times (February 2018): Cancer Waiting Times (Quarter 4 2017 – 2018)

- RTT – Incomplete Pathways
- Cancer 62 Day Waits – Screening Referral
- Cancer 62 Day Waits – GP Referral
- Cancer 31 Day Waits – Radiotherapy
- Cancer 31 Day Waits – Anti-Cancer Drugs
- Cancer 31 Day Waits – Surgery
- RTT – 52 Wk Waits
- RTT – Diagnostic 6wk Waits
- Cancer – 2WW – GP Referrals
- Cancer – 2WW – Breast Symptoms
- Cancer 31 Day Waits – 1st Treatment

Abbreviations:
- RTT – Referral to Treatment (waiting times),
- 2WW – 2 week wait,
- 52 Wk – 52 week,
- 6Wk – 6 week

Green = Achieving Target
Light Red = Underachieving against Target
Red = Failing against Target

Diagram 2. Cancelled operations, mixed sex accommodation breaches, ambulance standards, Accident and Emergency, and Dementia and Psychiatric access.

NHS Constitution Rights and Pledges 2017 – 18 CCG Aggregate Performance
A&E, EMSA and cancelled operations (YTD 2017 –18); CPA (Quater 4), Ambulance response time (March 2018)

- A&E 4hr Waits
- Cancellation Ops – 2nd Cancellations
- Cancellation Ops – Not Offered Within 28 days
- EMSA Breaches
- CPA 7 Day Follow-up
- Ambulance handovers
- Ambulance Response Times – Cat 4 90th percentile
- Ambulance Response Times – Cat 3 90th percentile
- Ambulance Response Times – Cat 2 average time
- Ambulance Response Times – Cat 1 90th percentile
- Ambulance Response Times – Cat 2 90th percentile
- Ambulance Response Times – Cat 1 average time

Abbreviations:

Green = Achieving Target
Light Red = Underachieving against Target
Red = Failing against Target
Areas for improvement and what the CCG is doing about them:

The NHS standards measure specific points within the health system, including:

- Accessing cancer services;
- Urgent and emergency care services;
- Access for elective care;
- Access to Psychological Therapies.

Although each area has shown some improvement during some, or all of, 2017/18, there remains further work to secure the standards.

Cancer access at North Cumbria University Hospitals NHS Trust (NCUHT) has been a priority focus area, and the region was rewarded for its significant programme of work in this area when it achieved the required standards in Quarter 4 2017/18. However, the ability to meet these constitutional standards remains a challenge as we continue to experience operational and capacity issues within the health economy, namely the significant challenge of recruiting suitable medical and consultant staff.

As we turn towards meeting the 28 day Faster Diagnosis Standard we aim to consistently achieve the required standards and will continue to work closely with our partners, including the Northern Cancer Alliance, to optimise cancer pathways and patient experience, whilst also ensuring that North Cumbria is an integral part of the planning and delivery of Cancer services in the North East and Cumbria.

Urgent and Emergency care has experienced high levels of pressure across the whole country, and North Cumbria has been no exception, with increasing numbers of patients attending A&E or admitted as urgent or emergency cases. Work to address the challenges being experienced in urgent care services continue, including:

- Prevention admissions that can be managed outside hospital;
- Improved discharge of patients when medically fit;
- Minimising delays within hospital (for example awaiting diagnostic tests and results);
- Reducing delays at point of discharge (for example transport or medication delays).

Despite NCUHT not achieving the 95% A&E four hour waiting time standard, it has performed better than the national average for most of the year, reflecting the very significant system reforms that are being introduced under the auspices of the A&E Delivery Board. In particular, the volume of patients who had their discharge delayed whilst waiting for care assessment and packages has dropped significantly in the year (to March 2018).

Whilst NCUHT achieved the required standard of 92% of elective care treatments being completed within the 18 week timeframe, in the earlier part of the year, capacity limitations within three key specialties (Orthopaedics, Ophthalmology, and Dermatology) have adversely impacted on the standard in the later part of 2017/18. Additionally all Trusts were required to prioritise urgent care patients over Christmas and New Year and this has further impacted on the ability to treat routine elective patients within the 18 week standard. The pressures of the urgent care system have led to cancellations of elective care cases where beds have had to be utilised for emergency admissions. However, cancellations of urgent and cancer cases are kept to an absolute minimum at all times.

Diagnostic Access within six weeks of referral has improved significantly through the year, although there have been issues at times with shortages of capacity for endoscopies.

Improved Access to Psychological Services (IAPT) – although the CCG meets the standards for access to IAPT services within 18 weeks and for recovery rates, capacity issues within the service means that there have been difficulties in providing the required six week access to services. Plans are in place, however, to allow this to be achieved for the coming year.

Dementia Diagnosis is an area where the CCG is working to improve its standard and although diagnosis rates have been lower than required through 2017/18, the plan is for the national standard to be met in 2018/19.
Clinical Priorities

The CCG is currently part way through a major transformation programme focussed on the NHS six clinical priorities of:

- Cancer
- Mental Health
- Dementia
- Diabetes
- Learning Difficulties
- Maternity

Details of performance in these areas are routinely published through the national ‘My NHS’ website. Since April 2016, NHS England has used the Improvement and Assessment Framework (IAF) to assess the wider performance of all CCGs in England. This framework provides a greater focus on assisting improvement alongside the statutory assessment functions with the aim of stimulating change and improvement in a number of key areas. It plays an important part in the delivery of the NHS Five Year Forward View.

The IAF has been constructed to cover indicators located in four domains:

- Better Health: this section looks at how the CCG is contributing towards improving the health and wellbeing of its population;
- Better Care: this principally focuses on care redesign, performance of constitutional standards, and outcomes, including in important clinical priority areas;
- Sustainability: this section looks at how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends;
- Leadership: this domain assesses the quality of the CCGs leadership, the quality of its plans, how the CCG works with its partners, and the governance arrangements that the CCG has in place to ensure it acts with probity, for example in managing conflicts of interest.

NHS England publishes an IAF Dashboard which assesses all CCG according to a nationally benchmarked position. In the latest IAF Dashboard, published in April 2018, North Cumbria CCG performed in the best quartile nationally in 11 indicators, and required improvement in eight indicators.

The CCG performed in the best quartile nationally in the following indicators:

**Better Health**

- People with diabetes diagnosed less than a year who attend a structured education course (20th out of 207); Rated Outstanding.
- The number of falls in people aged 65 years and over (43rd out of 207).

**Better Care**

- Provision of High Quality Care: Primary Medical Services (3rd out of 207 based on CQC ratings);
- Provision of High Quality Care: Adult Social Care (39th out of 207 based on CQC ratings);
- People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral (16th out of 207);
- Neonatal mortality and stillbirths (12th out of 207 based on MBRRACE Report of 2015);
- Experience of Maternity Services (17th out of 207 based on CQC survey data from 2017);
- Hospital bed use following an emergency admission (37th out of 207);
- Patient Experience of GP Services (41st out of 207 based on GP patient Survey);
- Primary Care Workforce (17th out of 207 based on GP workforce datasets).
The CCG required improvement in the following indicators:

**Better Health**

- **Anti-microbial prescribing:** Appropriate prescribing of antibiotics in primary care fell below the standard required (194th out of 207).

**Better Care**

- **Cancer** - one year survival rates (175th out of 207) based on 2015 data. More recent data shows improvement;
- **Cancer** - Patient experience of care – (157th out of 2107, based on National Cancer Patient Experience Survey 2016 data);
- Reliance on specialist inpatient care for people with a **learning disability** and/or **autism** (176th out of 207, based on NHS Digital Assuring Transformation Data);
- **Delayed transfers of care** per 100,000 population. (207th out of 207). Recent improvements have been made, especially to social care delays, and delayed transfers continue to be a key priority of the health and care system-wide A&E Delivery Board;
- **Eighteen week wait from Referral to Treatment** (162nd out of 207). Capacity pressures, especially over winter, have impacted on this standard.

**Leadership**

- **Staff engagement** index (171st out of 207, based on NHS staff survey). This data related to the former NHS Cumbria CCG, and provisional data for the new North Cumbria organisation indicates an improvement;
- Effectiveness of **working relationships in the local system** (202nd out of 207), based on NHS England CCG Stakeholder Survey 2016/17 - This data related to the former NHS Cumbria CCG.

Continued Improvement in our worst performing indicators is being addressed primarily through system-wide plans with our partners across health and social care, and this has been demonstrated in a number of the areas that are already showing improvement.
Financial Information

2017/18 was the first year for NHS North Cumbria CCG following the boundary change on 1 April 2017 and this report covers the year ending 31 March 2018. As a consequence the CCG’s resource allocation decreased in 2017/18 by £290m to reflect the reduced level of expenditure associated with the change (associated £4.265m decrease in revenue administration allocation). The CCG was approved, by NHS England (NHSE), under delegated commissioning arrangements to assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2017 which resulted in additional £46.5m resource allocation in 2017/18.

As with the previous four years as NHS Cumbria CCG, 2017/18 continued to be challenging as a result of continued pressures on both health and social care funding. NHS North Cumbria CCG has reported a small in-year deficit for 2017/18, although the level of financial challenge was recognised with the CCG agreeing a planned deficit with NHSE.

The CCG has a range of statutory and operational duties and the CCG’s performance against these are shown in the chart below:

**Financial Duties**
- The CCG achieved an in-year financial deficit of £337k which is consistent with the plan agreed by NHSE adjusted for NHSE business rules. This compares to a “like for like” deficit of £6.9 million in 2016/17 and as a consequence of this improvement the CCG was removed from formal direction – **Achieved**
- Revenue administration resource use does not exceed the amount specified in Directions – **Achieved**
- Capital resource use does not exceed the amount specified in Directions – **Achieved**

**Operational Duties**
- Manage year-end cash within 1.25% of monthly drawdown – **Achieved**
- Meet the “Better Payment Practice Code” (95%) – **Achieved**

**Statutory Financial Duties**

There are the following statutory (legal) financial duties for CCGs, as follows:

a) **Revenue resource use does not exceed the allocation (Break-even duty)**

This duty requires the CCG to report a surplus position (i.e. to spend less than the allocated funding). Although 2017/18 was a very challenging financial year the CCG achieved a small in-year deficit of £0.337 million alongside historic deficit of £6.898m. This is consistent with the plan agreed by the CCG and NHSE for 2017/18.

b) **Revenue administration resource use does not exceed the amount specified in Directions**

This duty requires the CCG not to spend in excess of its Running Cost allowance. This allocation for 2017/18 was £6.9m, with the CCG spending £6.2m on running costs; the balance was invested in patient care.

c) **Capital resource does use does not exceed the amount specified in Directions**

The CCG received and spent £9k capital resource in 2017/18.

**Administrative Financial Duties**

There are the following administrative financial duties applied to all CCGs in the same way as all other NHS organisations. Although these are not statutory duties, they are important in determining the performance and financial health of the CCG. Therefore performance is monitored internally and externally.

d) **Manage cash within 1.25% of monthly drawdown**

The CCG is required to have a cash balance at the end of the year no greater than 1.25% of the March cash drawdown. The CCG met this requirement.

e) **Better Payment Practice Code (BPPC)**

The BPPC states that 95% of invoices should be paid within 30 days of receipt of goods or a valid invoice (whichever is later). Performance is measured in terms of both numbers of invoices and value of invoices. For 2017/18 the CCG, on average, paid over 99% of invoices by both number and value in compliance with the code.
The accounts have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended).

A full breakdown of our annual accounts is included as Part 3.

How was the money spent in 2017/18?

The CCG works hard to ensure that the revenue allocation it receives is spent wisely, and that it supports the aim of commissioning high quality healthcare whilst ensuring effectiveness and value for money.

The chart below shows how the CCG’s expenditure of £505.2m was spent:

Statement of Going Concern

The CCG’s accounts have been prepared on the going concern basis despite a report to the Secretary of State for Health under section 30 of the Local Audit and Accountability Act 2014 for the breach of financial duties as indicated in note 2 to the accounts which shows the CCG has reported a small deficit of £0.3m in 2017/18.

Public Sector bodies are assumed to be a going concern where the continuation of the provision of services in the future is anticipated. The CCG has been formally notified of its financial allocations for 2018/19 which shows an increase in funding year on year. An NHS body will only have concerns about its going concern status if there is the prospect of services ceasing altogether in the future by itself or another public sector entity. The CCG has not been dissolved and its services continue to be provided.

Conclusion

NHS North Cumbria CCG has experienced a very challenging financial year and, following the Boundary Change, continues to work closely with partners in the North Cumbria health economy to deliver a financially sustainable health and social care system for the area.
Commissioning Activity

General Practice and Primary Care Development

Integrated Care Communities (ICCs) – what is an ICC?

An Integrated Care Community (ICC) works together to improve the overall health and wellbeing of the community. This will be achieved by:

- Joining up health and care services to work better together
- Providing more care out of hospital where possible
- Supporting people to have information about their health conditions

Health and social care professionals, GPs, the voluntary sector and the community will work as one team to support the health and wellbeing of local people.

The North Cumbria area is made up of eight ICCs based on groups of GP practices and their patients. By understanding the challenges that each area faces it is hoped that the community can work together with health and care organisations to improve the health and wellbeing of local people.

With the support of member practices, NHS North Cumbria CCG assumed delegated Level 3 commissioner responsibilities for General Practice from 1 April 2017. The CCG is now discharging these statutory primary medical services functions effectively and an internal audit in January 2018 provided “substantial assurance that the risks identified are managed effectively.”

Map Key

1. Carlisle Healthcare ICC
2. Carlisle Network ICC
3. Carlisle Rural ICC
4. Copeland ICC
5. Eden ICC
6. Keswick and Solway ICC
7. Maryport and Cockermouth ICC
8. Workington ICC

For more information on developments in the north Cumbria ICCs visit: www.northcumbriaccg.nhs.uk/iccs
In April 2016 NHS England produced a five year strategy, the General Practice Forward View. The publication set out a range of initiatives for local and national action supporting General Practice and helping to address the challenging problems that many practices face. As part of the strategy the CCG is now fully engaged in a range of initiatives supporting General Practice. One such initiative surrounds international recruitment of GPs and following a successful application for funding the CCG has been working to support the GP workforce through the recruitment of suitably qualified GPs from abroad.

The CCG continues to focus on ensuring a positive relationship with those member practices engaged with the CCG’s commissioning and performance priorities. A third annual GP conference was held in October 2017 with over 110 GPs in attendance.

General Practice remains at the heart of health care delivered in North Cumbria with GP practices and Cumbria Health on Call (CHoC – our GP Out of Hours Service) continuing to develop services and provide high quality care. The quality of Cumbria’s General Practice remains generally very good, as reflected in Care Quality Commission (CQC) ratings for practices, which show North Cumbria practices having a much higher performance than national averages. CHoC received a CQC rating of “outstanding” in 2017/18, the first time such a rating has been awarded to an out of hours GP provider.

The CCG is ranked 7th in the country for the provision of High Quality Primary Care as calculated by the practices’ CQC ratings and 87.8% of patients reported a good overall experience of GP services putting North Cumbria practices in the best quartile in the country.

The Quality Improvement Scheme (QIS) was established in 2016/17 to allow the CCG to support General Practice in focusing on clinical areas where the CCG believe using local and national data that we can improve the outcomes of care and the experience of patients. The scheme has been well received and was awarded the title of “CCG Innovation of the Year” at the North East Cumbria and Yorkshire and Humber Commissioning Awards 2017. The scheme continues in 2017/18 with revised metrics to reflect changes to national policy, new outlying areas identified by the CCG Improvement and Assurance Framework and Right Care as well as lessons learnt from 2016/17.
Children and Family services

Children and Family Services were an integral part of the Healthcare for the Future consultation. Future services are being developed that are better integrated around the needs of the child and family and reduce the number of children and young people admitted to hospital by:

- integrating services in community settings
- implementing clear care pathways
- providing alternatives to admission

To achieve this, teams are continuing to integrate and there is ongoing further development of:

- Child Health Community Hubs
- Short Stay Paediatric Assessment Units
- A Dedicated Ambulance Vehicle

Continued development of the Child and Adolescent Mental Health Services (CAMHS) service remains a priority with the need to increase the numbers of children and young people getting timely access to specialist mental health services. This continues to be challenging as a result of the rising numbers of children and young people in need of such services.

The Cumbria Local Transformation Plan has been refreshed and continued to secure significant additional funding. This has been used primarily on the priorities of developing Community Eating Disorder Services and services for children and young people experiencing a mental health crisis.

The partnership between the health system and Children’s services in Cumbria County Council continues to strengthen as new systems and practice embed across the multi-agency landscape.

Planning emotional wellbeing and mental health services continues on a whole Cumbria basis, however the ‘cross boundary’ (with respect to the West North East Cumbria and Lancashire & South Cumbria STPs) has resulted in the need for service providers and local authority partners to engage in an increased number of strategic forums with the result that the ‘whole Cumbria’ approach will be kept under review.

Maternity services

Maternity services have been reviewed in Cumbria over a number of years, with work taking place to ensure that services are safe and sustainable. The focus for many has been on the place of birth, however the quality and experience of the whole maternity journey from pre-conception to delivery is essential for the delivery of better health outcomes for mother and baby.

Due to Cumbria’s rurality and isolated geography there are concerns about the sustainability of maternity and interdependent services including obstetrics, paediatrics and anaesthetics.

The Better Births’ recommendations highlight seven key priorities to drive improvement and ensure women and babies receive excellent care wherever they live. Different elements of the recommendations are to be delivered at national, regional and local level.

Achieving this vision requires actions from commissioners and providers working together as well as a range of other local and regional stakeholders, supported by national bodies. The golden thread of improving safety runs through the work and will achieve the Secretary of State’s ambition to reduce the number of still births, neonatal and maternal deaths, and brain injuries by 50% by the Year 2030.

Objectives for 2017 – 2021

- To have safe and sustainable services
- To continuously improve to provide the best services for women and their families
- To work with the Maternity Voices in Partnership to develop services which are truly based around the needs of women
- To have effective partnerships with local staff, the North East Local Maternity Systems, Public Health Commissioners and NHS England Specialised Commissioning to strengthen local provision
To implement the Better Births recommendations in North Cumbria, emphasis is required on:

- The development of small place based midwifery teams to enhance continuity of carer within a network of maternity hubs
- Increasing the choice of birth environment by introducing Alongside Midwifery Led Units (AMLUs)
- Fully developing the use of birth plans as a means to support women to have the birth experience they would choose
- Fully develop the one team/two site/multi-disciplinary approach for maternity
- Co-production/co-design of all elements of service development and provision with women and partners and the community
- Full development and implementation of the safety agenda
- The development of more comprehensive peri-natal mental health services

Mental Health Transformation Programme

The Mental Health Transformation Programme continues to build on the success of 2017 by sustaining the Multi Agency Crisis Assessment Service (MACAS). This is a collaborative approach to supporting people in mental health crisis. Funding has been agreed for the continuation of the Single Point of Access telephone line and the continuation of a community hub in Carlisle called ‘The Lighthouse’ which is operated by MIND and the Glenmore Trust in partnership with other third sector providers. Learning from this has been shared and cascaded to develop the ‘Haven’ a further community hub based in the Lowther Street crisis house in West Cumbria.

The Mental Health Transformation Programme has been aligned to the Mental Health Five Year Forward View Implementation plan. The result has been to establish priorities for delivery across both North Cumbria and Lancashire Sustainability and transformation Plans.
Key areas to deliver for Cumbria in the Five Year Forward View are:

- By 2020/21, there will be increased access to psychological therapies, so that at least 25% of people (or 1.5 million) with common mental health conditions access services each year.
- Will maintain and develop quality in services; including meeting existing access and recovery standards so that 75% of people access treatment within six weeks, 95% within 18 weeks; and at least 50% achieve recovery across the adult age group. Implementing integrated IAPT (Improving Access to Psychological Therapies) for long term conditions management will be a priority.
- By 2020/21, adult community mental health services will provide timely access to evidence-based, person-centred care, which is focused on recovery and integrated with primary and social care and other sectors. This will deliver:
  - At least 60% of people with first episode psychosis starting treatment with a NICE recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral. Redesigned integrated offer for emerging early intervention of psychosis and age appropriate IAPT.
  - A reduction in premature mortality of people living with severe mental illness (SMI); and 280,000 more people having their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.
  - This will be achieved by designing an integrated mental and physical health Primary Care Clinical Model (Kings Fund Collaborative) aiming to improve life expectancy, reduce disability and reduce demand on mental health and acute services.

Key Projects include:

- A doubling in access to individual placement and support (IPS), enabling people with severe mental illness to find and retain employment.
- Increased access to psychological therapies for people of all ages with psychosis bipolar disorder and personality disorder.
- By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission.
- Out of area placements will essentially be eliminated for acute mental health care for adults.

Suicide Prevention:

- By 2020/21, the Five Year Forward View for Mental Health set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2016/17 levels. To support this, the CCG will fully contribute to the development and delivery of local multi-agency suicide prevention plans, together with their local partners.

Other Key Projects include:

- Bed modelling, profiling and consultation for Secondary Care provision.
- Develop a recovery focussed model and service user led principles of recovery to inform commissioning intentions.
- Development of dementia friendly communities and improving early diagnosis and post diagnostic support care for older adults with dementia, to promote independence and recovery and ensure people are cared for in the least restrictive manner.
- Redesigning the 24/7 acute liaison Service to ensure that the CCG has agreed and funded plans in place to aim for a core 24 (24 hours, seven days a week) service by 2020/21.
Multi Agency Crisis Assessment Service (MACAS)

Cumbria Police, the North West Ambulance Service, third sector partners and all health and care services are working together on this programme which enables people in mental health crisis get the right help, at the right time, by the right people.

The pilot of the programme enabled learning across all organisations involved, ensuring that best practice was in place to ensure those in mental health crisis are seen quickly by mental health professionals.

The two year pilot concluded at the end of March 2018 with funding secured to enable most elements of the programme to continue. The pilot was funded through the ‘Home Office Police Innovation Fund’ from Cumbria’s Police and Crime Commissioner’s Office and had four different elements, three of which will now continue:

- A Single Point of Access telephone triage line for Cumbria Police, the North West Ambulance Service, GPs and other NHS and care professionals. This provides immediate access, 24 hours a day, to a mental health professional who is able to look at health records and offer advice at any time.
- The Lighthouse service, provided by Carlisle Eden Mind and the Glenmore Trust, providing out of hours support to those who need it in order to try and prevent a crisis escalating.
- The high quality “s136 suite” will remain which gives a safe environment to those who need to be detained for safety reasons under the Mental Health Act.

The only part of the MACAS pilot that partners are unable to continue funding at the time this report was written are the three assessment beds. This facility allowed a small number of patients to be assessed for up to 72 hours without being detained. These beds will now return to form part of the specialist in-patient ward the Hadrian unit. Patients will still be able to be assessed at Carleton Clinic; however this is not an overnight facility.

For Transforming Care and Learning Disabilities please see the Quality section on page 29.
Urgent Care

NHS North Cumbria CCG worked closely with the whole health and care system during 2017/18. Performance against the four hour A&E standard was relatively good with the system achieving above 90% each month until the end of November 2017. Unfortunately, due to winter pressures performance deteriorated during December 2017 to March 2018 despite implementation of a number of initiatives to support the system. However, this was with the backdrop of a national deterioration in performance of urgent care systems and in comparison to nationally North Cumbria remained in the top third of systems throughout the period. Nevertheless, many patients experienced delays in the emergency departments and in admission where required and the system has worked hard to minimise these now and for the future.

North Cumbria has high levels of delayed transfers of care, a problem experienced nationally but particularly prevalent here. Working with Cumbria County Council the CCG agreed use of part of the Improved Better Care Fund to:

- develop a Hospital to Home service to support patients needing home care support until their home care package could commence.
- commission a number of care home beds to transfer patients no longer needing to stay in hospital but whose final discharge arrangements were not yet complete.

Further work is in progress to continue improvements in 2018/19. However, the largest single challenge to urgent care services remains recruitment of staff with gaps in staffing levels across all areas of care such as medical, nursing and home care support workers. Initiatives are under way as part of the Strategic Transformation Plan to address this.

Elective Care Commissioning

Out Patient Re-design Programme

Work has been on-going with North Cumbria University Hospitals NHS Trust to streamline out-patient services and ensure patients are asked to travel to hospital only if it is absolutely necessary to do so. This includes the introduction of patient initiated follow-ups, telephone consultations and more community based services;

North Cumbria Musculoskeletal Service

In 2017/18, the CCG commissioned additional Extended Scope Physiotherapists (ESP) across North Cumbria to ensure that our population can have access to specialist physiotherapy in community settings. The ESPs work closely with hospital consultants, reducing the need for patients to travel unnecessarily to an acute hospital. We are also continuing to work with General Practice to improve patient direct access to physiotherapy which is widely available across North Cumbria so that patient’s do not need to go to their GP before they can be referred to see a physiotherapist.

Pain Services

During 2017/18, the CCG has further enhanced and consolidated the new Persistent Physical Symptoms Service (PPSS) with an increased capacity for non-invasive care of chronic pain. This brings the CCG into line with best practice care for patients affected by persistent pain as recommended by NICE. Additionally 2017/18 saw the PPSS introduce a service for patients with medically unexplained symptoms who frequently suffer debilitating conditions, but which have not been able to be specifically diagnosed and treated. These patients often need to attend GPs or hospital on a frequent basis and their condition impacts very severely on their quality of life.

Ophthalmology Services

In North Cumbria, re-design work has been on-going across five ophthalmology pathways to ensure that patients are treated at the right place, at the right time by the right person. Community based optomitrists and GPs with special interest in ophthalmology will play key roles in the new pathways for glaucoma and minor eye conditions.
Advice & Guidance

On-line Advice & Guidance, provided by hospital consultants to GPs, was rolled out in 2017/18 and has been successfully adopted across 17 specialities, with 973 consultations resulting in 291 less unnecessary trips to Hospital for patients.

Procedures of Limited Clinical Value

The CCG continues to work with all primary and secondary care providers on ensuring that regional guidelines relating to Procedures of Limited Clinical Value (PLCV) are adhered to.

Cancer

Looking ahead to 2018/19, we have restructured the joint working group for Cancer in North Cumbria to allow for effective focus on our main work streams, ensuring that our patients are fully supported in all stages of their cancer pathway: Prevention and Awareness; Early Diagnosis, Quality and Waiting Times; and Living With and Beyond Cancer.

• Prevention and Awareness

At the front end of the pathway, it is crucial that we ensure our population is educated on signs and symptoms of cancer and that we are supporting them to make informed lifestyle choices to reduce their cancer risk. To this end, we have a task and finish group focused on introducing an appropriate model of care focused on address health inequalities in screening uptake, who will work alongside primary care and the third sector so as to engage with as much of the population as possible. Additionally, we will build upon the work of the bowel screening pilot spearheaded by the Learning Disability team, which focused on supporting people with learning disabilities to make informed choices regarding their cancer screening participation. We also look forward to the launch of the new bowel screening test by NHS England, a move from faecal occult blood testing (FOBT) to faecal immunochemical test (FIT), and rolling this out across North Cumbria, which will coincide with an awareness campaign targeting our most deprived and vulnerable wards.

• Early Diagnosis, Quality and Waiting Times

Following the launch of the new LINAC (linear accelerator), as funded by NHS England in January 2018, we work towards the anticipated introduction of a sister LINAC, for which timelines are to be confirmed and announced. In conjunction with this, we continue to develop plans with all local health partners regarding the build of the new cancer centre in Carlisle and will participate in staff and public engagement events focused on the design of the centre itself.

With the support of the Northern Cancer Alliance funding has been allocated to North Cumbria University Hospitals NHS Trust (NCUHT) to focus on access of cancer services. As part of this, the team at NCUHT will be working across organisations, liaising with primary care, to ensure that our most vulnerable cancer patients have the support and information they need in order to receive the best possible outcomes from their cancer treatment. In addition, further funding has been received from the Northern Cancer Alliance to prioritise implementation and sustainability of nationally agreed rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers, so that we can focus on our strategy to meet the cancer waiting times standards on a consistent basis going forward, which in turn ensures our patients receive the highest quality care possible.

Early diagnosis also remains a core priority for cancer services in North Cumbria and we expect to announce participation on two pilots later this year, of which one which will be focused on improving our pathways for patients with vague symptoms, and the other will focus on working with primary care pilot to improve diagnostics for patients with suspected colorectal cancer. Both of these pilots are expected to have a significant impact on our ability to diagnose cancers earlier, for the benefit of our cancer patients.
• **Living With and Beyond Cancer**
  The number of cancer survivors continues to increase because of both advances in early detection and treatment and the aging and growth of the population. With the support of the Northern Cancer Alliance and third sector partners, North Cumbria will be focusing on how best to provide support to our cancer survivors. This includes the introduction of health and wellbeing events and holistic needs assessments, for which funding has been allocated to identify the most appropriate and effective model of care. For this, we look to harnessing the third sector and coordinate pathways between primary and secondary care at the end of treatment. We will also work with the acute hospital to implement the risk stratified follow up model, firstly with the breast service by the end of March 2019, before replicating this across additional pathways.

**Next Steps**
The CCG Commissioning Team have been actively involved in developing STP business cases in partnership with local health and social care organisations, including areas consulted upon as part of the Success Regime work. Areas that continue to be under development currently include the Hyper Acute Stroke Unit, Early Supported Stroke Discharge and Neuro-rehabilitation services, Respiratory Pathways, Long Term Conditions, Persistent Pain Services and Diabetes pathways. Early scoping work has commenced in relation to the potential to design and commission a local Tier 3 Weight Management programme, in partnership with the Local Authority and local providers as part of the end to end weight management/bariatric pathway for North Cumbria.

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**Cumbria Learning and Improvement Collaborative (CLIC)**
CLIC brings together everyone working in health and social care in Cumbria, including people who use services, to devise a joint way to talk, think, learn and practice leadership and continuous improvement. For further information please visit [www.theclic.org.uk](http://www.theclic.org.uk)

**Education and Learning**
Over the last year, The Clinical Skills Team have gained national recognition for ‘Cross-sector Training’, collecting an HPMA (Healthcare People Management Association) award. CLIC brings together health and care workers from all of North Cumbria’s hospitals, community services, primary care and private care providers to offer training.

The programme brought staff together to learn; build new networks and standardised high quality training. Staff learnt alongside colleagues from other organisations, shared different experiences, and reflected on practice.

Following the success of a training programme for registered nurses, CLIC’s project provided the opportunity to deliver free clinical skill awareness workshops for all non-registered health and care support workers across the independent sector and NHS. It brought staff together from different organisations to share expertise, build networks, problem solve and build confidence.

Phase 2 of the Clinical Skills project came to a close at the end of June, with a few further SAGE & THYME workshops (Communication Skills Training) running until the end of the year. The Clinical Skills Phase 3 programme has begun to emerge, bringing together a joint central Clinical Skills team across North Cumbria University Hospitals NHS Trust (NCUHT) and Cumbria Partnership NHS Foundation Trust (CPFT). The new programme will focus initially on clinical skills prioritised across the system to facilitate patient discharge and prevent admissions where possible. Phase 3 steering and reference groups are currently being developed, to ensure good governance and adopt the learning from Phase 1 and Phase 2.
Cumbria Production System

Over the last year the CLIC team have led a number of Rapid Process Improvement Workshops within both NCUHT and CPFT including Larch A and B wards, Clozaril prescribing, Information Governance and A&E. All workshops have resulted in a number of improvements that have been sustained. Three bespoke Improvement Leader programmes for senior nurses were developed and delivered and have proved very popular with requests for further programmes which will run into next year. The CPFT “Listening into Action” Waves 5 and 6 were supported by the team and included system wide schemes in both the south and north of the county. A new system wide “Engaging for Improvement” programme was launched in October with further waves in January for NCUHT. CLIC presented two annual awards for continuous service improvement to two very deserving teams – the Ward 4 team at West Cumberland Hospital who have made considerable improvements to pressure area care and to an improvement scheme to support parents of children with cow’s milk allergy.

Leadership

The CLIC strategy has been refreshed to be more aligned to the System. The strategy has been built around the six principles of creating high performing teams (from Michael West). These are:

• Sharing and keeping alive the vision for the team
• Ensuring there are clear and challenging objectives set for each person that align with the vision
• Ensuring there are fair and robust processes for the team to work with that engage the team in decision making
• Enable the team to work well as a “real” team
• Use continuous improvement methods as a way of leading
• Underpinning all the above is a values driven environment

CLIC has been working with the Health Foundation Innovation award since January to deliver the Relational coordination project. The clinical pathways being surveyed as part of this are the Multi Agency Crisis Assessment Service, Mental health and Chemotherapy service in NCUHT. Both pathways have completed their surveys and are working on improvements identified.

Work continues with the ICC’s to support team development and change for leaders. The focus has been on the Coordination Hub set up in the first six months and now under development.

CLIC are working with the NHS Leadership Academy Graduate training scheme supporting Action Learning sets with the current intake.

Statutory Duties

CCGs are required to discharge a number of statutory duties (the “must dos”) as outlined in the Health and Social Care Act 2012. The following is an overview of how NHS North Cumbria CCG has delivered against each of these duties.

Sustainable Development

Sustainability is about the effective use of natural resources and behaving in a way that manages and minimises the impact we have on our environment. It requires us to pay particular attention to energy, travel, waste, procurement, water, infrastructure and buildings. As a commissioner of healthcare services and as an employer the CCG recognises the need to minimise our impact on the environment. Use of technical solutions for meetings (i.e. video/teleconferencing and webinars) are promoted to reduce travel across the county, which in turn reduces the CCG’S carbon footprint.

The two CCG office buildings are owned by NHS Property Services. The CCG works with NHS Property Services to ensure plans to reduce the carbon footprint are in line with the recommendations of the Sustainability Development Unit of NHS England.
Improve Quality – 14Z15 (2) (a)

In line with its statutory duties NHS North Cumbria CCG has maintained a significant focus on continuous improvement in the quality of services provided to its population during 2017/18. The CCG Improvement and Assessment Framework, including the six clinical priorities introduced by NHS England in 2016/17, was one of the key tools that underpinned the CCGs priorities and approach to service quality improvements. In particular on important clinical areas, to ensure that patients were accessing high quality, timely services. Areas included cancer, mental health, and learning disability, maternity and primary medical care.

The CCG uses a model for quality which includes the three domains of quality in High Quality Care for All in 2008 following the NHS Next Stage review led by Lord Darzi.

Our commitment to quality during 2017/18 has been developed and refocused with additional staff, expertise and experience in quality improvement and patient safety work. There has been a review of the Outcomes and Quality Assurance Committee membership and an agreement to develop a Quality Strategy for 2018/19 to support the developing ‘Integrated Health Care Partnership’. This will ensure a cohesive and joined up approach to quality improvement and assurance across the health and social care partnership.

The Outcomes and Quality Assurance Committee has provided assurance to the Governing Body on the quality of services commissioned and aimed to promote a culture of continuous improvement with respect to the safety of services, clinical effectiveness and patient experience to the Governing Body.

The Outcomes and Quality Assurance Committee has held providers to account and sought comprehensive assurance regarding the quality and safety of commissioned services via:

- Monthly overview report of provider quality (QRGs) including details about performance of providers against key quality indicators and details of Sis, Never Events and complaints
- SIRMs reports from Primary Care about their patient’s experiences of pathways of care through different services.
- Feedback from the Quality Surveillance Group (QSG)
- Reports on CCG/primary care progress and compliance with regards to infection prevention control (IPC) and the assurance framework
- Reports on the CCGs progress against the NHS England QIPP target for continuing healthcare (CHC) and contribution to the National Collaborative work
- Reports regarding care homes to provide assurance on the systems and processes in place across the health and social community

The review of providers quality reports has been a key element of the Committees monthly discussions and key areas have included:

- Performance against the national cancer standards and 28 day cancelled ops standards
- Progress against MRSA, Clostridium difficile (C.Diff) and GNBSI (Gram negative blood stream infections) targets
- Patient Safety aspects of care including mortality rates, harm free care, never events and serious incidents
- Updates on progress against the Commissioning for Quality and Innovation (CQUIN) and quality schedule indicators

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Care Home Sector

The CCG have developed a framework and information flow for monitoring the quality of care within the Care Home Sector. Quality visits are carried out, prioritising those homes that are under direction. An ‘Early Indicators’ meeting is held in North Cumbria where soft intelligence and audit information is brought together to identify providers who might be having difficulty so that support can be offered early. There is also a CCG led care home collaborative, which prepares our team for the emerging Enhanced Care Home Framework. This is an area where we work closely with our colleagues in social care to try to influence and drive change for improvement.

Healthcare Acquired Infections

NHS North Cumbria CCG continues to work with their colleagues in infection prevention, medicines management and health protection across the CCG’s health and social care economy to reduce healthcare acquired infection and improve quality of care. The teams are collaboratively working towards a ‘Cumbria Health and Social Care Economy Gram-negative Blood Stream Infection Improvement Plan’. The plan is based on the following national goals:

- To reduce healthcare associated Gram-negative Bloodstream Infections by 50% by March 2021.
- To reduce E.coli bloodstream infections by 10% in year 1 (2017/2018)

Clostridium Difficile Infections (CDI), MRSA and Escherichia coli (E. coli) blood infections are subject to national performance trajectories and are monitored continuously (Table I).

Continuing Healthcare

NHS Continuing Healthcare is the name given to a package of care that is arranged and funded solely by the NHS for individuals with long-term complex health needs, who are not in hospital but have been assessed as having a primary health need.

People of North Cumbria who have continuing healthcare needs, are supported by a joint CCG/NECS (North of England Commissioning Support) team of commissioners and professionals, who work together to ensure that the needs of this vulnerable group are met; in nursing homes, care homes and in their own homes. There has been a need to fine tune the ways of working in this service over the past year, and we have developed updated policies, a new Governance structure, and an ‘end to end’ process, which will improve how we help patients and their families navigate through this form of support in the future.

Transforming Care

Transforming care is all about improving health and care services so that more people can live in the community, with the right support, and close to home. This will mean that fewer people will need to go into hospital for their care.

The Adult Care and Treatment Review (CTR) process was reviewed throughout 2017 and is well embedded across North Cumbria. All adults with a learning disability and/or autism are reviewed through this process. The case is reported weekly to NHS England. All cases that require extra support are discussed in a weekly multi-agency call and recorded on a dynamic support register which will continue to inform national data collection throughout 2018. Currently North Cumbria and the North East are on target to meet the Transforming Care trajectories for people being supported out of hospital beds and into community placements.

An innovative project to pilot an enhanced community model in North Cumbria, maximising on existing resources in order to prevent unnecessary admissions and support people at home in a time of crisis, was successful in gaining funding and implementation will take place throughout 2018.

Intense multi-agency collaborative work has been undertaken to target those individuals who, due to the complex nature of the packages they require, are currently unnecessarily in a hospital bed. This has already facilitated successful discharges from long stay placements and repatriations which will continue throughout 2018.
The Cumbria Transforming Care Hub which has developed from the Cumbria Local Implementation Group is now well embedded and will lead and provide governance for local processes, challenges and innovations across NHS North Cumbria CCG, Cumbria County Council and local providers throughout 2018. NHS North Cumbria CCG continues to be well represented at a regional level, reporting from the Hub to the North Cumbria and North East Transformation Board and Executive Strategy Group. The Cumbrian LeDeR (Learning Disability Mortality Review Programme) steering group is now established and will, during 2018/19, work into the regional and national groups looking at the prevention of early and unavoidable mortality for those people with a learning disability. The CCG is also represented within the North West Hub in order to maintain alignment and equity across Cumbria for our entire population.

Safeguarding and Children Looked After (CLA)
The CCG has in place effective governance and accountability arrangements to fulfil its statutory duties of cooperation and best practice in relation to safeguarding. This includes the Annual Safeguarding and CLA Updates and Stocktake Reports to the Quality and Outcomes Assurance Committee and Governing Body. The CCG has outlined its priorities and key areas of focus in the 2015/16-2018/19 Safeguarding Strategy.

The CCG submits a comprehensive annual Safeguarding Self-Assessment to provide assurance of its arrangements to NHS England and resulting actions plans are also reported to the Quality and Outcomes Assurance Committee.

The Internal Audit Report completed as part of the audit cycle in the CCG provided good assurance of safeguarding governance, risk management and control arrangements that were managing risks effectively.

Following the CCG Boundary Change in March 2017, the Designated Leads for Safeguarding in NHS North Cumbria CCG and NHS Morecambe Bay CCG, have worked collaboratively to ensure leadership and engagement across the Cumbria wide safeguarding system.

The Named GP has provided ongoing advice and leadership to primary care and the CCG in support of achieving their safeguarding duties and responsibilities.

The CCG continues to make a significant contribution to the work of the Local Safeguarding Children’s Board and Cumbria Adult Safeguarding Board.

The statutory Health and Wellbeing Board with responsibility for safeguarding includes CCG representation.

As both a local leader in commissioning health care services for the population of North Cumbria and as an employer the CCG has issued the a formal statement in respect of its commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practices.

For Children Looked After the CCG has continued to take a lead role in coordinating service improvements across the health system through the Children Looked After Health Group to improve health outcomes: this group now reports directly into the Corporate Parenting Board.

As both a local leader in commissioning health care services for the population of North Cumbria and as an employer, the CCG has issued a formal statement in respect of its commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practices.

During 2017/18 the Safeguarding Leads have:

- Issued best practice guidance for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) for use in Primary Care.
- Issued a new PREVENT policy for CCG staff.
- Revised the General Practice protocols for Children’s and Adults’ Safeguarding.

14Z15 (2) (b) – CCG’s must contribute to the joint Health and wellbeing Strategy

The Cumbria Health and Wellbeing Board is designed to enable partner organisations to work collectively to improve health and wellbeing, and to reduce health inequalities. During 2017/18 the Board was chaired by the Leader of Cumbria County Council. The NHS North Cumbria CCG Chair fulfilled the role of Vice Chair for the Board during the year.

NHS North Cumbria CCG plays a full role in the Board, and has worked collaboratively to support the delivery of the annual Delivery Plan for the year as part of the 2016 – 19 Joint Health and Wellbeing Strategy. During 2017/18 the Health and Wealth Being Board has provided strategic leadership to a range of key developments, including:
• The development of the North Cumbria Integrated Health and Care System, including the vision, aims, objectives, transformation programmes and governance

• Identifying key priorities for 2018/19 and the longer term, focused on developing a new approach to population health management as a key feature of our Integrated health and Care System

• Specific pathway and performance challenges, including focussed work on reducing Delayed transfers of Care and making improvements to the urgent care system across health and social care

• Ensuring the effectiveness of the Better Care Fund, and overseeing the development of the Improved Better Care Fund as part of the Board’s assurance function

In 2018/19 the Board will provide continued leadership to these areas, and will ensure an effective response to Care Quality Commission System Review, which is anticipated to be published in May 2018.

14Z2 – Patient and Public Involvement
(Engaging people and communities)

The CCG is committed to involving our community in shaping services and encourage people to work with us and share ideas.

For more information visit: www.northcumbriaccg.nhs.uk/you

This web page has been developed so all members of the community, patients and carers can find out in one click from the home page how to get involved.

You can also e-mail: enquiries@northcumbriaccg.uk

How we make decisions and involve the public

The CCG follows government policy, gathers information from patients, health professionals, partners across the health & social care system and third sector organisations to ensure that it commissions the right healthcare, in the right place, at the right time.

The CCG’s Governing Body is our main decision-making forum and is made up of twelve Members, six of whom are non-officer Members which means they are not permanent post holders of the CCG but have put themselves forward for these roles because they are interested members of our communities.

They are there to provide effective challenge to the decision making process and, along with the other Governing Body Members, ensure the Governing Body carries out the functions conferred on it by national legislation together with any other functions which may be specified in regulations or in the CCG’s Constitution.

Denise Leslie is the Lay Member for Patient & Public Engagement with a remit to ensure that the CCG engages with its patients and its communities. In addition Healthwatch Cumbria and the Local Medical Committee are invited to attend all Governing Body and Primary Care Committee meetings and have observer status. This enables them to provide feedback from the public and GP perspectives during debates.

The public are invited to attend our Governing Body meetings, which are always held in public and are invited to ask questions at the start and end of each meeting. We are committed to patient and public involvement.

Details of Governing Body Members, the GP Leadership Team, the Senior Management Team as well as meeting dates, agendas and minutes, the Constitution, Standing Orders and Terms of Reference can be found at: www.northcumbriaccg.nhs.uk/gb

Healthcare for the Future Public Consultation – Next steps and updates on decisions

Since the consultation here has been considerable work in order to assure the transition of services made in a safe and sustainable way. The service changes consulted on were maternity, paediatrics, community hospitals, stroke services, accident and emergency and emergency surgery, trauma and orthopaedics.

The decisions were made at a meeting in public by NHS Cumbria Clinical Commissioning Group’s (CCG) Governing Body on 8 March 2017 in Workington.

Progress has been made by health and care providers and commissioners across North Cumbria and monitored by NHS North Cumbria CCG. The decisions from the consultation led to a co-production approach to working going forward. The focus of the work around co-production has been in the areas where we made decisions following the Healthcare for the Future consultation.
These are the areas that the CCG consulted on:

**Accident and Emergency**
The decision to continue 24/7 A&E at West Cumberland Hospital has been supported by the development of an award winning composite workforce model. The composite workforce model means traditional non-training junior and middle grade medical roles can be replaced by suitably trained and experienced clinicians from a variety of clinical backgrounds. The roles include advanced clinical practitioners, academic fellows, GP trainees and physician associates. This strengthens the acute medicine service, which supports emergency care. The model won the ‘Innovation in HR’ award at the 2017 HPMA (Healthcare People Management Association) awards.

**Community Hospitals**
The decision to close inpatient beds at Alston, Maryport and Wigton have seen the development of Community Alliances bringing the community, front line health staff and health leaders together to look at the population need and develop plans for new services to support those communities. Since the decision was made, it has also provided an opportunity to help shape services to support communities in alternative ways. This has meant the NHS, social care, third sector, primary care and community members sitting together to assess the needs of that community and consider alternative provision, especially for frail elderly and palliative care cases that should be offered care close to home. These community alliances have also considered the care and treatment of people in these areas, the amount of travel from those communities to treatment appointments and develop plans to bring some closer to home. There will be a phased approach between April – October 2018 to close the medical beds at these sites.

**Emergency Surgery, Trauma and Orthopaedics**
The Governing Body confirmed the decision on safety grounds in 2013 to centralise emergency surgery, trauma and orthopaedics. We have however agreed with the Trust that some of the more minor procedures can and have been returned to West Cumberland Hospital. In addition to this there has been an expansion of the elective surgery available at the West Cumberland Hospital site.

**Hyper Acute Stroke Unit**
The decision to develop a hyper acute stroke unit (HASU) at the Cumberland Infirmary in Carlisle (CIC) to provide treatment from a specialist team 24/7, which is a change from 5 day services at both West Cumberland Hospital and CIC. This will see better outcomes for our population with work continuing to develop a service that works for the whole of North Cumbria. The development of a HASU at the Cumberland Infirmary will mean all potential stroke patients are initially brought to the unit at Carlisle where they will have access to a specialist stroke team made up of consultants, nurses and therapists 24 hours a day, 7 days a week. Admission to this unit is likely to be for a maximum of 72 hours at which point the patient will be discharged home, or if they need more support and are from West Cumbria can be transferred to the West Cumberland Hospital. Patients from the north of the county requiring extra support will remain in Carlisle. Considerable work has been done alongside the work to develop a HASU to ensure that robust early supported stroke discharge (ESSD) teams support patients home, or closer to home, more quickly. This is in line with national best practice. Access and treatment at a HASU in its own right improves mortality (death rate) and long term ability to a far greater extent than traditional models.

**Maternity**
The decision to test the sustainability of consultant led maternity at West Cumberland Hospital with some women who may have babies identified as needing paediatric intervention at birth (giving birth in Carlisle) was referred to the Secretary of State. The recommendations of the Independent Reconfiguration Panel support that decision and urged us to keep developing our co-production work with the community and Health Scrutiny Committee. We are committed to this work and have established an Independent Review Group to assess our progress. This is chaired by Dr Bill Kirkup.

**Paediatrics**
The decision to establish short stay paediatric assessment units at Whitehaven and Carlisle is being developed with staff and these units will be introduced in a phased way throughout 2018/19. Overnight beds in Whitehaven will remain, until the final phase, when they will become lower acuity beds with inpatient beds at Carlisle.
What is co-production?

Following boundary change and decision making after the Healthcare For The Future consultation – more info at: www.wneucumbria.nhs.uk – the team has led our integrated health and care system development of co-production ‘as the way we do things’.

Co-production means ‘working together’ using the expertise and experience of patients, their families and carers, the community, the third sector, frontline NHS and care staff, as well as leaders, in developing and improving services.

The NHS in North Cumbria is committed to being more open and transparent about how we develop services and the challenges we face.

We have followed some very clear principles as the process and structure has developed:

1) We have heard clearly that the community wants a different relationship with our NHS and they don’t believe we have all the answers – the conversation must change

2) We can’t lift a co-production or co-creation model of the shelf and apply it to the challenges we face in North Cumbria – we have to develop a way of working that works for us

3) Our co-production processes are being developed with our communities

4) We recognise that we are all learning as we go, and we will get things wrong, but we committed to continuous improvement

This type of working was also endorsed by the Independent Reconfiguration Panel in their response to the referral to the Secretary of State which the CCG received in November 2017.

Developing co-production as the way we do things will take time to embed and effort is concentrated on the areas where work is most urgent – mainly around maternity and paediatrics.

Since April 2017 we have established a Working Together Steering Group, chaired by the Venerable Richard Pratt the Archdeacon of West Cumberland. It now has five active working groups feeding into it.

This way of working requires significant support and resource but is helping to shape a community more engaged with our ambition and understanding our challenges.

Highlights:

- Emerging development of welcome event for new staff to the area
- Co-produced a plan to share the NHS Child Health App with our communities
- Developing telemedicine pilots
- Provided direct input into clinical and patient experience audits

Open workshops, facilitated by the Stroke Association, have taken place in Workington and Carlisle with a further event planned Copeland.

The learning from this process is also helping to inform how co-production will work as the emerging Integrated Care Communities (ICC) develop and the redevelopment of West Cumberland Hospital progresses.

This work has been supported by Healthwatch Cumbria and Cumbria CVS (We have commissioned Healthwatch and Cumbria Learning and Improvement Collaborative (CLIC) to provide a toolkit to support the development of co-production which we will share with NHS England. We are working closely with CVS which has recruited a health partnerships officer to build and strengthen links between the third sector and the health and care system.
How we shape services
Our commissioning teams work with our providers to improve and develop services.

Our system wide workstreams are developing to involve patients, carers, the third sector, families and community groups - seeking their views, sharing their feedback and ensuring their voices help us to shape services.

Patient Participation Groups (PPGs)

PPGs involve patients working in partnership with Practice staff and GPs, who meet at regular intervals to discuss a variety of issues effecting patients and the Practice. The CCG is supporting the development of PPGs.

Each group determines its own activities according to the needs of the community and the practice itself and works by building a relationship between the practice and its patients that breaks down barriers and shares information.

Equality

The CCG is committed to delivering equality of opportunity for all staff and users of health services in Cumbria. The CCG wants to ensure all parts of our local communities have fair access to NHS information and services and that no one is disadvantaged or discriminated against by the services we put in place.

Much of our work has centred on the implementation of consultation decisions which was informed by the Equality Impact Analysis (EIA) report and addendum which was completed as part of the consultation work detailed above can be located at: www.northcumbriaccg.nhs.uk/you under the tab for equality.

To strengthen the input into the EIA process and to ensure that every effort has been made to cover as many of the protected characteristics and ‘hard to reach’ groups as possible a further three deliberative events were held - One for representatives of the Neurological Alliance and one for the representatives from the deaf community (both in West Cumbria) and one for the LGBT community (held in Carlisle).

The following documents are also available at: www.northcumbriaccg.nhs.uk/you under the tab for equality, which also has more information about protected characteristics.

- The Cumbria Public Sector Equality and Diversity Strategy 2016 – 2020
- Equality Delivery System (EDS2) Interim Report December 2017
- Equality Analysis 16/17
- The Accessible Information Standard document which includes links to the specification and implementation guidance.
- ‘Health and Wellbeing Passport’ – the passport is aimed at people who have communication difficulties. It enables people, with support if needed, to make a note of information that they might need to share when going into hospital or visiting their GP.

For more information contact: enquiries@northcumbriaccg.nhs.uk
14T – Duty to reduce inequalities

Through our work to develop our Integrated Care Communities (ICCs) work in particular we are working towards better outcomes for all.

Detailed profiles have been developed for each ICC to support the planning of future services. They cover information on the population and local health needs – this includes Health Inequalities.

You can view health profiles in north Cumbria at: www.cumbriaobservatory.org.uk/health-social-care/health-social-care-further-information

Health data is produced and provided by a range of sources including Public Health England, NHS Digital, and the Department of Health; as well as local sources including Cumbria County Council and Cumbria Clinical Commissioning Group. Here you will find a range of key reports and surveys relating to the health and wellbeing of the people of Cumbria.

Adult Social Care is part of Cumbria County Council and is responsible for providing help to adults, and their carers, when accessing care and support. They provide information, advice and sign-posting; advice about housing; preventative services such as re-ablement and equipment; short-term services; care assessments; care and support plans; information about funding; advice on personal budgets; support to carers; and safeguarding adults.

We work closely with Healthwatch Cumbria and Cumbria Council for Voluntary Service (CVS)

Healthwatch Cumbria is an independent organisation set up to champion the views of patients and social care users in Cumbria, with the goal of making services better and improving health and wellbeing.

You can also find out more about Healthwatch Cumbria at: http://healthwatchcumbria.co.uk

Have your say call: 03003 038 567
Email: info@healthwatchcumbria.co.uk

Cumbria CVS is a registered charity and membership organisation. They help community/voluntary/not-for-profit groups and organisations to develop and improve by providing training and services. In Cumbria it supports the Action for Health network sharing information and building relationships across our vibrant health related third sector organisations.

We have recruited a Health Partnerships Officer funded by the NHS but working with CVS to strengthen our relationship with third sector organisations.

Find out more about Cumbria CVS at: www.cumbriacvs.org.uk
Contact: 01768 800350
Email: info@cumbriacvs.org.uk

Communication and Engagement

The focus of activity has been largely on the development of co-production across the North Cumbria Health and Care System and on closer working across the communications community to provide more flexibility across the system communications colleagues, this has included developing the capacity to provide animations and films for the system.

The team also deals with:
- MP enquiries
- Freedom of Information Requests (FOIs)
- Media enquiries
- Public enquiries
- Parliamentary enquiries
- Website and social media
- Engagement advice for teams
- Supporting NHS England and NHS Improvement with national events and training
Implications/Actions for Public and Patient Engagement

The team promote and offer support and advice to any teams requiring help with patient and community engagement. The process of co-production is a new way of our system engaging with our community and sharing public and patient feedback.

Video and animation

This year we have invested in developing skills to highlight health messages through video and animation.

The team has provided animations for the system including:
• Christmas thank you to NHS and care staff
• What is co-production?
• Why get the NHS Child Health App?

We have also supported system events with short films including:
• GP conference
• LOC in the Lakes
• #hellomynameis… NHS 70 birthday celebrations featuring Chris Pointon visit.
• Asthma pathway
• GP education sessions

Building links with the north east communications and engagement teams

With many shared services and challenges we are also working with colleagues in the north east to develop greater impact on system messages including:
• Cross region working during the cyber attack
• Winter messaging – including paid for TV, radio and social media advertising around winter surge and choose wisely
• Shared promotion of the NHS Child Health App
• Sharing learning

Supporting national priorities

A lot of our work has focused on the importance of integrating services and explaining the national context surrounding the challenges around workforce, recruitment and vulnerable services.

We have also contributed to, presented at and led workshops at a national and regional level about our experiences of consultation, engagement and co-production.

We are also involved in the local system NHS70 celebrations, leading some events and working with the national team to create a national event.
Social Media

We work hard to make sure that information the public may want or need is available online and on social media. Sharing our messages through our own channels is becoming increasingly important as the traditional media faces decline.

We do this mainly through:
- **Twitter**: where we have 10,202 followers
- **Facebook**: where we have 2,554 followers

We use this route to:
- share our own information in a quick and direct manner – this is important during times of crisis i.e. snow messages, pressure on A and E.
- amplify national, regional and local health messages – this is an important way to share information i.e. flu messages
- share some of our positive stories – the system wide Glimpse of Brilliance, patient feedback, team achievements including the recent Watchtree Challenge
- interact with our community and wider health system – share information and gather feedback

We have increasing interaction across our accounts. We are building our use of animation and film to increase engagement. This was particularly effective during the recent severe weather ‘the beast from the east’.

Business as usual

In the past twelve months between 1 April 2017 and 31 March 2018 the CCG has:
- Responded to 73 enquiries from the media
- Responded to 39 enquiries from MPs.
- Eight contributions to briefings and parliamentary enquiries
- Produced 33 press releases

Freedom of Information (FOI) Requests

As a public authority we have a duty to be open and transparent about what we do. The Freedom of Information Act 2000 allows anyone to ask for information about the Trust’s business and we provide information to support this.

We received 258 Freedom of Information Act requests from 1 April 2017 to 31 March 2018. This is a decrease of 16% from previous year. 85% were responded to within the 20 day legislative timescales with one internal review requested in year.

![Freedom of Information Requests 2017/18](image)

- **Answered on time**: 219
- **Answered past 20 days timescale**: 37
Performance Report – Part 1

Internal

- Primary Care News – fortnightly
- Staff News – fortnightly
- Staff Engagement Group
- Development of Patient Participation Groups for GP Practices and increasingly for ICCs

Complaints

The CCG aims to improve the health and well-being of all people in North Cumbria by ensuring that our patients receive the highest standards of healthcare possible.

When mistakes happen, we ensure that lessons are learned to help avoid a similar incident occurring again.

We welcome feedback, both positive and negative, about NHS services commissioned or provided by those organisations as well as about the CCG itself.

The views and opinions of our patients and families help us to understand when the NHS is doing things well and when it could do something better. Complaints are an essential source of information and we believe that all complaints provide an opportunity to learn and a chance to put things right.

If you are unhappy with the treatment or service you, a relative or someone you care for has received from your local NHS, you have the right to make a complaint, have it looked into and get a response.

Healthcare organisations must provide a complaint service within the requirements of the Complaint Regulations 2009 and any complaint you make about NHS services should be acknowledged within three working days and properly investigated in a manner that is fair to both you and the staff involved.

The North of England Commissioning Support Unit (NECS) supports the CCG with the management of complaints. During the year, 77 complaints, concerns or enquiries were received by the NECS Complaints Team from or on behalf of NHS North Cumbria CCG residents, 34 of which related directly to CCG actions or decisions. Of these, 21 were managed under the formal complaints procedure and the remaining CCG cases were resolved on an informal basis.

The main themes of CCG cases were Continuing Healthcare decisions and processes; eligibility criteria for procedures/treatment and changes to the pain management service in North Cumbria.

The remaining 44 cases were passed to provider organisations (e.g. NHS Trusts) for action.

All cases were acknowledged by the NECS Complaints Team within the target timescale of three working days.
Corporate Governance Report

Directors’ and Members’ Report

The Directors and Members’ Report has been provided by the Governing Body and provides an overview of GP practices which are members of the CCG, the composition of the Governing Body, the Director Team, GP Leadership and Lay Representatives. It includes a biography of members of the Governing Body, Directors, Lead GP’s and Integrated Care Communities (ICC) GP Leads working with the CCG and other key points of interest.

Each individual who is a member of the Governing Body at the time this Report is approved, confirms so far as the member is aware, that there is no relevant audit information of which the CCG’s external auditor is unaware; and, that, as Interim 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.

The Annual Report and Accounts as a whole is fair, balanced and understandable and I take personal responsibility [for the Annual Report and Accounts and the judgments required for determining that it is fair, balanced and understandable] to ensure that those requirements are met.

The table below provides details of the Chair and Interim Accountable Officer during 2017/18 up to the signing of the Annual Report & Accounts.

<table>
<thead>
<tr>
<th>Name</th>
<th>Designate</th>
<th>Period during 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Rush</td>
<td>Lay Chair</td>
<td>1 April 2017</td>
</tr>
<tr>
<td>David Rogers</td>
<td>Interim Accountable Officer/Medical Director</td>
<td>1 December 2016</td>
</tr>
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</table>
**Member profiles – Our Member Practices**

NHS North Cumbria CCG is a clinically-led organisation which brings together 40 local GP Practices and other health professionals to plan and design services to meet local patients’ needs. Our member practices are:

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Practice Code</th>
<th>Practice Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alston Medical Practice</td>
<td>A82004</td>
<td>The Surgery, Cottage Hospital, Alston, Cumbria CA9 3QX</td>
</tr>
<tr>
<td>Appleby Medical Practice</td>
<td>A82006</td>
<td>The Riverside Building, Chapel Street, Appleby Cumbria CA16 6QR</td>
</tr>
<tr>
<td>Aspatria Medical Group</td>
<td>A82055</td>
<td>Aspatria Medical Group, West Street, Aspatria Cumbria CA7 3HH</td>
</tr>
<tr>
<td>Beechwood Group Practice</td>
<td>A82048</td>
<td>57 John Street, Workington, Cumbria CA14 3FT</td>
</tr>
<tr>
<td>Birbeck Medical Group</td>
<td>A82035</td>
<td>Penrith Health Centre, Bridge Lane, Penrith Cumbria CA11 8HW</td>
</tr>
<tr>
<td>Brampton Medical Practice</td>
<td>A82012</td>
<td>4 Market Place, Brampton, Cumbria CA8 1NL</td>
</tr>
<tr>
<td>Calbeck Surgery</td>
<td>A82014</td>
<td>Friar Row, Calbeck, Wigton Cumbria CA7 8DS</td>
</tr>
<tr>
<td>Carlisle Healthcare</td>
<td>A82016</td>
<td>Carlisle Healthcare, Spencer House, St Paul’s Square Carlisle, Cumbria CA1 1DG</td>
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<tr>
<td>Castlegate &amp; Derwent Surgery</td>
<td>A82021</td>
<td>Cockermouth Community Hospital &amp; Health Centre Isel Road, Cockermouth, Cumbria CA1 9HT</td>
</tr>
<tr>
<td>Castlehead Medical Centre</td>
<td>A82028</td>
<td>Ambleside Road, Keswick, Cumbria CA12 4DB</td>
</tr>
<tr>
<td>Court Thorn Surgery</td>
<td>A82631</td>
<td>Low Hesket, Carlisle, Cumbria CA4 0HP</td>
</tr>
<tr>
<td>Dalston Medical Group</td>
<td>A82022</td>
<td>Townhead Road, Dalston, Cumbria CA5 7PZ</td>
</tr>
<tr>
<td>Distington Surgery</td>
<td>A82023</td>
<td>Hinnings Road, Distington, Cumbria CA14 5UR</td>
</tr>
<tr>
<td>Eden Medical Group</td>
<td>A82020</td>
<td>Port Road, Carlisle, Cumbria CA2 7AJ</td>
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<tr>
<td>Fellview Healthcare Ltd</td>
<td>A82044</td>
<td>Cleator Moor Health Centre, Birks Road, Cleator Moor Cumbria CA25 5HP</td>
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<tr>
<td>Fusehill Medical Practice</td>
<td>A82019</td>
<td>Fusehill Medical Centre, Fusehill Street, Carlisle Cumbria CA1 2HE</td>
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<tr>
<td>Glenridding Health Centre</td>
<td>A82620</td>
<td>Greenside Road, Glenridding, Cumbria CA11 0PD</td>
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<tr>
<td>James Street Group Practice</td>
<td>A82047</td>
<td>James Street, Workington, Cumbria CA14 2DL</td>
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<tr>
<td>Kirkoswald Surgery</td>
<td>A82617</td>
<td>Ravenghyll, Kirkoswald, Cumbria CA10 1DQ</td>
</tr>
<tr>
<td>Longtown Medical Practice</td>
<td>A82646</td>
<td>Longtown Medical Centre, Moor Road, Longtown Cumbria CA6 5XA</td>
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<tr>
<td>Lowther Medical Centre</td>
<td>A82041</td>
<td>1 Castle Meadows, Whitehaven, Cumbria CA28 7RG</td>
</tr>
<tr>
<td>Mansion House Surgery</td>
<td>A82075</td>
<td>19/20 Irish Street, Whitehaven, Cumbria CA28 7BU</td>
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<td>Practice Name</td>
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<tr>
<td>Maryport Group Practice</td>
<td>A82032</td>
<td>Alneburgh House, Ewanrigg Road, Maryport Cumbria CA15 8EL</td>
</tr>
<tr>
<td>Orchard House Surgery</td>
<td>A82049</td>
<td>Ann Burrow Thomas Health Centre, South Williams Street, Workington, Cumbria CA14 2EW</td>
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<td>Oxford Street Surgery</td>
<td>A82050</td>
<td>20 Oxford Street, Workington, Cumbria CA14 2AJ</td>
</tr>
<tr>
<td>Queen Street Medical Practice</td>
<td>A82058</td>
<td>Richard Benedict House, 149 Queen Street Whitehaven, Cumbria CA28 7BA</td>
</tr>
<tr>
<td>Seascale Health Centre</td>
<td>A82024</td>
<td>Gosforth Road, Seascale, Cumbria CA20 1PN</td>
</tr>
<tr>
<td>Shap Medical Practice</td>
<td>A82031</td>
<td>Shap Health Centre, Peggy Nut Croft, Shap Cumbria CA10 3LW</td>
</tr>
<tr>
<td>Silloth Group Medical Practice</td>
<td>A82037</td>
<td>Lawn Terrace, Silloth-on-Solway, Cumbria CA7 4AH</td>
</tr>
<tr>
<td>Solway Health Services</td>
<td>A82623</td>
<td>Workington Community Hospital, Park Lane Workington, Cumbria CA14 2RW</td>
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<tr>
<td>Spencer Street Surgery</td>
<td>A82018</td>
<td>10 Spencer Street, Carlisle, Cumbria CA1 1BP</td>
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<tr>
<td>Temple Sowerby Medical Practice</td>
<td>A82038</td>
<td>Linden Park, Temple Sowerby, Cumbria CA10 1RW</td>
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<tr>
<td>The Croft Surgery</td>
<td>A82029</td>
<td>Kirkbride, Cumbria CA7 5JH</td>
</tr>
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<td>The Lakes Medical Practice</td>
<td>A82036</td>
<td>Penrith Health Centre, Bridge Lane, Penrith Cumbria CA11 8HW</td>
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<td>Upper Eden Medical Practice</td>
<td>A82013</td>
<td>The Health Centre, Silver Street, Kirkby Stephen Cumbria CA17 4RB</td>
</tr>
<tr>
<td>Warwick Road Surgery</td>
<td>A82015</td>
<td>65 Warwick Road, Carlisle, Cumbria CA1 1EB</td>
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<tr>
<td>Warwick Square Group Practice</td>
<td>A82654</td>
<td>Warwick Square, Carlisle, Cumbria CA1 1LB</td>
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<tr>
<td>Westcroft House</td>
<td>A82064</td>
<td>66 Main Street, Egremont, Cumbria CA22 2DB</td>
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<tr>
<td>Whitehaven Medical Centre</td>
<td>A82060</td>
<td>Catherine Street, Whitehaven, Cumbria CA28 7PA</td>
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<tr>
<td>Wigton Group Medical Practice</td>
<td>A82045</td>
<td>Southend, Wigton, Cumbria CA7 9PZ</td>
</tr>
</tbody>
</table>
The Governing Body is responsible for ensuring that the CCG has appropriate arrangements in place to exercise its functions efficiently and economically and in accordance with the CCG’s principles of good governance. It is made up of a membership that includes doctors and healthcare professionals, clinical and lay members and lay representatives.

Full details of the CCG’s committee structures, roles and responsibilities and an overview of the year’s work coverage can be found in the Annual Governance Statement contained in this document.

The CCG’s Register of Interests can be viewed in full on its website:

www.northcumbriaccg.nhs.uk
Les Hanley – Lay Member
Health Improvement.
Les worked at a senior level in the nuclear industry. Previously with NHS Cumbria CCG and transferred across to NHS North Cumbria CCG on 1 April 2017.

Governing Body Committees
Audit Committee.
Auditor Panel.
Finance & Performance Committee.
Outcomes & Quality Committee (Chair).
Remuneration Committee.
Primary Care Commissioning Committee.

Declarations of Interest
Director of Age UK, West Cumbria.

Dr Colin Patterson – Primary Care & ICC Development.
Dr Colin Patterson is a GP at the Carlisle Healthcare and has a special interest in cancer services. Previously with NHS Cumbria CCG and transferred across to NHS North Cumbria CCG on 1 April 2017.

Governing Body Committees
Governing Body.
Executive Committee.
Primary Care Committee – Non-voting Member.

Declarations of Interest
Carlisle Health Care(GP Practice).
CMS Contract sits with Carlisle Health Care Cumbria North, East & West Cumbria Medical Committee Member.
British Medical Association Member.

Dr Rachel Preston – GP Lead for Eden.
Rachel is a GP and is part of the Lakes Medical Practice in Penrith. She also has a GP Lead role and represents the north Cumbria GP membership on the Governing Body. Rachel was with the CCG from 1 April 2013 until 31 May 2017.

Governing Body Committees
Clinical Leads Group.
Eden Locality Executive (Chair).

Declarations of Interest
GP Partner,
The Lakes Medical Practice.

Dr David Rogers – Interim Accountable Officer and Medical Director.
David was a GP at Fellview Medical Practice, Cleator Moor prior to becoming Medical Director for NHS Cumbria CCG in 2013. Since December 2016 he has been the Interim Accountable Officer. Previously with NHS Cumbria CCG and transferred across to NHS North Cumbria CCG on 1 April 2017.

Governing Body Committees
Executive Committee.
Finance & Performance Committee.
Implementation Reference Group.
Outcomes & Quality Assurance Committee.
Primary Care Commissioning Committee.

Declarations of Interest
Nil.
Peter Rooney – Chief Operating Officer.
Peter is responsible for ensuring the effective functioning of the CCG an organisation with a focus on internal/external relationships and performance with the organisation. Previously with NHS Cumbria CCG and transferred across to NHS North Cumbria CCG on 1 April 2017.

Governing Body Committees
Executive Committee.
Finance & Performance Committee.
Implementation Reference Group.

Declarations of Interest
Nil.

Jon Rush – Lay Chair.
Jon was a Chief Superintendent with Greater Manchester Police and had spent 24 years working for Cumbria Constabulary. He joined the CCG upon its commencement in 2013 as the Lay Member for Patient Engagement and became the Lay Chair of North Cumbria CCG on 1 April 2017.

Governing Body Committees
Full Council of Members – Non-voting Chair.
Finance & Performance Committee.
Primary Care Commissioning Committee.
Joint CCG Committee for Cumbria and the North East.

Declarations of Interest
Chair of Redcar and Cleveland Local Safeguarding Children Board.
Governor (Independent)
Bury College.
Chair Stainton Sports and Recreation Committee Cumbria.
Peer reviewer – Safeguarding Children and Adults – Local Government Agency.
Chair of Joint CCG Committee.

Peter Scott – Lay Member Finance & Governance.
Vice Chair of the Governing Body and Conflict of Interest Guardian.
Peter has more than 30 years experience in the NHS, holding director of finance posts at local, regional and national level. Previously with NHS Cumbria CCG and transferred across to NHS North Cumbria CCG on 1 April 2017.

Governing Body Committees
Audit Committee (Chair).
Auditor Panel (Chair).
Finance & Performance Committee.
Remuneration Committee (Chair).

Declarations of Interest
Nil.

Charles Welbourn – Chief Finance Officer.
Charles was previously Deputy Director of Finance in the former NHS Primary Care Trust before securing his post upon the commencement of NHS Cumbria CCG in 2013. He was subsequently transferred to NHS North Cumbria CCG on 1 April 2017.

Governing Body Committees
Finance & Performance Committee.
Executive Committee.
Primary Care Commissioning Committee.

Declarations of Interest
Nil.
Dr Kevin Windebank – Secondary Care Doctor.
Kevin is a former paediatric oncologist and joined the Governing Body of NHS Cumbria CCG in September 2016 and transferred to NHS North Cumbria CCG on 1 April 2017.

Governing Body Committees
Finance & Performance Committee.
Outcomes & Quality Assurance Committee.
Implementation Reference Group.

Declarations of Interest
Fellow of the Royal College of Paediatrics and Child Health.
Zero hours contract with Newcastle-upon-Tyne Hospitals NHS Foundation Trust for Appraisals and Revalidation Support.

Denise Leslie
Lay Member Patient and Public Engagement
Denise is a former teacher and has been involved in community healthcare delivery in Greater Manchester for the last 9 years. Denise joined North Cumbria CCG in August 2017

Governing Body Committees
Outcomes and Quality Assurance Committee
Audit Committee
Audit Panel
Remuneration Committee
Finance and Performance Committee
Implementation Reference Group

Declaration of Interest
Director and Shareholder ABL Health Limited-SME based in Greater Manchester, Wirral, Hull and St Helen’s. Does not operate in Cumbria - no conflict of interest or business connection in Cumbria.

Dr Helen Horton – GP Lead - Commissioning and Specialised Commissioning.
Helen is partner of Distington Surgery, Distington and was appointed to her role at the CCG in September 2015.

Governing Body Committees
Executive Committee.

Declarations of Interest
GP Partner Distington Surgery.
Clinical Auditor for Cumbria Health on Call.
Locum GP for Cumbria Health on Call.

Dr William Lumb – Chief Clinical Information Officer.
Dr William Lumb provides both technical and informatics support to the CCG. He is helping to shape technological innovations and develop Cumbria’s Digital Roadmap. Previously with NHS Cumbria CCG and transferred across to NHS North Cumbria CCG on 1 April 2017.

Declarations of Interest
Senior Partner Member GP Practice
Married to a CCG Employee.

Dr Amanda Boardman and Dr Colin Patterson are also GP Leads and their details are provided in the Governing Body Membership table above.
ICC GP Leads

Dr Mark Alban – ICC Lead
- Brampton and Longtown.
Dr Mark Alban is GP at Brampton Medical Practice.

Declarations of Interest
Partner at Brampton Medical Practice.
Commissioned to provide GMS in Brampton.
Chairman of Statutory Body supporting General Practice in North East & West Cumbria.

Dr Niall McGreevy – ICC GP Lead
- Workington.
Dr Niall McGreevy is a GP at James Street Surgery.

Governing Body Committees
Executive Committee.
Primary Care Commissioning Committee
- Non-voting Member.

Declarations of Interest
Partner at James Street Group Practice, Workington.
James Street Group Practice owns one of five shares in Workington Health. Work as GP doing occasional weekend shifts for Workington Health.

Dr Simon Desert – ICC Lead
- Cockermouth & Maryport.
Dr Simon Desert is a GP at Castlegate & Derwent Surgery, Cockermouth.

Dr Alan Edwards – ICC Lead
– Carlisle Healthcare.
Dr Alan Edwards is a GP at Carlisle Healthcare.

Declarations of Interest
Partner at Carlisle Healthcare GP Practice.
Employed GP at CHOC – one session per month.
Section 12 Doctor.

Dr Peter Hemingway – ICC Lead
– Keswick and Solway.
GP at Castlehead Medical Centre.

Declarations of Interest
Nil.

Dr Celia Heasman – ICC Lead
– Copeland.
Dr Celia Heasman is a GP at Westcroft Surgery.

Declarations of Interest
GP Partner at a Westcroft House Surgery in North Cumbria.

Dr Ashley Liston – ICC Lead
– Eden.
Dr Ashley Liston is a GP at Appleby Medical Practice (left the practice 31 March 2018).

Declarations of Interest
Nil.
Dr Eve Miles – ICC Lead – Copeland.
Dr Eve Miles is GP at Seascale Health Centre.

**Governing Body Committees**
Attends Executive Committee on behalf of Celia Heasman.

**Declarations of Interest**
Nil.

Dr Susan Rossi – ICC Lead – Carlisle Network
Dr Susan Rossi is a GP at Eden Medical Group

**Declarations of Interest**
GP Partner Eden Medical Group.
Eden Medical Services Director.
North, East & West Cumbria Local Medical Committee Representative.

Dr Robert Westgate – ICC Lead for Carlisle Healthcare.
Dr Robert Westgate is a GP at Carlisle Healthcare.

**Governing Body Committees**
ICC Lead for Carlisle Healthcare.

**Declarations of Interest**
GP Partner at Carlisle Healthcare. GP with an interest in Diabetes.

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**Clinical Leaders**

Dr Nicola Cleghorn – Designated Doctor for Safeguarding Children.
Dr Nicola Cleghorn is an experienced Community Paediatrician with special interest in Safeguarding Children and Young People in Forensic Paediatrics. Nicola previously held this post in Cumbria before she moved back to the North East in 2014 and re-joined the CCG in January 2017.

**Governing Body Committees**
In attendance – Clinical Leads Group.

Andrea Loudon – Primary Care Development Lead and Medicines Lead.
Andrea Loudon was previously working as the medicines lead with the former NHS Cumbria Primary Care Trust and transferred over to the CCG upon its commencement in 2013.

**Governing Body Committees**
In attendance – Outcomes & Quality Assurance Committee.

**Declarations of Interest**
NICE Medicines and Prescribing Associate.
Spouse is employed by NECS as Medicines Optimisation Pharmacist in South Cumbria.
Senior Management Arrangements

In 2016/17 NHS England placed the CCG under Directions with effect from 1 September 2016. As a result NHS England, North East and Cumbria supported the CCG to appoint an Interim Accountable Officer and a Chief Operating Officer. In addition NHS England secured the secondment of an Interim Chief Executive, three days a week, to strengthen both the CCG’s senior management arrangements and the leadership across the Cumbria wide health system. These arrangements remained in place throughout 2017/18.

Senior Management Team

Stephen Childs – Interim Chief Executive.
Stephen joined the CCG on secondment in September 2016 to provide additional support three days per week to the Director Team. This arrangement will cease from 31 March 2018 and he will return full time to his substantive post of Managing Director of North of England Commissioning Support.

Governing Body Committees
Executive Committee
In attendance at the Governing Body.
Finance & Performance Committee.

Declarations of Interest
Managing Director of North of England Commissioning Support which supplies commissioning support to the CCG.

Eleanor Hodgson – Director for Children and Families.
Eleanor is the lead director for the commissioning of Children’s and Maternity services in Cumbria and works closely with Cumbria County Council and provider organisations. Eleanor also leads on organisational development. She previously worked for NHS Cumbria Primary Care Trust and transferred over to the CCG upon its commencement in 2013.

Governing Body Committees
Executive Committee.

Declarations of Interest
Nil.
Senior Management Team (continued)

Helen King – Director for Nursing and Quality.
Helen is a registered nurse and a registered midwife with over 35 years of experience in delivering, commissioning and leading healthcare in many settings and at local, regional and national levels. Helen worked for the CCG from May 2016 until Sept 2017.

Governing Body Committees
Outcomes & Quality Assurance Committee
Executive Committee.

Declarations of Interest
Nil.

Caroline Rea – Director of Primary Care and Integrated Care Communities.
Caroline was previously a Network Director for the PCT (Primary Care Trust) and leads on the Primary Care and Integrated Care Community Development. Previously with NHS Cumbria CCG and transferred across to NHS North Cumbria CCG on 1 April 2017.

Governing Body Committees
Executive Committee.
Primary Care Committee.

Declarations of Interest
Nil.

Stephen Singleton – Clinical Director of Innovation.
Stephen previously worked for the North East Strategic Health Authority until it was disbanded on 31 March 2013 and has been instrumental in setting up the Cumbria Learning and Improvement Collaborative (CLIC), providing education, training, leadership and team building and improvement techniques to support change across the Cumbria health and care economy.

Declarations of Interest
Director of ‘Zero Tolerance Healthcare Ltd’ (small consultancy company).

Anna Stabler – Director of Quality and Nursing.
Anna is a Registered Nurse and Midwife. She worked in Acute Primary Care and was previously Deputy Director of Nursing & Midwifery and Allied Health Professional at North Cumbria University Hospitals NHS Trust (NCUHT).

Governing Body Committees
Executive Committee.
Outcomes & Quality Assurance Committee.

Declarations of Interest
Nil.

Caroline Rea – Director of Primary Care and Integrated Care Communities.
Caroline was previously a Network Director for the PCT (Primary Care Trust) and leads on the Primary Care and Integrated Care Community Development. Previously with NHS Cumbria CCG and transferred across to NHS North Cumbria CCG on 1 April 2017.

Governing Body Committees
Executive Committee.
Primary Care Committee.

Declarations of Interest
Nil.

The Senior Management Team also includes Dr David Rogers, Peter Rooney and Charles Welbourn and their details are shown in the Governing Body Membership table above.
Register of Interests and Gifts, and Hospitality Register

In line with NHS England’s ‘Managing Conflicts of Interest: Revised Statutory Guidance for CCGs’ issued in June 2017 – available via NHS England’s website at: www.england.nhs.uk – the CCG has revised and approved its Business Code of Conduct policy and this was approved by the Governing Body on 4 October 2017. The Lay Member for Finance & Governance and Audit Committee Chair, Peter Scott, continues to be the CCG’s Conflicts of Interest Guardian.

The CCG has updated its Register of Interests in line with the 2017 guidance and it has been revised to show the ‘decision makers’ of the CCG. In addition the CCG has reviewed that register and, where it considers that there is the potential (perceived or otherwise) for a conflict of interest to occur, it has put monitoring measures in place to ensure conflicts are effectively managed. The Accountable Officer and Conflicts of Interest Guardian (through the Audit Committee) are provided with regular briefings.

In addition to the annual updating of the Register of Interests when new starters commence their employment with the CCG they are required to complete a Conflicts of Interest form. This information is then added to the Register of Interests and published on the CCG website.

The Gifts and Hospitality Register has also been revised in line with the template provided in the above guidance.

The interests of those people detailed in the Governing Body and Directors report are listed above. However the CCG’s Full Register of Interest and the Gifts and Hospitality Register is available on the CCG’s website on www.northcumbriaccg.nhs.uk/about-us/how-we-make-decisions/declaration-of-interests/index.aspx

Additional Disclosures

Complaints

All complaints are investigated and responded to in line with the Principles for Remedy (Parliamentary and Health Service Ombudsman). Any employee errors or maladministration are dealt with accordingly.

The CCG’s Chief Operating Officer or the Interim Accountable Officer/Medical Director personally sign off all complaint responses and detail all remedies or service improvements within the response.

Personal data related incidents

The Information Governance (IG) Team has recorded one IG incident between 1 April 2017 and 31 March 2018. This was a Level 2 incident which was reported diligently by the CCG on 1 August 2017. The incident has been closed and it is detailed in full in the Information Governance Section of the Annual Governance Statement.

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

The Modern Slavery Act 2015 has introduced changes in UK law focused on increasing transparency in supply chains, to ensure our supply chains are free from modern slavery (that is, slavery, servitude, forced and compulsory labour and human trafficking). As both a local leader in commissioning health care services for the population of North Cumbria and as an employer the CCG fully supports the Government’s objectives to eradicate modern slavery and human trafficking and has produced a statement in respect of its commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practices.

The statement was approved by the Governing Body on 4 October 2017 and can be found on the CCG’s website at the link below:


Health & Safety

The CCG recognises its responsibilities and duties under the Health & Safety at Work etc. Act (1974) and is committed to ensuring so far as is reasonably practicable the health, safety and welfare of its employees, visitors and other persons who may be affected by its activities.

The CCG will comply with legislation as a minimum and strive to improve performance on a continual basis by accepting best practice standards and the setting of performance targets in relation to the management of health & safety.

The CCG has commissioned health & safety services from the North East Commissioning Support (NECS) ensuring that there are robust arrangements in place for the management of health and safety across the organisation. Some of these arrangements consist of Health and Safety Strategy, Health and Safety Policies and Procedures, Annual Audits and quarterly update reports to Governing Body’s Finance and Performance Committee. Operationally the CCG also ensures that training and risk assessments are completed where need is identified such as fire wardens, first aiders, security management etc.

Statement of Accountable Officer’s Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Medical Director to be the CCG’s Interim Accountable Officer until 31 March 2019.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the CCG’s Accountable Officer appointment letter. They include being responsible 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 it to ensure that the accounts comply with the requirements of the Accounts Direction),
- Safeguarding the CCG’s assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).
Under the National Health Service Act 2006 (as amended) NHS England has directed each Clinical Commissioning Group 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,

• Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), ‘Managing Public Money’ and in my Clinical Commissioning Group Accountable Officer appointment letter.

Disclosures:

• Directions issued upon the CCG as detailed in the Governance Statement below which applied until 12 January 2018.

• S30a letter issued in March 2018 by the CCG’s External Auditor Grant Thornton UK LLP and detailed in note 2 of the Annual Accounts).

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.

• that 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.

David Rogers
Interim Accountable Officer/Medical Director
24 May 2018
Governance Statement

Introduction and context

CCG’s became corporate bodies established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). NHS North Cumbria CCG came into being on the 1 April 2017 following a boundary change which saw the southern part of the previous NHS Cumbria CCG join with North Lancashire CCG to create NHS Morecambe Bay CCG. NHS North Cumbria CCG covers the areas of Allerdale, Eden, Carlisle and most of Copeland. The changes were made to make local commissioning arrangements simpler and more efficient and it paved the way to the greater integration of health and social care services for both North Cumbria and Morecambe Bay.

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

As of the 1 September 2016, under Section 14Z21 of the National Health Service Act 2006, NHS England issued the following directions upon NHS Cumbria CCG. These were transferred to North Cumbria CCG as part of the boundary change handover.

Citation, commencement and application

1) These Directions are given to NHS Cumbria Clinical Commissioning Group (“NHS Cumbria CCG”) (subsequently transferred to NHS North Cumbria CCG from 1 April 2017).

2) These Directions may be cited as the NHS Cumbria CCG Directions 2016 and come into force on 1 September 2016.

3) These Directions apply until they are varied or revoked by the Board.

Exercise of functions

4) An organisational development review of NHS Cumbria CCG has been completed. The Board directs that:

(a) NHS Cumbria CCG shall develop an Improvement Plan to include recommendations arising from the review and any other matter required by the Board.

(b) The Improvement Plan shall be approved by the Board.

(c) NHS Cumbria CCG shall implement the Improvement Plan in accordance with the timelines set out within it and:

i. provide prompt and full disclosure of any information, documents and records requested by the Board; and make senior officers available to meet with the Board to discuss the implementation of the Improvement Plan.

(d) The Board may direct NHS Cumbria CCG in any other matters relating to the Improvement Plan including any variations to it.
5) The Board further directs that:

(a) NHS Cumbria CCG shall develop a credible financial recovery plan (the “Financial Recovery Plan”) which shall include but is not limited to:

i. a risk management strategy that sets out how NHS Cumbria CCG shall ensure, in the financial year 2016/17, that it achieves an in-year deficit of no more than £8.5 million and how it will remain in recurrent balance thereafter;

ii. confirmation that all facts, figures and projections within the Financial Recovery Plan have been subjected to independent scrutiny by an organisation approved by the Board;

iii. a complete analysis of the causes of the current underlying financial position and the reasons for the deterioration in the financial position;

iv. arrangements demonstrating clear links between the Financial Recovery Plan and internal budgets, reporting arrangements, activity plans, cash plans and contracting;

v. a clear risk assessment of the Financial Recovery Plan;

vi. arrangements for reporting progress against the Financial Recovery Plan to NHS Cumbria CCG’s Executive Team, NHS Cumbria CCG’s Governing Body and the Board to enable prompt action to be taken should there be any deviation from the Financial Recovery Plan;

vii. delivery of financial business rules.

(b) NHS Cumbria CCG shall ensure that the Financial Recovery Plan takes into account any potential impacts on NHS Cumbria CCG’s financial position arising from development and implementation of local sustainability and transformation plans outlined in the “NHS Planning Guidance 2016/17 – 2020/21 including by identifying any budget or contract that relates to matters in both of the transformation footprints agreed nationally for the purposes of the sustainability and transformation plans that cover NHS Cumbria CCG’s area.

(c) In addition to the matters set out in paragraphs 5(a) and (b), the Financial Recovery Plan shall meet any other requirements as set out by the Board.

(d) The Financial Recovery Plan shall be subject to the Board’s approval.

(e) NHS Cumbria CCG shall, if directed by the Board, vary or update the Financial Recovery Plan.

(f) NHS Cumbria CCG shall implement the Financial Recovery Plan.

(g) NHS Cumbria CCG shall co-operate with the Board regarding the implementation of the Financial Recovery Plan and its implementation.

(h) The Board may direct NHS Cumbria CCG in any other matters relating to the Financial Recovery Plan.

6) The Board further directs that:

(a) NHS Cumbria CCG ensures that its finance and programme management office functions are established and appropriately resourced to ensure appropriate financial management capacity and delivery of the Improvement Plan, the Financial Recovery Plan and NHS Cumbria CCG’s Right Care agenda.

(b) In addition to the matters set out in paragraph 6(a), NHS Cumbria CCG shall meet any other requirements as set out by the Board relating to its finance and programme management office functions.

(c) NHS Cumbria CCG shall:

i. provide prompt and full disclosure of any information, documents and records requested by the Board in relation to compliance with this paragraph; and

ii. make senior officers available to meet with the Board to discuss compliance with this paragraph.

(d) The Board may direct NHS Cumbria CCG in any other matters relating to the requirements of this paragraph.
Senior Officers

7) The Board directs that:
   (a) NHS Cumbria CCG shall:
      i. nominate an Accountable Officer to the Board; and
      ii. appoint a Chief Operating Officer.
   (b) The Board will determine the process to be followed to make such a nomination and appointment.
   (c) The nomination of the Accountable Officer and the appointment of the Chief Operating Officer will be subject to prior approval by the Board.
   (d) NHS Cumbria CCG will co-operate with the Board regarding the appointment of its Accountable Officer and its Chief Operating Officer, including but not limited to the prompt provision of information, documents and records requested by the Board and making senior officers available to meet with the Board.

8) The Board further directs that:
   (e) NHS Cumbria CCG will notify the Board of the need to make any appointments to its executive team or its next tier of management.
   (f) Where it considers it necessary to do so, the Board will determine the process to be followed by NHS Cumbria CCG in making appointments as referred to in paragraph 8(a).
   (g) The appointment of any person to a position referred to in paragraph 8(a) and the terms of such appointment will be subject to prior approval by the Board.
   (h) NHS Cumbria CCG will co-operate with the Board regarding the appointment of any person in accordance with paragraph 8(a), including but not limited to:
      i. the prompt provision of information, documents and records requested by the Board; and
      ii. making senior officers available to meet with the Board.

Compliance with these directions

9) The Board directs that NHS Cumbria CCG shall co-operate with the Board regarding the Board’s oversight of NHS Cumbria CCG’s compliance with these Directions, including but not limited to the prompt provision of information, document and records requested by the Board and making senior officers available to meet with the Board.

Simon Stevens
Chief Executive
NHS Commissioning Board
(here after referred to as NHS England)

The CCG worked actively with NHS England, North East and Cumbria and on 12 January 2018 the Directions were removed. This was in response to the CCG delivering the required changes to leadership, governance, financial control and organisational capacity set out in the Directions. In addition the CCG has worked well with its system partners to deliver the Five Year Forward View and as part of the move towards delivering an Integrated Care System in the West, East and North Cumbria.

Scope of responsibility

As Interim 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 Service Act 2006 (as amended) and in my CCG Interim Accountable Officer appointment letter dated 21 December 2016.

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

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

Compliance with UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, the CCG considers that compliance is good practice and strives through its leadership and governance arrangements to ensure it meets the main principles of the Code.

This has been demonstrated by:

- **Leadership** – ensuring the principles of effective leadership have been embedded during 2017/18. Even though the Directions have now been lifted this continues to be a key focus for the CCG. The CCG has continued to worked closely with NHS England, North East and Cumbria, our colleagues at North East Commissioning Support (NECS) and the Cumbria Learning Collaborative Improvement (CLIC) to strengthen, develop and embed the principles of effective leadership both in the CCG and across the Cumbria and North East wide health economies.

- **Effectiveness** – During 2017/18 the CCG undertook a full review of its effectiveness to deliver safe and effective services across the whole Cumbria Health Economy, especially in light of the requirement from NHS England for Sustainable Transformation Partnerships (STPs) and the development of Integrated Care Systems (ICSs). In addition closer working relationships have been developed with CCGs in the North East of England to ensure collective effective governance and decision making aids joint and streamlined commissioning decisions.

In light of the above the CCG has reviewed its Standing Orders, Scheme of Delegation, Prime Financial Regulations and Committee Terms of Reference to ensure they don’t just meet the national guidelines but are fit for purpose in this fast changing health system. In addition the CCG is working with its partners across the health system to review resources and re-align them to the development of ICCs. This includes sharing resources where possible.

- **Accountability** – The Governing Body receives regular updates and assurance from its committees to enable it to have an understandable assessment of the CCG’s position and prospects. Alongside of this the CCG’s risk assurance framework has continued to be revised, maintained and updated to provide the Governing Body with a clear understanding of its main risks to achieving its strategic objectives.

In addition, as part of the Directions on the CCG, it has produced an Improvement Plan which is monitored through the Director Group and NHS England (through its Quarterly Assurance meetings). Regular updates are made to the Finance & Performance Committee which provides assurance to the Governing Body.
• Remuneration – The CCG works within the Agenda for Change framework for the remuneration of its employees. For Very Senior Officers (VSM’s) the Remuneration Committee ensures it has a formal and transparent process for determining the remuneration packages of these officers. This includes evaluating the requirements of the post and undertaking comparisons with like for like organisations to ensure that the CCG retains professional, high quality officers.

• Relations with Stakeholders – Throughout 2017/18 the CCG has continued to work closely with its stakeholders. It has also established co-production, working with its communities to help shape the service changes in North Cumbria. This has included establishing a network within which information can be shared, feedback can be sought and new ideas being developed together. This has strengthened valuable links with the CCG’s communities. This has been supported by Healthwatch Cumbria and Cumbria CVS. The work of the co-production groups is informing the decisions of the Governing Body in relation to the implementation of the service changes agreed on 8 March 2017.

Through the narrative within this Annual Governance Statement, the Annual Report and Accounts the CCG has described how it has fulfilled the main principles of the Code specifically in relation to leadership, effectiveness, accountability and remuneration. For the financial year ended 31 March 2018, and up to the date of signing this statement the CCG has applied those principles of the code that are directly relevant, and via this Annual Governance Statement, Annual Report and Accounts, demonstrated how it has discharged its responsibilities.

The CCG’s Constitution

The CCG has a Constitution which has been agreed by its Member Practices. It sets out the arrangements it has in place to enable the CCG to undertake its responsibilities for commissioning care for the people for whom it is responsible.

It describes the governing principles, rules and procedures that ensure probity and accountability in the day to day running of the CCG to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to its goals.

In accordance with section 14L (2) (b) of the 2006 Act (as amended), section 4.4.3 of the CCG’s Constitution reflects that, throughout each year, the Governing Body will have an ongoing role in reviewing the CCG’s governance arrangements to ensure that the CCG continues to reflect the principles of good governance.

These include:

• The highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;
• The Good Governance Standard for Public Service;
• The standards of behaviour published by the Committee on Standards in Public Life (1995) known as the ‘Nolan Principles’;
• The Seven Key principles of the NHS Constitution;
• The Equality Act 2010
• The Bribery Act 2010
• NHS Counter Fraud Authority Standards
The CCG’s Constitution is a living document and as such is refreshed at least annually. Changes made during 2016/17 are as follows:

National guidance

The CCG has revised its Constitution and polices in line with national guidance. One example of this is NHS England’s ‘Managing Conflicts of Interest: Revised Statutory Guidance for CCGs’ issued in June 2017 and this has been demonstrated in the Accountability Report.

Members Information

This has been revised in line with the boundary change which came into effect on 1 April 2017 resulting in the reduction of the membership to 41 practices. In addition there was a practice merger in the Allerdale area and the membership details have been amended to reflect this and there are now only 40 member practices.

Editorial Changes

There have been a number of amendments to the CCG’s Scheme of Delegation which has provided authority to various committees to approve policies on behalf of the Governing Body. These include the following delegations:

- Clinical polices (excluding Safeguarding polices) – Executive Committee
- Safeguarding polices – Outcomes & Quality Assurance Committee
- Non-Clinical polices (i.e. HR, Health & Safety etc.) – Finance & Performance Committee

The Governing Body has also approved the establishment of the following committees:

Primary Care Committee – With effect from 1 April 2017 and in accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England delegated the exercise of primary medical care commissioning functions (as defined in the Committee’s Terms of Reference) to NHS North Cumbria CCG. One of the requirements of that delegation was that the Governing Body establish a Primary Care Committee.

Implementation Reference Group

On the 8 March 2017 the Governing Body agreed to establish this group as part of the governance structure following the completion of the Healthcare for the Future public consultation. It will apply critical review to implementation proposals relating to the service areas included within the Healthcare for the Future consultation and make recommendations to the Governing Body.

Joint CCG Committee for Cumbria and the North East (CNE) – This committee is made up of 12 CCGs from across the region to aid joint and streamlined commissioning decisions.

The CCG has agreed with North Cumbria University Hospitals Trust (NCUHT) and Cumbria Partnership Foundation Trust (CPFT) to establish a Committee in Common as part of a system leadership approach. This will allow for committees from each organisation to meet at the same time to discuss and determine system wide issues rather than, each NHS body having to take them separately through their Boards/Governing Body. This is in the early stages of development and the Committee has not yet met to date. However, it is envisaged that this arrangement will be progressed at pace in 2018/19.

In addition to the above, various minor formatting changes have been made. These changes are within the delegated authority that the Full Council of Members has given to the Governing Body.
Full Council of Members, Governing Body and the Committee Governance Structure

The CCGs governance meeting structure is headed by the Governing Body. The Governing Body has responsibility to undertake the roles and responsibilities as delegated through the Constitution approved by the Member Practices which constitute the CCG.

In line with the NHS Constitution and the duty to involve the public, CCG Clinicians and Directors along with Directors from NHS provider organisations regularly meet with members of the public, community and third sector groups at a local forum facilitated by Healthwatch and are actively involved in initiatives supported by the Action for Health network run by the local CVS.

The CCG has also established co-production, working with its communities to help shape the service changes in North Cumbria. This has included establishing a network within which information can be shared, feedback can be sought and new ideas be developed together. This has strengthened valuable links with the CCG’s communities.

The committee structure that has been established to support the Governing Body in fulfilling its functions is detailed in below:

---

**Full Council of Members**

---

**System Leadership Board/Committee in Common**
The Membership, Attendance and Activity Summary

Full Council of Members Role and Performance Highlights

The Full Council of Members is an arena in which all member practices have the opportunity to come together to:

- ensure that the continued development of the CCG is aligned to the principles and aspirations of the constituent practices
- shape the organisation’s strategic direction and key objectives
- approve the CCG’s Constitution
- ensure that the Governing Body has published its Annual Reports and Accounts

The Full Council met twice in 2017/18 and was fully quorate at both meetings (see attendance table overleaf).

In addition to formal Full Council of Members meetings there have also been a number of GP Events which have focussed on engaging with the Membership to develop primary care strategies and to keep them informed and involved in the development of Integrated Care Communities.

Performance/highlights include:

- The first year of a revised approach to engagement based on networks of practices working together in Integrated Care Communities. Each group has a dedicated GP lead. The GP leads work together to provide collective leadership.
- The continued development of an Integrated Care System
- Clinical developments including new pathways of care and the introduction of new services
- Integrated Care Communities Development
- Changes to the CCG’s Constitution and Scheme of Delegation including authorisation to committees to approve polices
- The Governing Body’s approval of the CCG being members of the Joint CCG Committee for Cumbria and the North East (CNE)
- Voting system for Full Council of Members Meeting.
<table>
<thead>
<tr>
<th>Member Practice</th>
<th>Name of Representative &amp; Role</th>
<th>Attendance (Maximum of 2 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alston Medical Practice</td>
<td>Dr Michael Hanley – GP</td>
<td>1</td>
</tr>
<tr>
<td>Appleby Medical Practice</td>
<td>Dr Ashley Liston – GP, Debbie Hewitt – Practice Manager</td>
<td>1</td>
</tr>
<tr>
<td>Aspatria Medical Group</td>
<td>Dr Julie Saxton – GP</td>
<td>2</td>
</tr>
<tr>
<td>Beechwood Group Practice</td>
<td>Dr Gary Li – GP</td>
<td>2</td>
</tr>
<tr>
<td>Birbeck Medical Group</td>
<td>Dr Gail Marshall – GP, Dr Peter Hodkin – GP, Amanda Riley – Practice Manager</td>
<td>2</td>
</tr>
<tr>
<td>Brampton Medical Practice</td>
<td>Dr Mark Alban – GP</td>
<td>1</td>
</tr>
<tr>
<td>Caldbeck Surgery</td>
<td>Dr Rachel Kidd – GP, Dr Richard Massey – GP</td>
<td>1</td>
</tr>
<tr>
<td>Carlisle Healthcare</td>
<td>Dr Alan Edwards – GP, Dr Ian Marshall – GP, Dr Robert Westgate – GP, Dr Colin Patterson – GP</td>
<td>2</td>
</tr>
<tr>
<td>Castlegate &amp; Derwent Surgery</td>
<td>Dr Simon Desert – GP</td>
<td>2</td>
</tr>
<tr>
<td>Castlehead Medical Centre</td>
<td>Dr Jo Crone – GP, Carole Bell – Practice Manager, Catherine Penrice – Practice Manager</td>
<td>1</td>
</tr>
<tr>
<td>Court Thorn Surgery</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Dalston Medical Group</td>
<td>Dr John French – GP</td>
<td>1</td>
</tr>
<tr>
<td>Distington Surgery</td>
<td>Dr Helen Horton – GP, Dr Dominic Booth – GP, Dr Heather Naylor – GP</td>
<td>2</td>
</tr>
<tr>
<td>Eden Medical Group</td>
<td>Dr Sue Rossi – GP</td>
<td>2</td>
</tr>
<tr>
<td>Fellview Healthcare Ltd</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Fusehill Medical Practice</td>
<td>Dr Charlotte Asquith – GP</td>
<td>1</td>
</tr>
<tr>
<td>Glenridding Health Centre</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Member Practice</td>
<td>Name of Representative &amp; Role</td>
<td>Attendance (Maximum of 2 meetings)</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>James Street Group Practice</td>
<td>Dr Cherryl Timothy-Anotine – GP Dr Niall McGreevy – GP</td>
<td>2</td>
</tr>
<tr>
<td>Kirkoswald Surgery</td>
<td>Dr Viv Purdy – GP</td>
<td>1</td>
</tr>
<tr>
<td>Longtown Medical Practice</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Lowther Medical Centre</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Mansion House Surgery</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Maryport Group Practice</td>
<td>Dr Andrea Mulgrew – GP Dr Dan Berkeley – GP Dr Mark Steel – GP Dr Pauline Gage – GP</td>
<td>1</td>
</tr>
<tr>
<td>Orchard House Surgery</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Oxford Street Surgery</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Queen Street Medical Practice</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Seascale Health Centre</td>
<td>Dr Eves Miles – GP</td>
<td>1</td>
</tr>
<tr>
<td>Shap Medical Practice</td>
<td>Dr Woodstrover – GP</td>
<td>1</td>
</tr>
<tr>
<td>Silloth Group Medical Practice</td>
<td>Dr Darren Hymers – GP</td>
<td>1</td>
</tr>
<tr>
<td>Solway Health Services</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Spencer Street Surgery</td>
<td>Dr Rupak Saha – GP Dr Alex Docton – GP</td>
<td>2</td>
</tr>
<tr>
<td>Temple Sowerby Medical Practice</td>
<td>Dr Jo Thompson – GP</td>
<td>1</td>
</tr>
<tr>
<td>The Croft Surgery</td>
<td>Dr Gareth Smith – GP</td>
<td>1</td>
</tr>
<tr>
<td>The Lakes Medical Practice</td>
<td>Dr Rachel Preston – GP Dr Juliet Rhodes – GP Dr Mark Plenderleith – GP</td>
<td>2</td>
</tr>
<tr>
<td>Upper Eden Medical Practice</td>
<td>Dr Davina Soloman – GP</td>
<td>1</td>
</tr>
</tbody>
</table>
# Accountability Report – Part 2

## Member Practice

<table>
<thead>
<tr>
<th>Member Practice</th>
<th>Name of Representative &amp; Role</th>
<th>Attendance (Maximum of 2 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warwick Road Surgery</td>
<td>Rebecca Ware – Practice Manager</td>
<td>1</td>
</tr>
<tr>
<td>Warwick Square Group Practice</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Westcroft House</td>
<td>Dr Celia Heasman</td>
<td>2</td>
</tr>
<tr>
<td>Whitehaven Medical Centre</td>
<td>No representatives present</td>
<td>0</td>
</tr>
<tr>
<td>Wigton Group Medical Practice</td>
<td>Dr Anna Turnbull – GP</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Dr Christina Russell – GP</td>
<td></td>
</tr>
</tbody>
</table>

## Non-voting attendees

<table>
<thead>
<tr>
<th>Governing Body Members</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Rush (Chair)</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>David Rogers – Interim Accountable</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Officer/Medical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles Welbourn – Chief Finance Officer</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Peter Rooney – Chief Operating Officer</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dr Amanda Boardman – GP Lead</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Kevin Windebank – Secondary Care</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Specialist Doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Les Hanley</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CCG Directors</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Childs – Interim Chief</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Executive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caroline Rea – Director of Primary</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Care &amp; Integrated Care Communities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eleanor Hodgson – Director of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s &amp; Families</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Please note that where there was more than one representative attending only one representative counted towards the meeting being quorate.*
Governing Body
Role and Performance Highlights
2017/18

The Membership of the Governing Body is outlined in the Accountability section of this report.

The prime focus of the Governing Body is to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG’s principles of good governance whilst remaining true to its vision and values.

In addition to its core business the Governing Body has effectively overseen the following key areas of work (Please note this list is not exhaustive and business transacted by the Governing Body in 2017/18 can be found on the CCG’s website at: www.england.nhs.uk

- The CCG’s Vision, Values and Objectives
- Healthcare for the Future of West, North & East Cumbria – implementation of decisions taken 8 March 2017
- The CCG’s Financial Plan 2017/18
- Boundary Change handover plan
- The CCG’s Organisational and Governing Body Development Plan
- Integrated Care Communities/Systems
- Joint Working Arrangements
- Safeguarding (Adults & Children) Annual Report
- Quality Reports
- Performance Reports
- Finance Reports
- Cumbria Learning Improving Collaborative Reports
- Implementation of the statutory guidance June 2017 on Conflicts of Interest
- Annual Reports and Annual Accounts (AGM)
- CCG Annual Assurance Review
- Review of the CCG Constitution, Standing Orders, Scheme of Delegation, Prime Financial Regulations and Committee Terms of Reference and approval of said documents
- Review of the work of the Governing Body

There were again an increased number of meetings of the Governing Body during 2017/18. This was due to the significant pace of work to develop stronger working relationships across the North Cumbria Health Care system and to ensure that the commitments made by the Governing Body on 8 March 2017, around service change from the Health Care for the Future, were effectively delivered. It met 10 times during the said period and attendance records demonstrate that all meetings were quorate.

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Attendance (Maximum of 10 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Rush</td>
<td>Lay Chair</td>
<td>10</td>
</tr>
<tr>
<td>Dr David Rogers</td>
<td>Interim Accountable Officer/Medical Director</td>
<td>6</td>
</tr>
<tr>
<td>Dr Rachel Preston</td>
<td>Lead GP</td>
<td>2</td>
</tr>
<tr>
<td>(left the CCG on 31 May 2017)</td>
<td></td>
<td>(out of a possible 2)</td>
</tr>
<tr>
<td>Dr Colin Patterson</td>
<td>Lead GP</td>
<td>7</td>
</tr>
<tr>
<td>(became a Member May 2017)</td>
<td></td>
<td>(out of a possible 9)</td>
</tr>
<tr>
<td>Dr Amanda Boardman</td>
<td>Lead GP</td>
<td>6</td>
</tr>
<tr>
<td>(became a Member May 2017)</td>
<td></td>
<td>(out of a possible 9)</td>
</tr>
<tr>
<td>Peter Rooney</td>
<td>Chief Operating Officer</td>
<td>9</td>
</tr>
<tr>
<td>(became a Member June 2017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td>7</td>
</tr>
<tr>
<td>Peter Scott</td>
<td>Lay Member – Finance &amp; Governance (Vice-Chair)</td>
<td>7</td>
</tr>
<tr>
<td>Denise Leslie</td>
<td>Lay Member – Public Engagement</td>
<td>2</td>
</tr>
<tr>
<td>(appointed to role August 2017)</td>
<td></td>
<td>(out of a possible 4)</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member – Health Improvement</td>
<td>8</td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>Registered Nurse</td>
<td>9</td>
</tr>
<tr>
<td>Kevin Windebank</td>
<td>Secondary Care Specialist Doctor</td>
<td>9</td>
</tr>
</tbody>
</table>

**Observers**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue Stevenson</td>
<td>Healthwatch Cumbria</td>
<td>9</td>
</tr>
<tr>
<td>N/A</td>
<td>Local Medical Council</td>
<td>0</td>
</tr>
</tbody>
</table>

**Non-voting attendees**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Childs</td>
<td>Interim Chief Executive</td>
<td>7</td>
</tr>
<tr>
<td>Eleanor Hodgson</td>
<td>Director of Children and Families</td>
<td>5</td>
</tr>
<tr>
<td>Helen King</td>
<td>Director of Nursing &amp; Quality</td>
<td>0</td>
</tr>
<tr>
<td>Anna Stabler</td>
<td></td>
<td>1 (out of a possible 1)</td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>Director of Primary Care &amp; Integrated Care Communities</td>
<td>3</td>
</tr>
</tbody>
</table>
Audit Committee
Role and Performance Highlights
2017/18

The Audit Committee is responsible for the CCG’s governance and risk management process controls and internal control arrangements.

The Committee met four times throughout 2017/18 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include:
Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted for 2016/17, can be found in the Governing Body papers on the CCG’s website at: www.england.nhs.uk

• External Auditors Assurance on the CCG’s internal control arrangements
• Internal Auditors Assurance on planned work programmes which included (please note this is not an exhaustive list):
  - Financial Planning, Budgetary Control and Performance Reporting
  - Financial Systems, Cash and Treasury Management
  - Primary Care Commissioning including Funding Requests
  - Continuing Health Care and Funded Nursing Care and Direct Payments
  - Risk Based Audit of Assurance Framework
  - Risk Based Audit of Conflicts of Interest
  - Governance Structures

All of the above Internal Audits have shown that governance, risk management and control arrangements provide substantial assurance that the risks identified were managed effectively. Compliance with the control framework was found to be taking place. This is the highest level of assurance available for these audits.

• Internal Auditor Assurance on Counter Fraud
• Implementation of NHS England’s Statutory Guidance (June 2017) for CCG’s: Managing Conflicts of Interest
• Assurance on year end processes including the production of the Annual Report and Accounts
• Review of the working arrangements for this Committee and its Terms of Reference
### Accountability Report – Part 2

<table>
<thead>
<tr>
<th>Member’s Name</th>
<th>Role</th>
<th>Attendance (Maximum of 4 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Scott</td>
<td>Lay Member – Finance &amp; Governance (Chair)</td>
<td>4</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member – Health Improvement</td>
<td>4</td>
</tr>
<tr>
<td>Denise Leslie</td>
<td>Lay Member – Public Engagement</td>
<td>1 (out of a possible 2)</td>
</tr>
<tr>
<td>(Appointed August 2017)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Non-voting attendees

<table>
<thead>
<tr>
<th>Non-voting attendees</th>
<th>Role</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td>4</td>
</tr>
<tr>
<td>Jo Brown</td>
<td>Grant Thornton</td>
<td>4</td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>Auditone</td>
<td>4</td>
</tr>
</tbody>
</table>
Auditor Panel
Role and Performance Highlights
2017/18

The prime responsibility of the Auditor Panel is to advise the CCG on the selection, appointment and removal of the CCG’s external auditors and ensure that the proposed contractual arrangements are appropriate.

The Committee met once throughout 2017/18 and attendance records demonstrate that the meeting was quorate.

Performance/highlights include:
• Procurement of the External Auditor for 2018/19 and 2019/20

<table>
<thead>
<tr>
<th>Member’s Name</th>
<th>Role</th>
<th>Attendance (Maximum of 1 meeting)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Scott</td>
<td>Lay Member – Finance &amp; Governance (Chair)</td>
<td>1</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member – Health Improvement</td>
<td>1</td>
</tr>
<tr>
<td>Denise Leslie</td>
<td>Lay Member – Public Engagement</td>
<td>1</td>
</tr>
</tbody>
</table>

Non-voting attendees

| Charles Welbourn | Chief Finance Officer | 1 |
Executive Committee
Role and Performance Highlights
2017/18

The Executive Committee ensures that there is continuous engagement with the CCG’s membership and that members’ views influence and inform the development of the CCG’s commissioning priorities, plans and arrangements for their implementation. It ensures effective engagement in determining clinical policies. It is responsible for compliance with statutory and regulatory duties, operational delivery of all CCG functions and performance management of the objectives of the organisation.

Performance/highlights include:

Please note this list is not exhaustive and business transacted by the Executive Committee in 2017/18, full details of what business has been undertaken in at the Committee via its minutes which can be found in the Governing Body papers on the CCG’s website at:


- QIPP Initiatives
- Five year forward view and implications for Cumbria and the North East
- Prescribing budgets
- Quality Improvement Scheme 2017/18
- Organisational Development (OD) Strategy and Action Plan
- Section 12 Doctors arrangements
- WNE Cumbria – Whole System Discharge
- WNE Cumbria Local Maternity System (LMS) Plan
- Integrated Care Systems
- Better Care Fund
- Co-production work with North Cumbria communities updates
- Review of the working arrangements for this Committee and its Terms of Reference
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Attendance (Maximum of 11 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr David Rogers</td>
<td>Interim Accountable Officer/Medical Director (Chair)</td>
<td>10</td>
</tr>
<tr>
<td>Dr Niall McGreevy</td>
<td>Integrated Care Community Lead GP</td>
<td>9</td>
</tr>
<tr>
<td>Dr Amanda Boardman</td>
<td>Lead GP</td>
<td>10</td>
</tr>
<tr>
<td>Dr Colin Patterson</td>
<td>Lead GP</td>
<td>8</td>
</tr>
<tr>
<td>Dr Celia Heasman</td>
<td>Integrated Care Community Lead GP</td>
<td>4</td>
</tr>
<tr>
<td>Dr Helen Horton</td>
<td>Lead GP</td>
<td>9</td>
</tr>
<tr>
<td>Dr Eve Miles (Attends in the absence of Dr Celia Heasman)</td>
<td>Integrated Care Community Lead GP</td>
<td>2</td>
</tr>
<tr>
<td>Dr Rachel Preston (Left 31 May 2017)</td>
<td>Lead GP</td>
<td>1 (out of a possible 1)</td>
</tr>
<tr>
<td>Stephen Childs</td>
<td>Interim Chief Executive</td>
<td>2</td>
</tr>
<tr>
<td>Peter Rooney</td>
<td>Chief Operating Officer</td>
<td>7</td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td>9</td>
</tr>
<tr>
<td>Eleanor Hodgson</td>
<td>Director for Children’s &amp; Families</td>
<td>8</td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>Director for Primary Care &amp; Integrated Care Communities</td>
<td>7</td>
</tr>
<tr>
<td>Helen King (Left September 2017)</td>
<td>Director of Nursing &amp; Quality</td>
<td>2 (out of a possible 5)</td>
</tr>
<tr>
<td>Anna Stabler (From February 2018)</td>
<td>Director of Nursing &amp; Quality</td>
<td>2 (out of a possible 2)</td>
</tr>
</tbody>
</table>
Finance & Performance Committee
Role and Performance Highlights
2017/18

The core aims and responsibilities of the Finance & Performance Committee are to provide assurance to the Governing Body on the CCG’s finances and performance issues. Including:

- providing leadership in making recommendations to the Governing Body for the deployment of resources and budgets
- providing leadership in ensuring that the CCG is fulfilling its responsibilities in improving the performance of the health care system against standards, and in managing its contract activity effectively.

The Committee met twelve times throughout 2017/18 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include:

Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted for 2017/18, can be found in the Governing Body papers on the CCG’s website at: www.northcumbriaccg.nhs.uk/about-us/how-we-make-decisions/Governing-Body-Meetings/index.aspx

- Financial & Cost Improvement Programme
- Performance Report & Winter Planning Updates
- Approach to Care Home Funding
- Finance Reports
- Better Care Fund Update Reports
- Pensions Automatic Enrolment
- NHS Cumbria CCG Improvement Plan
- NHS Cumbria CCG Assurance Assessments (undertaken by NHS England)
- NHS Cumbria CCG Operational Plan
- Approval of non-clinical based policies (e.g. HR, Business Code of Conduct)
- Scrutiny of non-clinical Business Cases prior to approval
- Assurance Framework & Risk Register
- Health & Safety Update Report
- HR Update Reports
- Review of the work of the Governing Body
<table>
<thead>
<tr>
<th>Member’s Name</th>
<th>Role</th>
<th>Attendance (Maximum of 12 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Rush</td>
<td>Chair</td>
<td>11</td>
</tr>
<tr>
<td>David Rogers</td>
<td>Interim Accountable Officer/ Medical Director</td>
<td>1</td>
</tr>
<tr>
<td>Stephen Childs</td>
<td>Interim Chief Executive</td>
<td>8</td>
</tr>
<tr>
<td>Peter Rooney</td>
<td>Chief Operating Officer</td>
<td>11</td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td>12</td>
</tr>
<tr>
<td>Peter Scott</td>
<td>Lay Member – Finance &amp; Governance (Chair)</td>
<td>7</td>
</tr>
<tr>
<td>Denise Leslie</td>
<td>Lay Member – Public Engagement</td>
<td>3 (out of a possible 8)</td>
</tr>
<tr>
<td>(Appointed August 2017)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member – Health Improvement</td>
<td>8</td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>Registered Nurse</td>
<td>10</td>
</tr>
<tr>
<td>Kevin Windebank</td>
<td>Secondary Care Specialist Doctor</td>
<td>10</td>
</tr>
</tbody>
</table>
Outcome & Quality Assurance Committee 
Role and Performance Highlights 2017/18

The Outcomes & Quality Assurance Committee examines, in detail, the areas of concerns in the quality of care provided to patients in North Cumbria. It works closely with the Nursing & Quality team to ensure that the assurance provided to the Governing Body is robust and demonstrates that the quality assurance systems and processes are in place.

During the course of 2017/18 this Committee has undertaken a number of reviews and agreed a refreshed approach to the monitoring of quality and safety. This has included the development and approval of a Quality Strategy. This will support the assurance process to the Governing Body that the services commissioned by the CCG meets the requirements of the NHS Constitution.

The Committee met seven times throughout 2017/18 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include:
Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted for 2017/18, can be found in the Governing Body papers on the CCG’s website at: www.northcumbriaccg.nhs.uk/about-us/how-we-make-decisions/Governing-Body-Meetings/index.aspx

- Scrutinising Quality Report prior to presentation to the Governing Body (including unexplained deaths, pressure ulcers, serious untoward incidents, never events)
- Safeguarding (including the CCG’s Self-Assessment submission, Policies and Safeguarding Annual Reports)
- Regulation 28 Action Plan
- Receipt of minutes from the Quality Review Group
- Area Prescribing Recommendations
- Non-medical Prescribing Policy
- Review of the working arrangements for this Committee and its Terms of Reference
<table>
<thead>
<tr>
<th>Member’s Name</th>
<th>Role</th>
<th>Attendance (Maximum of 7 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Les Hanley</td>
<td>Lay Member – Health Improvement</td>
<td>6</td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>Registered Nurse</td>
<td>7</td>
</tr>
<tr>
<td>Denise Leslie (Appointed August 2017)</td>
<td>Lay Member – Public Engagement</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(out of a possible 5)</td>
</tr>
<tr>
<td>David Rogers</td>
<td>Interim Accountable Officer /Medical Director</td>
<td>2</td>
</tr>
<tr>
<td>Helen King (Left September 2017)</td>
<td>Director of Nursing &amp; Quality</td>
<td>0</td>
</tr>
<tr>
<td>Louise Mason Lodge</td>
<td>Interim Director of Nursing &amp; Quality</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(out of a possible 4)</td>
</tr>
<tr>
<td>Andrea Loudon</td>
<td>Head of Primary Care Development/Medicines Management Lead</td>
<td>4</td>
</tr>
<tr>
<td>Anna Stabler (Appointed February 2018)</td>
<td>Director of Nursing &amp; Quality</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(out of a possible 1)</td>
</tr>
<tr>
<td>Kevin Windebank</td>
<td>Secondary Care Doctor</td>
<td>4</td>
</tr>
</tbody>
</table>
Primary Care Committee

On the 1 April 2017 North Cumbria CCG was delegated authority by NHS England to review, plan and procure primary medical care services in North Cumbria. As part of that delegation the Governing Body established a Primary Care Committee which meets in public to manage those functions agreed between NHS England and the CCG together with certain duties delegated to it by the CCG as set out in its Scheme of Delegation.

The Committee’s full Terms of Reference can be found on the CCG website: www.england.nhs.uk

The Committee met seven times throughout 2017/18 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights include:

Please note this list is not exhaustive and the minutes of this Committee outlining the business transacted for 2017/18, can be found in the Governing Body papers on the CCG’s website at: www.northcumbriaccg.nhs.uk/about-us/how-we-make-decisions/Governing-Body-Meetings/index.aspx

- Sale of Lease back of GP Premises
- Changes to GP contract 2017/18
- Applications for branch closures
- Extension of list closures
- CCG Quality Improvement Schemes
- CCG Gain Share Schemes
- Primary Care Quality Assurance and Improvement Framework
- Review of the working arrangements for this Committee and its Terms of Reference
<table>
<thead>
<tr>
<th>Member’s Name</th>
<th>Role</th>
<th>Attendance (Maximum of 7 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Rush</td>
<td>Lay Chair</td>
<td>7</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member – Health Improvement</td>
<td>1 (stepped down January 2018)</td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>Registered Nurse</td>
<td>7</td>
</tr>
<tr>
<td>David Rogers</td>
<td>Interim Accountable Officer /Medical Director</td>
<td>6</td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td>7</td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>Director of Primary Care &amp; Integrated Care Communities Development</td>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-voting attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Colin Patterson</td>
</tr>
<tr>
<td>Dr Niall Mcgreevy Dr Alan Edwards</td>
</tr>
<tr>
<td>Sue Gallagher</td>
</tr>
<tr>
<td>Helen Horne</td>
</tr>
<tr>
<td>Andrew Gosling</td>
</tr>
<tr>
<td>Andrea Loudon</td>
</tr>
<tr>
<td>Kay Wilson</td>
</tr>
<tr>
<td>Denise Jones Helen Renyard Jenny Long</td>
</tr>
<tr>
<td>Local Medical Council Representative</td>
</tr>
</tbody>
</table>
Remuneration Committee
Role and Performance Highlights
2017/18

The Remuneration Committee is responsible for making recommendations to the Governing Body about appropriate remuneration and terms of service for all posts above the top threshold of the National Agenda for Change (AfC) pay-scale, including off-payroll appointments, including:

- all aspects of salary (including any performance-related elements/bonuses);
- provisions for other benefits e.g. car allowances
- advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

The Committee met three times during the course of 2017/18 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Part 2 Governing Body meetings. All Very Senior Managers salaries considered by this Committee are disclosed as part of the Remuneration Report contained in this document.

The Governing Body and all the Committee’s listed above have undertaken a review of the work they have undertaken throughout 2017/18 to ensure that they have fulfilled their remit and responsibilities. This has included reviewing the membership of the Committees and any training requirements there may be for Committee Members. These reviews have informed the work programmes for 2018/19.

<table>
<thead>
<tr>
<th>Member’s Name</th>
<th>Role</th>
<th>Attendance (Maximum of 3 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Scott</td>
<td>Lay Member – Finance &amp; Governance (Chair)</td>
<td>3</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member – Health Improvement</td>
<td>3</td>
</tr>
<tr>
<td>Denise Leslie (Appointed August 2017)</td>
<td>Lay Member – Public Engagement</td>
<td>1 (out of 1)</td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>Registered Nurse</td>
<td>3</td>
</tr>
<tr>
<td>Kevin Windebank</td>
<td>Secondary Care Specialist Doctor</td>
<td>2</td>
</tr>
</tbody>
</table>
Implementation Reference Group
Role and Performance Highlights
2017/18

On 8 March 2017, NHS Cumbria CCG’s Governing Body agreed to establish an Implementation Reference Group as part of the governance structure following the completion of the Healthcare for the Future public consultation. These were:

- Maternity Services
- Paediatric Services
- Community Hospitals
- Emergency & Acute Care
- Hyper-Acute Stroke Services
- Emergency Surgery, Trauma and Orthopaedic Services

The Group first met in November 2017 and its role is to apply critical review to implementation proposals relating to the above service areas and to make recommendations to the Governing Body.

The Committee met four times throughout 2017/18 and attendance records demonstrate that each meeting was quorate. The minutes of this Committee are presented for assurance to the Governing Body.

Performance/highlights are:

- Maternity and Paediatrics Services
- Community Hospitals Proposals
- Hyper Acute Stroke Services

<table>
<thead>
<tr>
<th>Member’s Name</th>
<th>Role</th>
<th>Attendance (Maximum of 4 meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kevin Windebank</td>
<td>Secondary Care Specialist Doctor</td>
<td>3</td>
</tr>
<tr>
<td>David Rogers</td>
<td>Interim Accountable Officer/Medical Director</td>
<td>4</td>
</tr>
<tr>
<td>Denise Leslie</td>
<td>Lay Member – Public Engagement</td>
<td>4</td>
</tr>
<tr>
<td>Peter Rooney</td>
<td>Chief Operating Officer</td>
<td>4</td>
</tr>
<tr>
<td>Celia Heasman or Eve Miles</td>
<td>ICC GP Lead</td>
<td>3</td>
</tr>
<tr>
<td>Caroline Otley</td>
<td>Third Sector Representative</td>
<td>3</td>
</tr>
<tr>
<td>Sue Stevenson</td>
<td>Healthwatch Cumbria</td>
<td>4</td>
</tr>
</tbody>
</table>
Joint CCG Committee for Cumbria and the North East (CNE)

This Committee is made up of 12 CCGs from across the region and has been established to aid joint and streamlined commissioning decisions. This Committee is in the early development stage and has only met twice during 2017/18. Whilst the Terms of Reference have been agreed by all 12 CCGs the work programme is still in the process of being developed. North Cumbria CCG is represented on the Committee by Jon Rush, Lay Chair and David Rogers, Interim Accountable Officer/Medical Director. Jon Rush has also been appointed Chair of this Committee.

Performance/highlights are:

- Establishment of the Committee and agreeing Committee Terms of Reference
- Procurement of 111 Services – Pertinent to the North East CCG’s only

Internal Audit for Governance Structures 2017/18

Auditone has undertaken a risk based audit on Governance Structures during 2017/18 and concluded that the governance, risk management and control arrangements in this area of work provided substantial assurance that the risks identified were managed effectively. Compliance with the control framework was found to be taking place.
Better Care Fund Governance Arrangements

The Better Care Fund (BCF) is a single pooled budget, managed through a Section 75 Agreement, which began in 2014/15. It was introduced to further encourage joint commissioning of integrated health and social care services and brings together a portion of existing NHS and local government resources.

Whilst, at a local level, North Cumbria CCG, Morecambe Bay CCG and Cumbria County Council are the accountable bodies for their respective elements of the BCF, the Cumbria Joint Commissioning Board, established as a working group of the Cumbria Health and Wellbeing Board, leads the performance management and provides the co-ordination role for the delivery of the Better Care Fund.

The Joint Commissioning Board is chaired by Cumbria County Council’s Corporate Director of Health and Care Services.

The NHS England Policy Framework for the Better Care Fund requires the Health and Wellbeing Board to receive and sign off the final plan and quarterly progress reports to ensure oversite of the strategic direction and delivery of better integrated care. This helps to fulfil their statutory duty to encourage integrated working between commissioners.

In North Cumbria the schemes identified within the BCF plan are all closely aligned to the West North East Cumbria Sustainability and Transformation Plan.

Cumbria Health Care Fund Integrated System Governance
Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG’s statutory duties. Each directorate has an OGIM (Objectives, Goals, Initiatives and Metrics) framework to ensure that the CCG’s objectives are met. The OGIM’s are reviewed on a monthly basis at the Programme Review Board.

Risk management arrangements and effectiveness

The CCG’s Risk Management Framework sets out the approach and arrangements for the management of risk. The CCG ensures a common and systematic approach to risk management to ensure it is embedded across all directorates, which enables risks to be identified and managed effectively in the most appropriate place.

These principles are consistent with those within the NHS England’s Risk Management Policy and Process Guide issued in January 2015.

As part of the Boundary Change process the risk register was reviewed and risks associated with South Cumbria were transferred to Morecambe Bay CCG as part of the handover process. This was with effect from 1 April 2017.

Throughout 2017/18 the CCG has continued to work with North of England Commissioning Support (NECS) to review and embed the way risks are managed and recorded and ensure that they are closely linked with the CCG’s objectives.

NECS continues to run through each section’s risks with the Risk Champions so they fully understand the importance of ensuring that there is a thorough process of risk assessment in place.
This has helped to embed the systematic and effective management of risk and has informed and guided staff as to the way in which all significant risks must be controlled. This has supported the following:

- ensuring an organisational wide approach is taken to risk management
- minimising the exposure to operational, financial and business risks by effective risk identification and risk prioritisation
- ensuring that risks to enable the achievement of CCG’s objectives are fully understood and effectively managed
- the maintenance of a risk management framework which assures the Governing Body that strategic and operational risks are being effectively managed
- ensuring that risk management has a cohesive element of the internal control systems within the CCG’s corporate governance framework
- ensuring that risk management is an integral part of the CCG’s culture and its operating systems
- ensuring that the CCG meets its statutory obligations including those relating to health and safety and data protection
- providing assurance to customers, staff and partner organisations that the CCG is committed to managing risk appropriately, including through its supply chain
- protecting the services, staff, reputation and finances of the CCG through the process of early identification of risk, risk assessment, risk control and elimination

This has resulted in:

- risk management being embedded as an integral part of the management approach to the achievement of the CCG’s objectives
- management of risk has been seen as a collective and individual responsibility, managed through the Programme Review Group and agreed committees
- staff have been encouraged to report problems and incidents with a view to individuals and the organisation learning the lessons
- customer feedback, complaints and staff feedback being used as an integral part of the approach to risk management
- risk management training continues to be available from the North of England Commissioning Support (NECS) for all the senior team and administration
- each directorate reviews its risks and updates them on a monthly basis and these are reviewed at the CCG’s Programme Review meetings (monthly) prior to being presented to the Finance & Performance Committee and then the Governing Body

This has resulted in:

- risk management being embedded as an integral part of the management approach to the achievement of the CCG’s objectives
- management of risk has been seen as a collective and individual responsibility, managed through the agreed committee and management structures
- staff have been encouraged to report problems and incidents with a view to individuals and the organisation learning the lessons
- customer feedback, complaints and staff feedback being used as an integral part of the approach to risk management
- risk management training having been provided by the North of England Commissioning Support (NECS) for all the senior team and administration
- each directorate reviews its risks and updates them on a monthly basis and these are reviewed at the CCG’s Programme Review meetings (monthly) prior to being presented to the Finance & Performance Committee and then the Governing Body
Capacity to Handle Risk

The CCG’s Governing Body has overall responsibility for governance, assurance and management of risk. The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes and controls in place to mitigate those risks and the impact they may have on the organisation and its stakeholders.

Whenever risks have been identified risks have been assessed and recorded so that the appropriate controls have been put in place to eliminate or mitigate the risk.

Risks have been assessed in terms of the likelihood of occurrence and the consequences of impact. In order to arrive at an overall risk rating of the residual risk, the risk has been rated to take account of the effectiveness of the controls, i.e. whether they were considered to be satisfactory, have some weaknesses or considered to be weak. This has then provided the overall residual risk rating. Once this was determined a plan identifying further mitigating action(s) were put in place.

For each risk that was not adequately controlled, an action plan to reduce or eliminate the risk was put in place. The implementation of the action plan and the residual risk assessment has been kept under review to assess whether planned actions have reduced or eliminated the risk as expected.

The CCG has endeavoured to reduce risks to the lowest possible level that was reasonably practicable. Where possible all risks have be avoided, transferred or retained. Where this has not been possible, every effort has been made to mitigate the remaining risk(s).

The threshold level of risk exposure which, when exceeded, has triggered an escalation to bring the situation to the attention of a senior manager. Where risks have scored as 15 or above they have been escalated to a senior manager and the Director. It is then reviewed, monitored and reported through the Programme Review Group and the present to the Finance & Performance Committee and Governing Body four monthly. Low, moderate and high risks have been managed and monitored at directorate level. However, where a risk has not been scored as extreme, but nevertheless has been a cause of concern, it has been highlighted to the Programme Review Group for escalation to the Finance & Performance Committee and the Governing Body.
Risk Assessment

The Governing Body has reviewed the Assurance Framework on a four-monthly basis. The Corporate Risk Register has been reviewed monthly by Directors and Senior Managers at the Programme Review Group.

The CCG’s Audit Committee has developed, implemented, and monitored a risk management review process. This has ensured that the management and aligned risk registers have been managed effectively. This has resulted in the Governing Body being assured that there are robust sound and safe risk escalation and management processes in place across the organisation. In 2017/18 Audit One undertook a risk-based audit of the Assurance Framework and found that governance, risk management and control arrangements, in this area of work, provided substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.

The Finance & Performance Committee has reviewed the corporate risk register on a four-monthly basis and has provided assurance to the Governing Body.

The Directors and Senior Managers, through the Programme Review Group, have reviewed the Corporate Risk Register and have verified controls and ensured mitigating action plans are in place. They have also considered the emerging corporate risks escalating operation problems for onward reporting through the Corporate Risk Register. They have ensured staff comply with all organisational policies and procedures and have led the management of risk by devising short, medium and long-term strategies to identify and manage risk, including the production of any action plans.

The diagram below illustrates the governance structure and control mechanisms which are established and support the processes specified above:
Risk Register

Listed over the following pages is the corporate risk assurance framework which highlights the CCG’s principal risks and the measures being taken to mitigate those risks.
### 1. Support Continuous Improvement Within Existing Services, Including General Practice

<table>
<thead>
<tr>
<th>Strategic Risk Ref</th>
<th>Description</th>
<th>Director Owner</th>
<th>Controls</th>
<th>Internal Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1935</td>
<td>North Cumbria University Hospitals NHS Trust (NCUHT) will fully implement the recommendations of Better Births and the decisions made following consultation. This will result in the CCG being unable to commission the preferred maternity service identified through consultation, which will result in an increased travel for women and babies and reputational risk to the CCG.</td>
<td>Director of Children’s Integration</td>
<td>Public consultation carried out leading to a hierarchy of options, with Option 1 to be actively pursued for one year (yet to start).</td>
<td>Co-production meeting arrangements and records.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decision has been subject to external scrutiny and has been approved by the Secretary of State.</td>
<td>Work of the independent panel has begun.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Comprehensive Better Births plan is in place.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Co-production infrastructure is in place Independent panel assessing progress against the plan is in place.</td>
<td></td>
</tr>
<tr>
<td>964</td>
<td>NCUHT is unable to continue to provide sustainable services that are accessible to the population of North Cumbria.</td>
<td>Chief Operating Officer</td>
<td>The Cumbria &amp; North East NHS England Medical Director is leading a process to support ‘distressed services’ across the sub region, with direct input from the CCG and NCUHT Medical Directors.</td>
<td>Implementation Reference Group will report to the CCG’s Governing Body in relation to the service changes agreed after the public consultation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>A formal governance process for requesting mutual aid/partnership working/collaborative working/clinical networks with Newcastle Hospitals NHS Foundation Trust will be established in 2018.</td>
<td>Governing Body receives a report at each meeting on progress following the Consultation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Performance and Quality issues are reviewed through the contracting process and reported to the appropriate Governing Body Committee.</td>
<td></td>
</tr>
<tr>
<td>External Assurances</td>
<td>Gaps in Controls</td>
<td>Gaps in Assurances</td>
<td>Action on Gaps</td>
<td>Risk Rating</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Better Births plan and supporting documents from sub groups.</td>
<td>National challenge in recruiting sufficient midwives, and agreeing working models that can deliver continuity of care.</td>
<td>The independent panel has commenced, however until their report is complete and signed-off full assurance cannot be provided (hence no change to the scoring of the risk). has commenced, however until their report is complete and signed-off full assurance cannot be provided (hence no change to the scoring of the risk).</td>
<td>None being taken (pending receipt of independent panel report).</td>
<td>Very High (Red)</td>
</tr>
<tr>
<td>Following the most recent CQC inspection the Trust has been removed from special measures (it is now rated as “requires improvement”).</td>
<td>Completion of the final Business Cases for each of the service changes agreed following the public consultation</td>
<td>None identified.</td>
<td>None identified.</td>
<td>High (Amber)</td>
</tr>
</tbody>
</table>
2. Commission A Range Of Health Services...

<table>
<thead>
<tr>
<th>Strategic Risk Ref</th>
<th>Description</th>
<th>Director Owner</th>
<th>Controls</th>
<th>Internal Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1937</td>
<td>Changes to Section 136 and 135 of the Mental Health act 1983, as a result of the planned implementation of the Policing and Crime Act 2017 (Dec 2017). Risk of non compliance to the Act in terms of the reduced section 136 timeframe of 24 hours. Main risks for North Cumbria CCG: 1) inability of the CCG to provide access to CAMHS psychiatry within the required timescale 2) Potential litigation risk to the CCG as a result of 1) Above. 3) Reputational Impact of non-compliance with The Mental Health</td>
<td>Director of Children’s Integration. Policing &amp; Crime act multi agency work group established. Guiding principles document drafted to cover exceptional cases, whereby the system is unable to fully adhere to the Act. Arrangements for the spot purchase of access to CAMHS psychiatry being explored</td>
<td>Final draft guiding principles document (initially agreed 25.7.17) for sign-off via each agencies’ Governing Body for implementation 4/9/17. However, in light of CCG legal advice (to reframe document to ensure compliance with legal requirements of the Act) final draft guiding principles document (initially agreed 25.7.17) for sign-off via each agencies’ Governing Body for implementation 4/9/17.</td>
<td></td>
</tr>
<tr>
<td>1931</td>
<td>Delivery of A&amp;E four hour constitutional standard. Pressure in the urgent care system impacts on the ability to deliver the 95% four hour A&amp;E standard and the trajectories agreed with NHS England and NHS.</td>
<td>Chief Operating Officer</td>
<td>A&amp;E Delivery Board provides system-wide oversight of the standard. CCG Finance and Performance Committee and Programme Review Board receives monthly performance reports. Pathway reviews as part of ICC development and work with Primary Care, North West Ambulance Service and Community Services to avoid attendance and admission to acute services</td>
<td>Monthly reporting to Finance and Performance Committee, including an additional update during the winter period. Sustainability and Transformation Partnership (STP) and CCG Programme Management.</td>
</tr>
<tr>
<td>External Assurances</td>
<td>Gaps in Controls</td>
<td>Gaps in Assurances</td>
<td>Action on Gaps</td>
<td>Risk Rating</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------</td>
<td>--------------------</td>
<td>----------------</td>
<td>------------</td>
</tr>
<tr>
<td>Not applicable; Internal assurances only in place</td>
<td>None identified.</td>
<td>None identified.</td>
<td>None identified.</td>
<td>Very High (Red)</td>
</tr>
<tr>
<td>Monthly A&amp;E Delivery Board meetings, including representation from NHS England and NHS Improvement.</td>
<td>None identified.</td>
<td>Sign-off of investment and service changes.</td>
<td>Needs to be accepted as a sustainable plan which will be self-financing</td>
<td>High (Amber)</td>
</tr>
</tbody>
</table>
## Corporate Risk Register

<table>
<thead>
<tr>
<th>Strategic Risk Ref</th>
<th>Description</th>
<th>Director Owner</th>
<th>Controls</th>
<th>Internal Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Commission A Range Of Health Services...</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1932</td>
<td>Achievement of 18 week Elective and 6 week diagnostic Referral to Treatment (RTT) targets. Capacity (workforce and infrastructure) constraints impact on the ability to deliver the RTT constitutional standards.</td>
<td>Chief Operating Officer.</td>
<td>Contract Review Group meets monthly to consider contract issues and risks. Monthly CCG Performance Report to Programme review Group. National mandates to reduce elective workload during times of peak non-elective demand (such as Christmas / New year) reduces risk in the short term, but increases the risk of non-achievement during the recovery period.</td>
<td>Reporting to Finance and Performance Committee.</td>
</tr>
<tr>
<td>1933</td>
<td>Risk of non-achievement of the Cancer Constitutional Standards Increasing demand, together with both capacity issues at NCUHT and the impact of patient transfers to other providers for treatment impact on the ability to meet the national constitutional cancer standards. Where local recovery standards have been agreed, the risk is assessed against these standards. 14 Day, 31 Day and 62 Day Standards.</td>
<td>Chief Operating Officer.</td>
<td>Contract Review Group between CCG and NCUHT. Increased local treatment capacity through the new “Linear Accelerator”. Improved patient tracking following additional resources deployed by NCUHT, together with increased rigour at weekly patient tracking meetings and better management of multi-disciplinary teams (MDTs).</td>
<td>Regular reporting to Finance and Performance Committee. CCG Performance Report.</td>
</tr>
<tr>
<td>External Assurances</td>
<td>Gaps in Controls</td>
<td>Gaps in Assurances</td>
<td>Action on Gaps</td>
<td>Risk Rating</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>------------------</td>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>North Cumbria University Hospitals NHS Trust (NCUHT) and Cumbria Partnership Foundation NHS Trust (CPFT) to agree a performance trajectory with NHS Improvement</td>
<td>None identified.</td>
<td>NCUHT have not agreed a Referral to Treatment (RTT) recovery trajectory with CCG or NHS Improvement</td>
<td>None identified.</td>
<td>High (Amber)</td>
</tr>
<tr>
<td>The Cumbria and North East Cancer Alliance Board is providing additional support and scrutiny on the cancer standards.</td>
<td>Final business case approval for the second replacement “Linear Accelerator”</td>
<td>Staff training and turnover still means that risks exist in ensuring a sustainable tracking service.</td>
<td>Recruitment, training and working with clinical departments and IT to achieve streamlined tracking processes that people understand and can respond to.</td>
<td>High (Amber)</td>
</tr>
<tr>
<td>Strategic Risk Ref</td>
<td>Description</td>
<td>Director Owner</td>
<td>Controls</td>
<td>Internal Assurances</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1778</td>
<td>Financial Planning &amp; Control.</td>
<td>Chief Operating Officer.</td>
<td>Financial position reported monthly to Finance and Performance Committee and standing item on Governing Body.</td>
<td>Plan and budget based upon PCBC and system buy-in of risks. CCG holding reserves apart from “must dos” to increase uncommitted contingency</td>
</tr>
<tr>
<td></td>
<td>The CCG does not deliver the agreed financial control total for 2017/18.</td>
<td></td>
<td>Detailed cost improvement plan established and phased throughout the year.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ongoing monitoring through Programme Delivery Group.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Background monitoring of system-wide finances undertaken by all Organisations.</td>
<td></td>
</tr>
<tr>
<td>External Assurances</td>
<td>Gaps in Controls</td>
<td>Gaps in Assurances</td>
<td>Action on Gaps</td>
<td>Risk Rating</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------</td>
<td>--------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>System-wide risk share to be established for the end of Q2: outline agreement supported by System Leadership Board.</td>
<td>Further mitigations required if plans do not deliver.</td>
<td>To date, on plan - but risks highlighted if schemes do not deliver in coming months.</td>
<td>CCG working with NCUHT &amp; CPFT to support the delivery of all organisations’ control totals.</td>
<td>High (Amber)</td>
</tr>
<tr>
<td>Further review of system-wide schemes through System Leadership Board and sub-structure.</td>
<td>Resources continue to be sought to cover risks flagged in PCBC</td>
<td>CCG negotiated additional risk share with Cumbria County Council regarding Better Care Fund - February 2017.</td>
<td>CCG identified 17 practices to actively work with regarding unexplained and unwarranted variation.</td>
<td></td>
</tr>
<tr>
<td>Establishing system-wide financial reporting from October 2017.</td>
<td></td>
<td>CCG proposed sparsity mitigation to UHMBFT - February 2017.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## 4. Continuously Improve Our Organisation And Support Our Staff To Excel

<table>
<thead>
<tr>
<th>Strategic Risk Ref</th>
<th>Description</th>
<th>Director Owner</th>
<th>Controls</th>
<th>Internal Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>1773</td>
<td>Difficulties in recruiting to general practice workforce. General practice across Cumbria has significant workforce issues, due to inability to recruit GPs and nurses. High levels of vacancies means general practice in some areas is at risk of being unable to deliver core services, potentially resulting in reduced quality and harm to patients. This would also have a consequent impact on other provider services. This risk is consistent with the difficulties being faced by many CCGs’ across the country.</td>
<td>Director of Primary Care &amp; ICC Development</td>
<td>Successful bid to NHSE for Overseas recruitment support. First wave of recruits arrive in Sept 2017. Developed a Virtual Recruitment Hub to support GP recruitment in Cumbria. Bursary from Health Education England (HEE) for GP trainees. New models of delivery for services. Development of workforce modelling for general practice</td>
<td>Steering group in place, training director appointed, NHSE assurance process in place. Dedicated member of staff seconded to manage and develop this work Increased awareness of bursary availability to GP trainees in Cumbria. Director of Primary Care is working in close liaison with CPFT Medical Director.</td>
</tr>
<tr>
<td>External Assurances</td>
<td>Gaps in Controls</td>
<td>Gaps in Assurances</td>
<td>Action on Gaps</td>
<td>Risk Rating</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>NHSE aware and supporting project monitoring via GP training leads.</td>
<td>Recruits did not arrive in September 2017.</td>
<td>Availability of second agency may be compromised by demands from second wave CCGs’.</td>
<td>Tender underway for expert support to provide expertise on Overseas recruitment</td>
<td>Very High (Red)</td>
</tr>
<tr>
<td>CPFT are leading in the development of a new governance structure for General Practice in Cumbria (Termed an alliance model).</td>
<td>Consideration been given to the appointment of a second recruitment agency.</td>
<td>See gaps in controls noted which are being worked through with appropriate legal advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The CCG has applied (2 Feb 18) to NHSE for resilience funding to support the development of the model</td>
<td>The model is still in the developmental phase and legal advice is being sought to identify and address governance issues.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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, 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 specified above the CCG’s Internal Auditors, Audit One, undertook a risk based audit of the Assurance Framework in April 2018 and found that governance, risk management and control arrangements provided substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCG’s (published June 2017) requires CCG’s to undertake an annual internal audit of conflicts of interest management. To support CCG’s to undertake this task, NHS England has published a template audit framework.

Auditone completed the audit in April 2018 and concluded that the governance, risk management and control arrangements for managing conflicts of interest provided substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place. Last year’s audit provided ‘reasonable assurance’ and the result of this year’s assessment demonstrates that the action plan put in place after that audit has been effectively managed and improvements have been made.

Data Quality

The Governing Body relies on the data quality elements in its contracts with providers. This includes both the requirement that providers quality assure their data prior to submission, and the active monitoring and management of the data quality improvement plans included within the contracts. In addition, the CCG commissions the North of England Commissioning Support (NECS) services to manage all local and national information flows on behalf of the CCG, including quality assurance, analysis and reporting. Therefore the CCG’s contract with NECS outlines our expectations with respect to data quality and reporting.

Information Governance

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

The CCG takes the Information Governance (IG) agenda seriously including its compliance with the Data Protection Act 1998 and other legal frameworks upon which IG is based. The CCG contracts its Information Governance services from Cumbria Partnership NHS Foundation Trust (CPFT). Between January and February 2018, Auditone undertook an audit on the Information Governance Toolkit and at the date of review all seven requirements reviewed could be substantiated at the level reviewed.
The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. It has established an information governance management framework and has developed information governance processes and procedures in line with the information governance toolkit in conjunction with CPFT. It has ensured all staff undertakes information governance training and has implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. The CCG is developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

The **Information Governance Toolkit** submission is required by 31 March each year and is a measurement of performance to ensure that personal and sensitive data is dealt with securely and confidentially. Unique for 2017/2018, the IG Toolkit has been a “roll over” year allowing some time to plan for the significant changes that are occurring in 2018/2019 and the latter parts of 2017/2018, namely:

- On 12 July 2017, the Government accepted the ten data security standards recommended by Dame Fiona Caldicott, the National Data Guardian for Health and Care. CPFT has been working to demonstrate that they are implementing these ten data security standards prior to a new assurance framework coming into place from April 2018.

- From April 2018, the new Data Security Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit. It will form part of a new framework for assuring that organisations are implementing the ten data security standards and meeting their statutory obligations on data protection and data security. CPFT has been preparing in advance for the new arrangements.

- The General Data Protection Regulation (GDPR) implementation date is 25 May 2018. Alongside this Regulation is the Data Protection Bill (published in September 2017) which introduces a number of changes to the GDPR requirements which are extensive.

- Compliance with the Information Commissioner’s twelve step approach to GDPR together with receipt of associated guidance from the Article 29 Working Party) and receipt of specific health IG guidance from NHS England, IG Alliance.

- National Data Opt Out Programme
Accountability Report – Part 2

IG Toolkit

The CCG’s Information Governance Assessment Report overall score for 2017/2018 was 90%, and was graded Satisfactory (Green).

Incident Report

During the reporting period, the Information Governance Team has recorded one IG incident between 1 April 2017 and 31 March 2018. The CCG uses the national Incident Reporting Tool to report Level 2 Information Governance ‘Serious Incidents Requiring Investigation’ (IG SIRI) to the Department of Health (DH), Information Commissioner’s Office (ICO) and other regulators. Level 2 IG SIRIs are those incidents which are sufficiently high profile or serious enough to be reportable; these will mainly involve a breach of Data Protection Act principles or the Common Law Duty of Confidentiality. The severity of the incident will also be determined by the number of data subjects affected and the sensitivity of the information compromised.

IG Performance

The CCG has a well embedded performance management framework in place ensuring that performance in all key IG areas is monitored on a continual basis with any issues quickly identified and escalated to CPFT who, manage the reporting of incidents on the CCG’s behalf. The CPFT’s IG compliance programme and performance against the IG Toolkit is closely monitored by senior representatives from the Clinical Governance Group.

Information Governance Compliance

- Introduced new IAO/IAA training and assessment
- All CCG assets and processes assessed
- Development of a data mapping electronic tool to support the requirement for a “record of processing activities” as a result of implementing new Data Protection legislation.

<table>
<thead>
<tr>
<th>Date of Incident</th>
<th>IG SIRI Reference Number</th>
<th>IG SIRI Level</th>
<th>Status</th>
<th>Summary of Incident</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 August 2017</td>
<td>Local CCG ref no used</td>
<td>2</td>
<td>Closed</td>
<td>Care needs assessment documentation for seven individuals were found in the reception area of the Lonsdale Unit at Penrith Hospital (CCG Headquarters). On review the CCG were unable to identify the source of the data and proactively reported as found on their premises.</td>
<td>ICO notified and closed on 9 August 2017.</td>
</tr>
</tbody>
</table>
Improvement figures

<table>
<thead>
<tr>
<th>CCG</th>
<th>Status</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asset Validation IAO</td>
<td>100%</td>
<td>22%</td>
</tr>
<tr>
<td>Asset Validation IAA</td>
<td>100%</td>
<td>30%</td>
</tr>
<tr>
<td>IAO Training</td>
<td>100%</td>
<td>20%</td>
</tr>
<tr>
<td>IAA Training</td>
<td>100%</td>
<td>No Change</td>
</tr>
</tbody>
</table>

Information Rights

- Freedom of Information Act requests – As a public authority we have a duty to be open and transparent about what we do. The Freedom of Information Act 2000 allows anyone to ask for information about the CCG’s business and we provide information to support this. The CCG received 258 Freedom of Information Act requests from 1 April 2017 to 31 March 2018. This is a decrease of 16% from previous year. 85% were responded to within the 20 day legislative timescales with one internal review requested in year.
- Subject Access Requests (SARs) – This process gives individuals the right to find out what personal data we hold about them, why we hold it and who we disclose it to. The team have dealt with one request within 2017/2018.
- All staff have been trained in information governance (hitting over 95% compliance)

Business Critical Models

As part of the on-going accreditation of the CCG to become an accredited safe haven and to meet Level 3 of the Information Governance toolkit in line with HSCIC recommendations, all of the CCG’s business-critical models have been identified and noted on the CCG Information Asset Register.

Third party assurances

As a result of the support service arrangements provided by the North of England Commissioning Support (NECS) under a signed services level agreement, the CCG will receive a number of assurance reports covering from the 1 April 2017 to 31 March 2018. However these will not be available until the final submission of the annual report.
Control Issues

As previously noted in the Accountably Statement of this report the CCG had its Directions removed on 12 January 2018. This was in response to the CCG delivering the required changes to leadership, governance, financial control and organisational capacity set out in the Directions.

Since month nine Governance Statement, the CCG, has continued to actively work with NHS England to strengthen and develop improved relationships with both NCUHT and CPFT to address the financial, performance and quality issues facing West, North and East Cumbria. This is as part of the agreed strategy to bring the health economy back into financial balance by 2020/21. To further these close working relationships, a virtual control to date for West, North and East Cumbria has been agreed between partners for 2017/18. The CCG is also working closely with its system partners (NCUHT, CPFT and Cumbria County Council (CCC)) to deliver the Five Year Forward View and also to move towards an Integrated Care System (ICS) in West, North and East Cumbria.

It is noted in the month 9 Governance Statement that in 2017/18 the CCG forecasted a deficit of £3.1 million. However, whilst the CCG is still in breach its financial duties this deficit has been reduced to £0.3 million. This was as a consequence of a national agreed half percent release of CCG reserves and impact of a national price reduction in “Category M” drugs.

The CCG is working through the A&E Delivery Boards in North Cumbria to improve and achieve the A&E four hour standard of 95%. This work programme is to deliver improved signposting and streaming through A&E and more effective patient flow across the health and social care system. Work is ongoing to improve access to post discharge facilities such as care homes to improve the discharge process by trusted assessors, the use of interim beds, discharge lounges and early day discharges. A&E streaming was introduced in quarter 3 to better integrate primary care and A&E, and ensure that patients were seen in the most appropriate place. Further development in 2017/18 is building on the work initiated previously around a single point of access for GPs, expansion of Emergency Admission Unit EAU, Home First principles, and the use of a discharge co-ordination hub. Daily system calls at strategic and operational level are also in place.

Business Cases are being developed to strengthen out of hospital support to both reduce avoidable admissions and sustain post discharge care.

Clinical capacity issues, together with the need to prioritise bed, theatre and ITU capacity have impacted on routine elective work resulting in not meeting the 18 week RTT standard. Additionally, where necessary, priority has been given to urgent elective and cancer patients. This has resulted in further pressure on the 18 week standard for non-urgent patients. In order to mitigate this orthopaedic beds have been ring fenced and additional sub contracted capacity has been used to ease the situation. In addition further external capacity is being sought to manage specific issues such as dermatology and gastroenterology. New pathways introduce in Muscle-Skeletal (MSK) and Pain Management which is reducing the volume of new acute referrals. There has also been significant resources put into providing advice and guidance, and patient initiated follow ups to reduce outpatient appointments.

Review of economy, efficiency and effectiveness of the use of resources

The CCG has been working rigorously with NHS England, North East and Cumbria Team and partners across the system to ensure that resources are shared/pooled where possible. This will continue to be fully explored and implemented as the North Cumbria Health System as it moves towards an Integrated Care System (ICS).

The CCG has also continued to ensure that any staff vacancies are assessed via the Vacancy Panel which requires the line manager to produce a business case for any post(s) that they may wish to recruit to.

As part of the CCG’s Organisational Development Programme continuous improvement champions have been established. This is to ensure that it is embedded into the day to day work of staff.
An internal audit work plan was agreed by the Audit Committee at its meeting on the 27 April 2017 and Auditone has been systematically undertaking the reviews planned for 2017/18. Reviews undertaken include:

- Financial Planning, Budgetary Control and Performance Reporting
- Cash and Treasury Management
- Primary Care Commissioning Including Funding Requests
- Governance Structures
- Assurance Framework
- Conflicts of Interest
- Continuing Health Care and Funded Nursing Care & Direct Payments
- Serious Incidents & Incident Reporting System
- Information Governance Toolkit

In all of the above domains the conclusion was that the governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.

The Audit Committee is made aware of the findings of each review and the proposed actions made by management to address any areas of concerns raised. Audit One has also implemented an action follow up system; this seeks confirmation that the actions programmed as a result of an audit have been completed.

Counter fraud arrangements

The CCG is working closely with Auditone to ensure that it complies with the NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption. Auditone has an Accredited Counter Fraud Specialist who is contracted to undertake counter fraud work proportionate to identify risks. The CCG’s Audit Committee receives a report against each of the Standards for Commissioners at least annually and there is executive support and direction for a proportionate proactive work plan to address identified risks.

The Chief Finance Officer is a Governing Body Member and responsible for ensuring that the CCG has effective measures in place to tackle fraud, bribery and corruption. He also ensures that appropriate action is taken regarding any NHS Protect quality assurance recommendations.

During 2017/18 the CCG in conjunction with the Local Counter Fraud Specialist (LCFS) reviewed and updated the CCG’s Counter Fraud Bribery and Corruption Policy which was approved by the Governing Body on 4 October 2017. This policy clearly identifies how staff can report perceived incidents of fraud (including “Whistleblowing”) and provides contact information for the LCFS and the NHS Fraud and Bribery Reporting Line. In addition, as part of the Organisational Development Programme for 2017/18 the LCFS has attended two of the CCG’s four staff events to help raise awareness.
Head of Internal Audit Opinion

1. Introduction

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion on the overall adequacy and effectiveness of the organisation’s system of internal control.

The purpose of this report is to provide the Audit Committee with the final Head of Internal Audit Opinion for the year ending 31 March 2018, which should be used to inform the Annual Governance Statement.

The timeline for submission of the Head of Internal Audit Opinion is as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 16 March (noon)</td>
<td>CCGs to submit a full copy of the draft Head of Internal Audit Opinion.</td>
</tr>
<tr>
<td>By 20 April (5pm)</td>
<td>CCGs to submit the draft annual report (which will include the draft Head of Internal Audit Opinion statement as issued by the CCG’s internal auditors).</td>
</tr>
<tr>
<td>By 29 May (noon)</td>
<td>CCGs to submit the final annual report (which will include the final Head of Internal Audit Opinion statement as issued by the CCG’s internal auditors).</td>
</tr>
</tbody>
</table>

This version has been prepared for the 29 May submission date.

2. Head of Internal Audit Opinion on the Effectiveness of the System of Internal Control at North Cumbria CCG for the year ending 31 March 2018

2.1 Roles and responsibilities

The Accountable Officer is responsible for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control, including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.
The organisation’s Assurance Framework should bring together all the evidence required to support the Annual Governance Statement requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit is required to provide an annual opinion, based upon, and limited to, the work performed, on the overall adequacy and effectiveness of the organisation’s risk management, control and governance processes (i.e. the organisation’s system of internal control). This is achieved through a risk-based plan of work, approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans, generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Accountable Officer takes into account in making the Annual Governance Statement.

The Accountable Officer will need to integrate these results with other sources of assurance when making a rounded assessment of control for the purposes of the Annual Governance Statement.

2.2 The Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpins the organisation’s own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist in the completion of the Annual Governance Statement.

My opinion is set out as follows:

2.2.1 Overall opinion;
2.2.2 Basis of the opinion;
2.2.3 Commentary.

2.2.1 Overall Opinion

From my review of your systems of internal control, I am providing substantial assurance that the system of internal control has been effectively designed to meet the organisation’s objectives, and that controls are being consistently applied.

2.2.2 Basis of the Opinion

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes for governance and the management of risk;

2. An assessment of the range of individual opinions arising from audit assignments, contained within risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management’s progress in respect of addressing control weaknesses;

3. Brought forward Internal Audit assurances;

4. An assessment of the organisation’s response to Internal Audit recommendations; and

5. Consideration of significant factors outside the work of Internal Audit.
Accountability Report – Part 2

2.2.4 Commentary

The below commentary provides the context for my opinion and together with the opinion should be read in its entirety.

<table>
<thead>
<tr>
<th>Opinion Area</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Design and operation of the Assurance Framework and supporting processes</strong></td>
<td>Internal audit reviewed the Assurance Framework, and the underpinning Risk Management processes, in bringing together all of the activities and objectives of the CCG. An opinion of Substantial Assurance was provided for both areas.</td>
</tr>
<tr>
<td><strong>Outturn of Internal Audit Plan</strong></td>
<td>A table of individual opinions arising from audit assignments reported throughout the year is contained at Appendix A. Definitions of individual opinions are given at Appendix B.</td>
</tr>
<tr>
<td></td>
<td>All eight general audits have been issued as final, with the exception of one, Serious Untoward Incidents that will be issued shortly. All eight general audits were provided with an opinion of Substantial Assurance. The IGT audit was completed, AuditOne do not provide a level of assurance for this audit. No significant issues have been identified in our work to date.</td>
</tr>
<tr>
<td></td>
<td>Work is split between core assurance and assurance arising from risk-based audits, with core assurance being provided on an annual basis in those areas central to the operation of the CCG. Risk-based audits are carried out on a cyclical basis, in line with the CCG’s risk profile and the contents of the CCG’s Assurance Framework.</td>
</tr>
<tr>
<td><strong>Brought forward Internal Audit assurances</strong></td>
<td>The Head of Internal Audit Opinion given for the year ended 31 March 2017 gave a level of assurance of ‘substantial’. There were no material issues identified to be brought forward for consideration in this opinion statement.</td>
</tr>
</tbody>
</table>
There is a formal process in place to follow up on outstanding actions to address risks identified in internal audit reports. Progress against outstanding actions is reported in regular progress reports to the Audit Committee throughout the year, with specific attention drawn to any actions where the target date has been put back, or where no update has been received from officers within the CCG. As at 17 May 2018, all significant actions from final reports that were due for implementation had been implemented.

**Significant factors outside the work of internal audit**

Whilst the Head of Internal Audit Opinion provides the CCG with assurances in relation to the areas covered by the Internal Audit plan, it is only one of the sources of assurance available to the CCG. As the CCG outsources many of its functions, assurances from third parties are equally as important when the CCG draws up its Annual Governance Statement.

The main ones that we have been made aware of are summarised below, and although we have reviewed these for any significant items of control, we have not taken account of these in providing the overall opinion except where indicated:

- Payroll services are provided by NHS Payroll Services hosted by Northumbria Healthcare NHS Foundation Trust. North Cumbria CCG, through its membership of the Payroll Consortium, receives an annual assurance letter setting out the results of the internal audit work carried out during the year. This assurance letter is normally available towards the end of April.

- The CCG outsources many of its support services to the North of England Commissioning Support Unit (NECS), hosted by NHS England, under a signed service level agreement.

- Assurances on the operation of certain financial and payroll controls during 2017/18 are provided by NHS England’s internal auditors, Deloitte LLP, via ISAE 3402 Type II reports covering the period from 1 March 2017 to 31 March 2018.

- Operation of the CCG’s financial ledger is outsourced by means of a national contract to Shared Business Services (SBS). An ISAE 3402 Type II report covering the operation of the system is issued annually, with the report for 2017/18 expected to be issued in May 2018.

- Management of the prescriptions payments process is provided by NHS Business Services Authority, the costs of which are reflected in the CCG’s accounts. An ISAE 3402 Type II report covering the operation of the national system is issued annually, and the report for 2017/18 is expected to be issued in May 2018.

- Assurance on the NHS Business Services Authority (BSA) Dental Payments Process is provided by NHS BSA’s auditors PwC LLP via an ISAE 3402 Type II report.
I would like to take this opportunity to thank the staff at North Cumbria CCG for the co-operation and assistance provided to my team during the year.

**Opinion Area Commentary**

<table>
<thead>
<tr>
<th>Opinion Area</th>
<th>Commentary</th>
</tr>
</thead>
</table>
| **Significant factors outside the work of internal audit (continued)**       | • Your Local Counter Fraud Specialist is required to submit an annual self-assessment (SRT) to the NHS Counter Fraud Agency in relation to the CCG’s counter fraud arrangements, which provides a source of assurance over the systems and culture to detect and deter fraudulent activities. The assessment document should be available from the NHS Counter Fraud authority shortly.  
• The Electronic Staff Record (ESR) service is provided by McKesson UK. A report covering the operation of the national system is issued on an annual basis and is expected to be available in May 2018.  
It is for the CCG to decide what assurance to take from these reports. Nevertheless, I can advise the Governing Body that the work on the outsourced payroll functions will have been undertaken in accordance with the Public Sector Internal Audit Standards. |

Carl Best  
Director of Internal Audit  
AuditOne  
17 May 2018
### Summary of work undertaken – Appendix A

<table>
<thead>
<tr>
<th>Audit area</th>
<th>Assurance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NCCCG 1718 11/13: Financial Planning, Budgetary Control and Performance Reporting</td>
<td>Substantial</td>
<td>✓</td>
</tr>
<tr>
<td>NCCCG 1718 12: Cash and Treasury Management</td>
<td>Good</td>
<td>✓</td>
</tr>
<tr>
<td>NCCCG 1718 19: Information Governance Toolkit</td>
<td>Reasonable</td>
<td>✓</td>
</tr>
<tr>
<td>NCCCG 1718 16 Primary Care Commissioning Including Funding Requests</td>
<td>Limited</td>
<td>✓</td>
</tr>
<tr>
<td>NCCCG 1718 14/18 Continuing Health Care and Funded Nursing Care &amp; Direct Payments</td>
<td>Substantial</td>
<td>✓</td>
</tr>
<tr>
<td>NCCCG 1718 10: Governance Structures</td>
<td>Substantial</td>
<td>✓</td>
</tr>
<tr>
<td>NCCCG 1718 02: Assurance Framework</td>
<td>Substantial</td>
<td>✓</td>
</tr>
<tr>
<td>NCCCG 1718 04: Conflicts of Interest</td>
<td>Substantial</td>
<td>✓</td>
</tr>
<tr>
<td>NCCCG 1718 07 Serious Incidents &amp; Incident Reporting System</td>
<td>Limited</td>
<td>✓</td>
</tr>
</tbody>
</table>

At the time of our review all seven of the requirements reviewed were substantiated at the scored level.

### Definitions of Assurance Levels assigned to individual audit assignments – Appendix B

<table>
<thead>
<tr>
<th>Assurance Levels</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial</td>
<td>Governance, risk management and control arrangements provide substantial assurance that the risks identified are managed effectively. Compliance with the control framework was found to be taking place.</td>
</tr>
<tr>
<td>Good</td>
<td>Governance, risk management and control arrangements provide a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found to be taking place. Minor remedial action is required.</td>
</tr>
<tr>
<td>Reasonable</td>
<td>Governance, risk management and control arrangements provide reasonable assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place in a consistent manner. Some moderate remedial action is required.</td>
</tr>
<tr>
<td>Limited</td>
<td>Governance, risk management and control arrangements provide limited assurance that the risks identified are managed effectively. Compliance with the control framework was not found to be taking place. Immediate and fundamental remedial action is required.</td>
</tr>
</tbody>
</table>
Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by improvements in the Audits undertaken on the Risk Assurance Framework, Managing Conflicts of Interest and Governance Structures, comments made by the external auditors in their annual audit letter and other reports which have been provided throughout the year.

The CCG’s 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. This has been particularly so during 2017/18 with NHS England lifting the Directions in January 2018. The CCG also has strong connections not only in the North Cumbria Health System but across the North East and the North West.

I have been advised on the implications of the result of this review by:

- the Governing Body
- the Audit committee
- the Finance & Performance committee
- Internal audit

The CCG has a programme of continuous improvements and will continue to review how it undertakes its duties to ensure that they are delivered in an effective and efficient way.

As Accountable Officer I work closely with the Chief Finance Officer who is the Senior Information Risk Owner (SIRO) and leads on the CCG Assurance Framework. This framework details the principal risks to the CCG achieving its objectives. As documented in the Risk Management Framework the CCG has ensured that there is ownership of the risk register at all levels through the Programme Review Group which is made up of Directors and Senior Managers from across the organisation. The CCG’s General Manager and NECS support the risk management framework to ensure that staff receive advice and training on risk management.

Managers within the organisation who have responsibility for the development and maintenance of the system of internal control continue to provide me with assurance. The Assurance Framework itself provides me with the evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by audit reports received by the Audit Committee from the CCG’s internal audit throughout the year.
Other sources of evidence included:

• External Audit via their Annual Audit Letter which provides a high level summary of audit work carried out
• Regular Director Group and Programme Review Group meetings
• Reports to the Audit Committee by the Local Counter Fraud Specialist
• Information Governance Toolkit submission
• Review of the Assurance Framework by the various Programme Review Group meetings and CCG committees and the Governing Body (as detailed in the Risk Management Framework section of this report)
• Strong networks across North Cumbria and the North East which are driving change and working to deliver an Integrated Care System
• Regular meetings with the NHS England Area Team (Quality Surveillance Groups, quarterly checkpoints and assurance meetings)
• Attendance at the main providers of acute, community and mental health services quality committees/meetings
• Executive to Executive meetings with other CCGs

Conclusion

A system of internal control has been maintained throughout the year and up to the date of approval of the annual report and accounts. Based on the work undertaken in 2017/18, substantial assurance has been provided by the Head of Internal Audit (although draft at this stage) that there is a generally sound system of internal control, designed to meet the CCG’s objectives, and that the controls are generally being consistently applied. No significant issues have been identified.

Dr David Rogers
Interim Accountable Officer/Medical Director
24 May 2018
Remuneration and Staff Report

Remuneration Committee

The Remuneration Committee is a non-executive committee of the Governing Body and was established in accordance with the CCG’s Constitution.

The remit of the Committee is to consider and make recommendations to the Governing Body on the appropriate remuneration and terms of service for the Clinical Chair, Deputy Clinical Chair, Medical Director, GP’s with a CCG role, Chief Officer, Chief Finance Officer and other Very Senior Managers.

The Committee’s responsibilities include:

- All aspects of salary (including performance-related elements/bonuses)
- Provisions for other benefits e.g. car allowances
- Severance payments for those specified above taking into account any legal relevant national guidance as is appropriate and oversee appropriate contractual arrangements for said staff
- Disciplinary arrangements where the Chief Officer is an employee or member of another CCG.

The Membership consists of:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Rush</td>
<td>Lay Chair</td>
<td>From April 2017 (Previously the Lay Member – Patient Engagement from April 2013)</td>
</tr>
<tr>
<td>Peter Scott (Chair)</td>
<td>Lay Member (Finance &amp; Governance)</td>
<td>From April 2013</td>
</tr>
<tr>
<td>Denise Lesley</td>
<td>Lay Member (Patient Engagement)</td>
<td>From August 2017</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member (Health Improvement)</td>
<td>From April 2013</td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>Clinical Member (Registered Nurse)</td>
<td>From June 2014</td>
</tr>
<tr>
<td>Kevin Windebank</td>
<td>Clinical Member (Secondary Care Specialist Doctor)</td>
<td>From October 2016</td>
</tr>
</tbody>
</table>

The Committee has met three times in 2017/18 and full details can be seen in the Governance Statement.
Senior Managers
Performance Related Pay

The Remuneration Committee has not given consideration during 2017/18 to the payment of senior managers’ performance related pay.

Policy on the remuneration of senior managers

The CCG remains committed to the principles it adopted to ensure that it is in a position to attract and retain high quality senior officers. This includes maintaining salaries at a competitive level, whilst taking into account the previous level of experience of post holders; application of appropriate promotional increases to new appointees and application of relevant percentage increases (as determined at national level), all whilst recognising the restraint on the public purse.

As part of the steps the CCG takes to satisfy itself the remuneration is reasonable, the Remuneration Committee also takes cognisance of the following reference documents:

- NHS Commissioning Board (NHSCB) Clinical Commissioning Groups: Remuneration Guidance for Chief Officers (where the senior manager also undertakes the Accountable Officer role) and Chief Finance Officer
- The Hay Group CCG Remuneration Guidance on GPs Remuneration in CCGs in North West England
- Tenon Technical Employment Status Guidance – tax, national insurance and superannuation implications for GPs involved in Clinical Commissioning Group roles

The CCG currently has 16 posts which receive remuneration in excess of £150,000 pro rata per annum; all except one are part-time.

These posts are all Clinical roles (Doctor Level) and are broken down as follows:

- Governing Body x3 posts (4 post holders, one of which is full time)
- System Wide Clinical Leaders x3 posts
- ICC GP Leads x9 post holders (covering 8x1 day per week posts)

Remuneration for these posts was approved by the Remuneration Committee as per the steps outlined above.

The CCG is now required to seek the views of ministers via NHS England before making VSM appointments to salaries higher than the Prime Minister’s salary of £150,000 per annum.
Senior Manager Remuneration (including salary and pension entitlements)

Salaries & Allowances (Subject to Audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title NHS North Cumbria CCG 2017 – 18</th>
<th>Title NHS Cumbria CCG 2016 – 17</th>
<th>Note</th>
<th>2017/18 Salary (bands of £5,000)</th>
<th>2017/18 Expense payments (taxable) (Note 9) (rounded to the nearest £100)</th>
<th>2017/18 All pension-related benefits (Note 10,11) (bands of £2,500)</th>
<th>Total (bands of £5,000)</th>
<th>2016/17 Salary (bands of £5,000)</th>
<th>2016/17 Expense payments (taxable) (Note 9) (rounded to the nearest £100)</th>
<th>2016/17 All pension-related benefits (Note 10,11) (bands of £2,500)</th>
<th>Total (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jon Rush</td>
<td>Chair</td>
<td>Lay Member: Patient &amp; Public Engagement</td>
<td>1, 4</td>
<td>25-30</td>
<td>-</td>
<td>-</td>
<td>25-30</td>
<td>20-25</td>
<td>-</td>
<td>-</td>
<td>20-25</td>
</tr>
<tr>
<td>Dr David Rogers</td>
<td>Medical Director (Accountable Officer)</td>
<td>Medical Director (Accountable Officer)</td>
<td>3</td>
<td>145-150</td>
<td>2,800</td>
<td>10-12.5</td>
<td>160-165</td>
<td>170-175</td>
<td>2,700</td>
<td>22.5-25</td>
<td>200-205</td>
</tr>
<tr>
<td>Dr Hugh Reeve</td>
<td>Clinical Chair [Interim Chief Clinical Officer (Accountable Officer)]</td>
<td></td>
<td>1, 11</td>
<td>105-110</td>
<td>-</td>
<td>-</td>
<td>105-110</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>105-110</td>
</tr>
<tr>
<td>Dr Geoff Jolliffe</td>
<td>Lead GP (South)/GP Lead: Furness (Interim Clinical Chair)</td>
<td></td>
<td>1, 7</td>
<td>90-95</td>
<td>-</td>
<td>5-7.5</td>
<td>95-100</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
</tr>
<tr>
<td>Dr Kevin Windebank</td>
<td>Clinical Member: Secondary Care Clinician</td>
<td>Clinical Member: Secondary Care Clinician</td>
<td>4</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
<td>5-10</td>
<td>-</td>
<td>-</td>
<td>5-10</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member: Health Improvement</td>
<td>Lay Member: Health Improvement</td>
<td>4</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
</tr>
<tr>
<td>Peter Scott</td>
<td>Lay Member: Finance &amp; Governance</td>
<td>Lay Member: Finance &amp; Governance</td>
<td>4</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
<td>15-20</td>
<td>-</td>
<td>-</td>
<td>15-20</td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td>Chief Finance Officer</td>
<td>110-115</td>
<td>8,000</td>
<td>27.5-30</td>
<td>145-150</td>
<td>110-115</td>
<td>6,200</td>
<td>25-27.5</td>
<td>140-145</td>
<td>2016-17</td>
</tr>
<tr>
<td>Peter Rooney</td>
<td>Chief Operating Officer</td>
<td>Chief Operating Officer</td>
<td>1, 6</td>
<td>105-110</td>
<td>4,500</td>
<td>25-27.5</td>
<td>135-140</td>
<td>150-110</td>
<td>4.00</td>
<td>25-27.5</td>
<td>135-140</td>
</tr>
<tr>
<td>Dr Colin Patterson</td>
<td>Clinical Lead: Primary Care, 111, Cancer and ICC Development</td>
<td>GP Lead: Carlisle</td>
<td>6</td>
<td>120-125</td>
<td>-</td>
<td>15-175</td>
<td>135-140</td>
<td>70-75</td>
<td>-</td>
<td>110-115</td>
<td></td>
</tr>
<tr>
<td>Dr Amanda Boardman</td>
<td>Clinical Lead: Children’s Commissioning, Mental Health, Learning Disability &amp; Safeguarding</td>
<td></td>
<td>6</td>
<td>150-155</td>
<td>-</td>
<td>15-175</td>
<td>135-140</td>
<td>70-75</td>
<td>-</td>
<td>110-115</td>
<td></td>
</tr>
<tr>
<td>Dr Rachel Preston</td>
<td>Lead GP (North)/GP Lead: Eden</td>
<td>Lead GP (North)/GP Lead: Eden</td>
<td>6</td>
<td>20-25</td>
<td>-</td>
<td>20-25</td>
<td>75-80</td>
<td>22.5-25</td>
<td>95-100</td>
<td></td>
<td>116</td>
</tr>
</tbody>
</table>

Notes:
1. Peter Rooney was appointed to the substantive role of Chief Operating Officer as of 1 August 2016 having acted as interim Chief Operating Officer since 9 February 2015. Stephen Childs was appointed interim Chief Executive on 19 September 2016 when Hugh Reeve stepped down as Chief Officer to resume the Clinical Chair role to 31 March 2017, with Geoff Jolliffe returning to his lead GP role to 31 March 2017. Jon Rush was appointed Chair 1 April 2017.
2. Stephen Childs is also Managing Director of NHS North of England Commissioning Support Unit (NECS). Stephen splits his time working 2 days a week for NECS and working three days a week for the CCG. Stephen Childs remains employed by NECS and the CCG are recharged for his gross costs via invoice.
3. David Rogers was appointed interim Accountable Officer 1 December 2016. David reduced his sessions from 10 to 8 per week from 1 July 2017 onwards.
4. Lay members receive a flat daily rate and thus remuneration received reflects the number of days worked. Denise Leslie was appointed 15 August 2017 on a fixed term contract to 31 July 2020. Kevin Windebank was appointed 19 October 2016 on a 2 year contract. The other lay members’ tenure has been extended to 31 July 2018 with the exception of Jon Rush who was appointed Chair of NHS North Cumbria CCG as of 1 April 2017.
5. Helen King was appointed Director of Nursing & Quality as of 11 May 2016, taking over the role from Laura Carr who left 10 April 2016. Helen King left the CCG with effect 8 September 2017 and received a payment in lieu of notice. Anna Stabler joined the CCG as Director of Nursing & Quality on 12 February 2018 on secondment from North Cumbria University Hospitals NHS Trust (NCUH). Anna Stabler remains employed by NCUHT and the CCG are recharged for her gross costs via invoice.
6. NHS North Cumbria CCG’s constitution was approved by Full Council of Members on 19 May 2017 which included changes to the Governing Body membership: the role of Chief Operating Officer was given Governing Body status and the 2 GP representative roles were revised. Rachel Preston left 30 June 2017 and received a redundancy payment (£0-5K) which was accrued and disclosed as an exit payment in 2016-17 Accounts. Colin Patterson increased his sessions from 5 to 8 per week.
7. NHS England approved changes to NHS North Cumbria CCG’s constitution as of 1 April 2017 whereby 32 GP practices in the South of the county joined those GP Practices of NHS Lancashire North CCG (renamed as NHS Morecambe Bay CCG (MBCCG)) and the remaining GP Practices of the North of the County renamed to NHS North Cumbria CCG (INCCCG). As a consequence of this boundary change, Anthony Gardner, Geoff Jolliffe and Jim Hacking transferred to MBCCG.
8. During 2016-17 Stephen Singleton worked additional sessions for the Success regime which were recharged to Cumbria Partnership NHS Foundation Trust.
10. The amount included here is the annual increase in pension entitlement and not actual remuneration received by individuals during the year. This is a national figure calculated by a formula directed by the Department of Health Group Manual for Accounts based on figures provided by the NHS Pensions Agency.
11. Hugh Reeve opted out of the NHS Pensions scheme as of 1 April 2014. Stephen Singleton is already in receipt of pension.
Senior Manager Remuneration (including salary and pension entitlements)

Salaries & Allowances (Subject to Audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Title</th>
<th>Note</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Salary (£000)</td>
<td>Salary (£000)</td>
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<td></td>
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<td>(rounded to nearest £1000)</td>
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<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Expense payments (taxable) (£000)</td>
<td>Expense payments (taxable) (£000)</td>
</tr>
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<td></td>
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<td>(Note 9)</td>
<td>(Note 9)</td>
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<td></td>
<td>(rounded to the nearest £1000)</td>
<td>(rounded to the nearest £1000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(bands of £2,500)</td>
<td>(bands of £2,500)</td>
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<td></td>
<td>£000</td>
<td>£000</td>
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<td></td>
<td></td>
<td></td>
<td>All pension-related benefits (£000)</td>
<td>All pension-related benefits (£000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Note 10,11)</td>
<td>(Note 10,11)</td>
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<td></td>
<td></td>
<td></td>
<td>Total (£000)</td>
<td>Total (£000)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>(rounded to the nearest £1000)</td>
<td>(rounded to the nearest £1000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(bands of £2,500)</td>
<td>(bands of £2,500)</td>
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<td>£000</td>
<td>£000</td>
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<td></td>
<td></td>
<td>Total (£000)</td>
<td>Total (£000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(bands of £5,000)</td>
<td>(bands of £5,000)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Senior Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stephen Childs</td>
</tr>
<tr>
<td>Anthony Gardner</td>
</tr>
<tr>
<td>Caroline Rea</td>
</tr>
<tr>
<td>Helen King</td>
</tr>
<tr>
<td>Anna Stabler</td>
</tr>
<tr>
<td>Laura Carr</td>
</tr>
<tr>
<td>Eleanor Hodgson</td>
</tr>
<tr>
<td>Dr Helen Horton</td>
</tr>
<tr>
<td>Dr Jim Hacking</td>
</tr>
<tr>
<td>Stephen Singleton</td>
</tr>
</tbody>
</table>

No performance pay or bonuses were paid during the year ended 31 March 2018 (2016/17 £nil).

No long term performance pay and bonuses were paid during the year ended 31 March 2018 (2016/17 £nil).
Pension Benefits as at 31 March 2018 (Subject to Audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Note</th>
<th>Real increase in pension at pension age</th>
<th>Real increase in pension lump sum at pension age</th>
<th>Total accrued pension at pension age at 31 March 2018</th>
<th>Lump sum at pension age related to accrued pension at 31 March 2018</th>
<th>Cash Equivalent Transfer Value at 1 April 2017</th>
<th>Real Increase in Cash Equivalent Transfer Value</th>
<th>Cash Equivalent Transfer Value at 31 March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amanda Boardman</td>
<td>Clinical Lead: Children’s Commissioning, Mental Health, Learning Disability &amp; Safeguarding</td>
<td></td>
<td>2.5-5</td>
<td>0-2.5</td>
<td>20-25</td>
<td>40-45</td>
<td>300</td>
<td>52</td>
<td>351</td>
</tr>
<tr>
<td>Stephen Childs</td>
<td>Chief Executive</td>
<td>1</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>35-40</td>
<td>105-110</td>
<td>658</td>
<td>42</td>
<td>727</td>
</tr>
<tr>
<td>Eleanor Hodgson</td>
<td>Director for Children and Families</td>
<td></td>
<td>2.5-5</td>
<td>10-12.5</td>
<td>45-50</td>
<td>140-145</td>
<td>939</td>
<td>143</td>
<td>1,082</td>
</tr>
<tr>
<td>Helen Horton</td>
<td>Commissioning GP: Specialised Commissioning &amp; Pathway Development, Map of Medicine &amp; IFR</td>
<td></td>
<td>0-2.5</td>
<td>0</td>
<td>10-15</td>
<td>25-30</td>
<td>125</td>
<td>14</td>
<td>139</td>
</tr>
<tr>
<td>Helen King</td>
<td>Director of Nursing &amp; Quality</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>20-25</td>
<td>70-75</td>
<td>513</td>
<td>20</td>
<td>558</td>
</tr>
<tr>
<td>Colin Patterson</td>
<td>Clinical Lead: Primary Care, 111, Cancer and ICC development</td>
<td></td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>10-15</td>
<td>40-45</td>
<td>262</td>
<td>31</td>
<td>293</td>
</tr>
<tr>
<td>Rachel Preston</td>
<td>Lead GP (North)/GP Lead: Eden</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>15-20</td>
<td>40-45</td>
<td>234</td>
<td>5</td>
<td>256</td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>Network Director</td>
<td></td>
<td>0-2.5</td>
<td>5-7.5</td>
<td>40-45</td>
<td>130-135</td>
<td>879</td>
<td>91</td>
<td>971</td>
</tr>
<tr>
<td>David Rogers</td>
<td>Medical Director (Accountable Officer)</td>
<td></td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>25-30</td>
<td>80-85</td>
<td>555</td>
<td>47</td>
<td>602</td>
</tr>
<tr>
<td>Peter Rooney</td>
<td>Chief Operating Officer</td>
<td></td>
<td>0-2.5</td>
<td>-</td>
<td>20-25</td>
<td>50-55</td>
<td>293</td>
<td>39</td>
<td>332</td>
</tr>
<tr>
<td>Anna Stabler</td>
<td>Director of Nursing &amp; Quality</td>
<td>4</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>25-30</td>
<td>85-90</td>
<td>469</td>
<td>9</td>
<td>534</td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td></td>
<td>0-2.5</td>
<td>0</td>
<td>35-40</td>
<td>95-100</td>
<td>612</td>
<td>59</td>
<td>671</td>
</tr>
</tbody>
</table>

Notes:
1. Stephen Childs joined the CCG as interim Chief Executive as of 19 September 2016, working three days a week for the CCG, but remains employed by NHS North of England Commissioning Support Unit and the above figures are the CCG’s proportionate share of his pension benefits.
2. Rachel Preston left the CCG 30 June 2017.
3. Helen King left the CCG 8 September 2017.
4. Anna Stabler joined the CCG as Director of Nursing as of 12 February 2018, working full-time for the CCG, but remains employed by North Cumbria University Hospitals NHS Trust and the above figures are the CCG’s proportionate share of her pension benefits.

Pensions information provided excludes general practitioner pension contributions.
Cash equivalent transfer values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s (or other allowable beneficiary’s) pension payable from the scheme. CETVs are calculated in accordance with the SI 2008 No. 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

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

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

Real increase in CETV

This reflects the increase in CETV that is effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Compensation on early retirement of for loss of office

No payments for loss of office have been made to a Senior Manager of the CCG in 2017/18.

Payments to past members

No payments have been made to past members in 2017/18.

Pay multiples (subject to Audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid member in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid member of the Governing Body in the clinical commissioning group in the financial year 2017 – 18 was £177.5k (2016 – 17, £177.5k). This was 3.32 times (2016 – 17, 3.56 times) the median remuneration of the workforce, which was £53,384 (2016 – 17, £50k) which resulted from an increase in GP representatives (ICC roles) following a review of the CCG’s clinical leadership. The pay multiple would be 3.52 and the median remuneration of the workforce would be £50,452 excluding these new ICC roles.

In 2016 – 17 no employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration packages ranged from £17k to £198k (2015 – 16, £17k to £198k).

In 2017 – 18 one employee (2016 – 17, no employees) received remuneration in excess of the highest paid member of the Governing Body. Remuneration packages ranged from £17k to £180k (2016 – 17, £17k to £198k).

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

Number of Senior Managers

Number of directors/senior civil servants (or equivalent):

The CCG has a total of:
- Four Directors at Very Senior Managers (VSM) pay
- Three Directors at Agenda for Change band 9 pay
- Five Clinical leads at Clinical/Medical pay
  (one post holder left June 2017, one post holder left March 2018)

<table>
<thead>
<tr>
<th>Employee Benefits</th>
<th>2017 – 18</th>
<th>Administration</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Permanent Employees</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>4,185</td>
<td>4,020</td>
<td>165</td>
</tr>
<tr>
<td>Social security costs</td>
<td>463</td>
<td>450</td>
<td>13</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension Scheme</td>
<td>508</td>
<td>494</td>
<td>14</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>5</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>15</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td>Gross employee benefits expenditure</td>
<td>5,176</td>
<td>4,984</td>
<td>192</td>
</tr>
</tbody>
</table>

**Employee Benefits**

<table>
<thead>
<tr>
<th>2016 – 17</th>
<th>Administration</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Permanent Employees</td>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
<td>Permanent Employees</td>
<td>Other</td>
</tr>
<tr>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>5,479</td>
<td>4,965</td>
</tr>
<tr>
<td>Social security costs</td>
<td>563</td>
<td>557</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension Scheme</td>
<td>651</td>
<td>644</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Gross employee benefits expenditure</td>
<td>6,699</td>
<td>6,173</td>
</tr>
</tbody>
</table>

Average number of people employed

<table>
<thead>
<tr>
<th>2017 – 18</th>
<th>2017 – 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>Permanent Employees</td>
</tr>
<tr>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>6</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>64</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
</tr>
</tbody>
</table>
Staff composition

The tables below provide an analysis of the number of each sex who were directors, clinical leaders and other employees:

<table>
<thead>
<tr>
<th>Role</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director Male</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Director Female</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Other Staff Male</td>
<td>20</td>
<td>60</td>
</tr>
<tr>
<td>Other Staff Female</td>
<td>60</td>
<td></td>
</tr>
</tbody>
</table>

Sickness absence data

All sickness absence at the CCG is managed in line with the sickness absence policy. This policy enables managers to address sickness absence issues, both short and long-term, in a fair, consistent and equitable manner. It is recognised however that all cases must be dealt with on an individual basis because of differing circumstances. Managers and staff have access to the Occupational Health Service as appropriate.

The sickness absence data provided is calendar year figures (January – December 2016)

<table>
<thead>
<tr>
<th>Average of 12 Months (2017 Calendar Year)</th>
<th>Average FTE 2016</th>
<th>FTE-Days Available</th>
<th>FTE-Days Lost to Sickness Absence</th>
<th>Average Sick Days per FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.93%</td>
<td>80.45</td>
<td>29,364.74</td>
<td>1,154.23</td>
<td>14.35</td>
</tr>
</tbody>
</table>

Ill Health Retirements

<table>
<thead>
<tr>
<th>2017 – 18 Number</th>
<th>2016 – 17 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of persons retired early on ill health grounds</td>
<td>1</td>
</tr>
<tr>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Total additional pension liabilities accrued in the year</td>
<td>29</td>
</tr>
</tbody>
</table>
Staff policies

As an employer, the CCG actively works to remove any discriminatory practices, eliminate all forms of harassment and promote equality of opportunity in our recruitment, training, performance management and development practices.

The CCG has a suite of policies in place to support this including;

- Sickness Absence
- Management of Organisational Change
- Flexible Working
- Other Leave
- Performance Management
- Disciplinary
- Grievance
- Raising Concerns (Whistleblowing)

Expenditure on consultancy

<table>
<thead>
<tr>
<th>External Consultancy Fees</th>
<th>Description</th>
<th>£’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Want Great Care</td>
<td>iWantGreatCare</td>
<td>52</td>
</tr>
<tr>
<td>DevelopChange Ltd</td>
<td>ICC Workshops and Coaching</td>
<td>7</td>
</tr>
<tr>
<td>Deloittes</td>
<td>VAT Recovery – 1617 Development of models to support the STP submissions</td>
<td>-10</td>
</tr>
<tr>
<td>University of Cumbria</td>
<td>Education Consultancy</td>
<td>5</td>
</tr>
<tr>
<td>Catherine Beverley</td>
<td>Website Development and Support</td>
<td>3</td>
</tr>
<tr>
<td>Northumberland, Tyne and Wear NHS Foundation Trust</td>
<td>Maternity Services Review</td>
<td>3</td>
</tr>
</tbody>
</table>

Losses and Special payments

The CCG had no losses cases nor made any special payments during 2017/18.
### Off-payroll engagements

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

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of existing arrangements as of 31 March 2018</td>
</tr>
<tr>
<td>Of which the number that have existed:</td>
</tr>
<tr>
<td>for less than one year at the time of reporting</td>
</tr>
<tr>
<td>for between one and two years at the time of reporting</td>
</tr>
<tr>
<td>for between two and three years at the time of reporting</td>
</tr>
<tr>
<td>for between three and four years at the time of reporting</td>
</tr>
<tr>
<td>for four or more years at the time of reporting</td>
</tr>
</tbody>
</table>

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 longer than six months:

<table>
<thead>
<tr>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018</td>
</tr>
<tr>
<td>Number of new engagements which include contractual clauses giving NHS Cumbria CCG the right to request assurance in relation to income tax and National Insurance obligations</td>
</tr>
<tr>
<td>Number for whom assurance has been requested</td>
</tr>
<tr>
<td>Of which</td>
</tr>
<tr>
<td>number assessed as caught by IR35</td>
</tr>
<tr>
<td>number assessed as not caught by IR35</td>
</tr>
<tr>
<td>engagements terminated as a result of assurance not being received</td>
</tr>
<tr>
<td>Of which</td>
</tr>
<tr>
<td>number engaged directly (via PSC contracted to the entity) and are on the departmental payroll</td>
</tr>
<tr>
<td>number of engagements reassessed for consistency/assurance purposes during the year</td>
</tr>
<tr>
<td>number of engagements that saw a change to IR35 status following the consistency review</td>
</tr>
</tbody>
</table>
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 of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year. | 2 |
| Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements. | 29 |

Stephen Childs was appointed as Interim Chief Executive on 19 September 2016. He is also Managing Director of NHS North of England Commissioning Support unit (NECS) and split his time working two days a week for NECS and working three days a week for the CCG. Stephen Childs remains employed by NECS and the CCG were recharged for his gross costs via invoice. Stephen’s secondment ended on 31 March 2018.

Anna Stabler joined the CCG as Director of Nursing & Quality on 12 February 2018 on secondment from North Cumbria University Hospitals NHS Trust (NCUHT). Anna Stabler remains employed by NCUHT and the CCG are recharged for her gross costs via invoice.
Exit packages, including special (non-contractual) payments (subject to audit)

Table 1: Exit Packages

<table>
<thead>
<tr>
<th></th>
<th>2017 –18</th>
<th>2017 –18</th>
<th>2017 –18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compulsory redundancies</td>
<td>Other agreed departures</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>£</td>
<td>Number</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>1</td>
<td>1,381</td>
<td>-</td>
</tr>
<tr>
<td>£10,001 – £25,000</td>
<td>1</td>
<td>13,333</td>
<td>-</td>
</tr>
<tr>
<td>Net employee benefits</td>
<td>2</td>
<td>14,714</td>
<td>-</td>
</tr>
</tbody>
</table>

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

Redundancy and other departure costs have been calculated in accordance with statutory provisions.

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

No exit payments were agreed with any individuals named in the remuneration report.

There were no departures where special payments have been made.

Parliamentary Accountability and Audit Report

NHS North Cumbria CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities are included in note 12 of the financial statements. Losses and special payments are included at page 122 of the report.
Independent Auditor’s Report to the members of the Governing Body of NHS North Cumbria Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion
We have audited the financial statements of NHS North Cumbria Clinical Commissioning Group (the ‘CCG’) for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017 – 18 and the requirements of the Health and Social Care Act 2012.

In our opinion the financial statements:
• give a true and fair view of the financial position of the CCG as at 31 March 2018 and of its expenditure and income for the year then ended; and
• have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017 – 18; and
• have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion
We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor’s responsibilities for the audit of the financial statements section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC’s Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to
This report is made solely to the members of the Governing Body of the 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 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 CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern
We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:
• the Accountable Officer’s use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
• the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG’s ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.
Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages (5 to 125), other than the financial statements and our auditor’s report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the CCG’s arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

• the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017 – 18 and the requirements of the Health and Social Care Act 2012; and

• based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, 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 in the financial statements conform to the authorities which govern them.

Basis for qualified opinion on regularity

The CCG reported a deficit of £0.3 million and that expenditure exceeded income in its financial statements for the year ending 31 March 2018, thereby breaching its duties under the National Health Service Act 2006, as amended by paragraphs 223H and 223I of Section 27 of the Health and Social Care Act 2012, to ensure that its expenditure does not exceed income and that the revenue resource use in a financial year does not exceed the amount specified by direction of the NHS Commissioning Board.

We have nothing to report in this regard.
Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

• we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or

• we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

• we have made a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 20 March 2018 we referred a matter to the Secretary of State under section 30(a) of the Local Audit and Accountability Act 2014 in relation to the CCG’s breach of its revenue resource limit for the year ended 31 March 2018.

Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer’s responsibilities (set out on pages 54 to 55), the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG’s ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the CCG lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the CCG.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Governing Body is Those Charged with Governance.

Auditor’s responsibilities for the audit of the financial statements

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 an auditor’s report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council’s website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor’s report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.
Report on other legal and regulatory requirements - Conclusion on the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - 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, in our opinion we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in respect of the above matter.

Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor’s responsibilities for the review of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) 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 and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, 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. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS North Cumbria Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Joanne Brown
For and on behalf of Grant Thornton UK LLP, Appointed Auditor
Grant Thornton UK LLP
110 Queen Street
Glasgow
25 May 2018
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<td>Trade and other receivables</td>
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<td>151</td>
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The Primary Statements

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

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2017/18 £000</th>
<th>2016/17 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2017/18</td>
<td>2016/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>3</td>
<td>Income from sale of goods and services</td>
<td>(215)</td>
<td>(511)</td>
</tr>
<tr>
<td>3</td>
<td>Other operating income</td>
<td>(371)</td>
<td>(319)</td>
</tr>
<tr>
<td></td>
<td>Total operating income</td>
<td>(586)</td>
<td>(830)</td>
</tr>
<tr>
<td>4,5</td>
<td>Staff costs</td>
<td>5,176</td>
<td>6,699</td>
</tr>
<tr>
<td>5</td>
<td>Purchase of goods and services</td>
<td>500,525</td>
<td>744,873</td>
</tr>
<tr>
<td>5</td>
<td>Other operating expenditure</td>
<td>112</td>
<td>204</td>
</tr>
<tr>
<td></td>
<td>Total operating expenditure</td>
<td>505,813</td>
<td>751,776</td>
</tr>
<tr>
<td></td>
<td>Comprehensive net expenditure for the year ended 31 March 2018</td>
<td>505,227</td>
<td>750,946</td>
</tr>
</tbody>
</table>

NHS England approved changes to the Clinical Commissioning Group’s constitution as of 1 April 2017, under which 32 (from South Cumbria and North Yorkshire areas) of its 71 GP practices moved from NHS Cumbria Clinical Commissioning Group (renamed NHS North Cumbria Clinical Commissioning Group) to join NHS Lancashire North Clinical Commissioning Group (renamed NHS Morecambe Bay Clinical Commissioning Group [MBCCG]). As a consequence, on average, 38% of costs (on a population split) were transferred to MBCCG, although this varies by type of expenditure.

The Clinical Commissioning Group was approved, by NHS England, under delegated commissioning arrangements to assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2017 which resulted in additional £45.4m expenditure.

The notes 2 to 5 on pages 143 to 148 form part of this statement.
## Statement of Financial Position as at 31 March 2018

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 2018 £000</th>
<th>31 March 2017 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Total non-current assets</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>9</td>
<td>10,951</td>
</tr>
<tr>
<td>Cash</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Total current assets</td>
<td></td>
<td>10,971</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>10,980</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>11</td>
<td>(19,268)</td>
</tr>
<tr>
<td>Total current liabilities</td>
<td></td>
<td>(19,268)</td>
</tr>
<tr>
<td><strong>Assets less liabilities</strong></td>
<td></td>
<td>(8,288)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers’ Equity:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td>(8,288)</td>
</tr>
<tr>
<td>Total taxpayers’ equity</td>
<td></td>
<td>(8,288)</td>
</tr>
</tbody>
</table>

The notes 8 to 11 on pages 151 to 153 form part of this statement.

The financial statements on pages 133 to 135 were approved by the Audit Committee, under delegation from the Governing Body, on 24 May 2018 and signed on its behalf by:

Dr David Rogers  
Interim Accountable Officer/Medical Director
Statement of Changes In Taxpayers Equity for the year ended 31 March 2018

<table>
<thead>
<tr>
<th>Note</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General fund £000</td>
<td>General fund £000</td>
</tr>
<tr>
<td>Balance at 1 April</td>
<td>(14,703)</td>
<td>(21,927)</td>
</tr>
<tr>
<td>Changes in NHS Clinical Commissioning Group taxpayers’ equity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(505,227)</td>
<td>(750,946)</td>
</tr>
<tr>
<td>Net Recognised Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(519,930)</td>
<td>(772,873)</td>
</tr>
<tr>
<td>Net funding</td>
<td>511,642</td>
<td>758,170</td>
</tr>
<tr>
<td>Balance at 31 March</td>
<td>(8,288)</td>
<td>(14,703)</td>
</tr>
</tbody>
</table>

Statement of Cash Flows for the year ended 31 March 2018

<table>
<thead>
<tr>
<th>Note</th>
<th>2017/18</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Cash Flows from Operating Activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(505,227)</td>
<td>(750,946)</td>
</tr>
<tr>
<td>(Increase)/decrease in trade and other receivables</td>
<td>9</td>
<td>(3,545)</td>
</tr>
<tr>
<td>Decrease in trade and other payables¹</td>
<td>11</td>
<td>(2,870)</td>
</tr>
<tr>
<td>Net Cash Outflow from Operating Activities</td>
<td>(511,642)</td>
<td>(758,152)</td>
</tr>
<tr>
<td>Net Cash Outflow before Financing</td>
<td>(511,642)</td>
<td>(758,152)</td>
</tr>
<tr>
<td>Cash Flows from Financing Activities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Funding Received</td>
<td>511,642</td>
<td>758,170</td>
</tr>
<tr>
<td>Net Cash Inflow from Financing Activities</td>
<td>511,642</td>
<td>758,170</td>
</tr>
<tr>
<td>Net increase in Cash</td>
<td>10</td>
<td>-</td>
</tr>
<tr>
<td>Cash at the Beginning of the Financial Year</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>Cash at the End of the Financial Year</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

¹Excludes movement in Capital Payables

The notes 9 to 11 on pages 151 to 153 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 despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014.

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.

1.3 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.

1.4 Pooled Budgets

The Clinical Commissioning Group has entered into a pooled budget arrangement with Cumbria County Council in accordance with Section 75 of the National Health Service Act 2006 (as amended). Under the arrangement, funds are pooled for developing an integrated approach between health and social care and for improving the general well-being and life-chances of anyone with a learning disability. Note 17 provides details of the income and expenditure. The pooled budgets are hosted by Cumbria County Council. 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 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.

1.5 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the Clinical Commissioning Group’s accounting policies, management is required to make 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.

1.5.1 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 and that have the most significant effect on the amounts recognised in the financial statements:

- Determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets.
- Determining the nature and accounting treatment of the pooled budget arrangement of the Better Care Fund which is a joint initiative between the NHS and Local Government to develop an integrated approach between health and social care.

1.5.2 Key Sources of Estimation Uncertainty

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

- IAS 36 Impairments: management makes judgement on whether there are any indications of impairments to the carrying amounts of the Clinical Commissioning Group’s assets;
- IAS 37 Provisions: where the Clinical Commissioning Group can place a reasonable estimate on a potential future liability, and that liability is reasonably likely to materialise, the Clinical Commissioning Group makes provision in its accounts for that liability. Where one of these conditions is not met, the Clinical Commissioning Group discloses details under Contingencies;
- Significant estimates are inherent in a number of operational areas including accruals for prescribing costs, and expenditure dependent on secondary, tertiary and independent sector activity information. This is because the outturn information is not available at the time of preparation of the financial statements. Such estimates are informed by underlying data and trends and therefore are not expected to be significantly mis-stated; and,
- Maternity Pathways: expenditure relating to all antenatal maternity care is made at the start of a pathway. As a result at the year-end part completed pathways are treated as a prepayment. The Clinical Commissioning Group agrees to use the figures calculated by the local providers.

1.6 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. The Clinical Commissioning Group’s principle funding source is cash drawings from NHS England linked to its main revenue allocation.

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

1.7.1 Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

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.

1.7.2 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 NHS body 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.

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

1.9 Intangible Assets

1.9.1 Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the clinical commissioning group’s business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.9.2 Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost.
1.10 Depreciation, Amortisation and 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.

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.

1.11 Leases

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

1.11.1 The Clinical Commissioning Group as lessee

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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.

1.12 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

In the Statement of Cash Flows, cash is shown net of bank overdrafts that are repayable on demand and that form an integral part of the Clinical Commissioning Group’s cash management.
1.13 Provisions

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

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

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

1.14 Clinical Negligence Costs

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

1.15 Non-clinical Risk Pooling

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

1.16 Continuing Healthcare Risk Pooling

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

1.17 Contingencies

A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group; or,
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.
1.18 Financial Assets

Financial assets are recognised on the Statement of Financial Position 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 de-recognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise in accordance with generally accepted pricing models based on discounted cash flow analysis.

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. This 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 Statement of Financial Position date, the Clinical Commissioning Group assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

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

1.19 Financial Liabilities

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

Financial liabilities are initially recognised at fair value. After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. 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.

1.20 Value Added Tax

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

1.21 Foreign Currencies

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

1.23 Accounting Standards that have been issued but have not yet been adopted

The DHSC 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)

Where practicable the CCG has assessed the impact of the standards that have not yet been adopted and assessed that 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. Financial performance targets

NHS Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended).

The Clinical Commissioning Group’s performance against those duties was as follows:

<table>
<thead>
<tr>
<th>NHS Act</th>
<th>2017 – 18</th>
<th>2016 –17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target £000</td>
<td>Performance £000</td>
</tr>
<tr>
<td>223H (1) Expenditure not to exceed income</td>
<td>505,476</td>
<td>505,813</td>
</tr>
<tr>
<td>223I (2) Capital resource use does not exceed the amount specified in Directions</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>223I (3) Revenue resource use does not exceed the amount specified in Directions</td>
<td>504,890</td>
<td>505,227</td>
</tr>
<tr>
<td>223J (1) Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>223J (2) Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>223J (3) Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>6,951</td>
<td>6,155</td>
</tr>
</tbody>
</table>

**Note:** for the purposes of 223H(1) 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).

Previously NHS England has reported CCG financial performance by reference to the cumulative surplus/deficit position. For 2017/18 onwards, CCG financial performance is now reported on an in-year basis. Accordingly, the 2017/18 figures within this note reflect only the in-year position, being the difference between the in-year allocation and total expenditure, rather than the total cumulative deficit position shown in 2016/17.

The Clinical Commissioning Group has not met the statutory requirement ‘223H(1) Expenditure not to exceed income’ as the actual 2017 – 18 expenditure performance is £0.337m over the income received. A formal notification of this position was made by the CCG’s external auditors, Grant Thornton UK LLP, to the NHS Commissioning Board (NHS England) in March 2018. A referral to the Secretary of State under Section 30a of the Local Audit and Accountability Act 2014 was also made at the same time.

NHS England approved changes to the Clinical Commissioning Group’s constitution as of 1 April 2017, under which 32 (from south Cumbria and North Yorkshire areas) of its 71 GP practices moved from NHS Cumbria Clinical Commissioning Group (renamed NHS North Cumbria Clinical Commissioning Group) to join NHS Lancashire North Clinical Commissioning Group (renamed NHS Morecambe Bay Clinical Commissioning Group). As a consequence the Clinical Commissioning Group’s resource allocation decreased in 2017/18 by £290m to reflect the reduced level of expenditure associated with the change (associated £4.265m decrease in revenue administration allocation). The Clinical Commissioning Group was approved, by NHS England, under delegated commissioning arrangements to assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2017 which resulted in additional £46.5m resource allocation in 2017/18.
### 3. Other operating revenue

<table>
<thead>
<tr>
<th></th>
<th>2017 – 18</th>
<th>2016 – 17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>39</td>
<td>108</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS¹</td>
<td>35</td>
<td>14</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>176</td>
<td>403</td>
</tr>
<tr>
<td>Other revenue</td>
<td>336</td>
<td>305</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>586</strong></td>
<td><strong>830</strong></td>
</tr>
</tbody>
</table>

**Note:** ¹ These contributions received specifically support cancer services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the Clinical Commissioning Group and credited to the General Fund.

Revenue is totally from the supply of services. The Clinical Commissioning Group has received no revenue from the sale of goods in 2017 – 18 nor 2016 – 17.
4. Employee benefits and staff numbers

4.1 Employee benefits

<table>
<thead>
<tr>
<th>Employee Benefits</th>
<th>2017 – 18</th>
<th></th>
<th>2016 – 17</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>£4,185</td>
<td>£165</td>
<td>£5,479</td>
<td>£513</td>
</tr>
<tr>
<td>Social security costs</td>
<td>£463</td>
<td>£13</td>
<td>£563</td>
<td>£6</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>£508</td>
<td>£14</td>
<td>£651</td>
<td>£7</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>£5</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>£15</td>
<td>-</td>
<td>£6</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total employee benefits expenditure</strong></td>
<td><strong>£5,176</strong></td>
<td><strong>£192</strong></td>
<td><strong>£6,699</strong></td>
<td><strong>£526</strong></td>
</tr>
</tbody>
</table>

On 1 April 2017 as a result of a boundary change, 16 employees (equating to a cost of £800k) transferred to NHS Morecambe Bay CCG. There was also an overall reduction of nine whole time equivalent employees resulting from the net impact of starters and leavers in both years. The CCG also reduced its reliance on agency staff to fill vacancies and fixed term temps.

4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2017 –18</th>
<th></th>
<th>2016 – 17</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>70</td>
<td>4</td>
<td>103</td>
<td>11</td>
</tr>
</tbody>
</table>

On 1 April 2017 as a result of a boundary change, 16 employees transferred to NHS Morecambe Bay CCG. The average number was also reduced overall of nine whole time equivalents employees resulting from the net impact of starters and leavers in both years. The CCG also reduced its reliance on agency staff to fill vacancies and fixed term temps (2016/17 4.57 wte primary care IT project workers).
4.3 Staff sickness absence and ill health retirements

This information is included in the Staff report on page 121 of the Annual report.

4.4 Exit packages agreed in the financial year

<table>
<thead>
<tr>
<th></th>
<th>2017 – 18</th>
<th>2017 – 18</th>
<th>2017 – 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compulsory redundancies</td>
<td>Other agreed departures</td>
<td>Total</td>
</tr>
<tr>
<td>Number</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>1</td>
<td>1,381</td>
<td>1</td>
</tr>
<tr>
<td>£10,001 – £25,000</td>
<td>1</td>
<td>13,333</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>14,714</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compulsory redundancies</td>
<td>Other agreed departures</td>
<td>Total</td>
</tr>
<tr>
<td>Number</td>
<td>£</td>
<td>£</td>
<td>£</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>4</td>
<td>5,748</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>5,748</td>
<td>4</td>
</tr>
</tbody>
</table>

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

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change.

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

No exit payments were agreed with any individuals named in the remuneration report.

There were no departures where special payments have been made.
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 £508,048 were payable to the NHS Pensions Scheme at the rate of 14.38% of pensionable pay (2016 – 17: £688,296 14.3%). 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.
5. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2017 – 18</th>
<th>2016 – 17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>4,420</td>
<td>6,133</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>756</td>
<td>566</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>5,176</td>
<td>6,699</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCG’s and NHS England</td>
<td>2,862</td>
<td>5,145</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>128,710</td>
<td>322,778</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>201,380</td>
<td>211,010</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>54,608</td>
<td>90,717</td>
</tr>
<tr>
<td>Purchase of social care</td>
<td>13</td>
<td>140</td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>111</td>
<td>203</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>164</td>
<td>313</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>347</td>
<td>5,940</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>60</td>
<td>533</td>
</tr>
<tr>
<td>Establishment</td>
<td>2,395</td>
<td>3,667</td>
</tr>
<tr>
<td>Transport</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>Premises</td>
<td>358</td>
<td>512</td>
</tr>
<tr>
<td>Audit fees(^\text{4})</td>
<td>54</td>
<td>86</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>54,504</td>
<td>86,729</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS(^\text{2})</td>
<td>54,754</td>
<td>15,498</td>
</tr>
<tr>
<td>Other professional fees excl. audit(^\text{3})</td>
<td>44</td>
<td>199</td>
</tr>
<tr>
<td>Legal fees</td>
<td>192</td>
<td>87</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Education and training</td>
<td>69</td>
<td>221</td>
</tr>
<tr>
<td>CHC Risk Pool contributions(^\text{3})</td>
<td>-</td>
<td>1,278</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>500,637</td>
<td>745,077</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>505,813</td>
<td>751,776</td>
</tr>
</tbody>
</table>

Notes:

As a result of the boundary change on 1 April 2017, on average, 38% of costs (on a population split) were transferred to NHS Morecambe Bay CCG, although this varies by type of expenditure.

\(^\text{1}\)2016 – 17 £5m non-recurrent funding for Success Regime programme costs.

\(^\text{2}\)In addition to the boundary change impact, £45.384m co-commissioning costs resulting from being fully delegated on 1 April 2017.

\(^\text{3}\)Contributions determined by NHS England.

\(^\text{4}\)The audit fee is inclusive of VAT. The auditor’s liability for external work carried out for the financial year 2017/18 is limited to £2,000,000.

\(^\text{5}\)Internal Audit and local counter fraud services are provided by Audit One at a cost of £32k for 2017 – 18 (£53k 2016 – 17).

\(^\text{6}\)As a result of account classifications in 2017 – 18, 2016 – 17 comparator figures have been restated:

- £53k internal audit fees reclassified from services from NHS foundation trusts to other professional fees,
- £140k social care costs reclassified from purchase of healthcare from non NHS Bodies to separate line, and
- £87k legal fees reclassified from other professional fees to separate line.
### 6. Better Payment Practice Code

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£000</td>
<td>Number</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices Paid in the Year</td>
<td>20,532</td>
<td>125,620</td>
<td>38,148</td>
<td>131,285</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices Paid within target</td>
<td>20,274</td>
<td>125,155</td>
<td>37,909</td>
<td>130,521</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>98.74%</td>
<td>99.63%</td>
<td>99.37%</td>
<td>99.42%</td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>3,606</td>
<td>343,535</td>
<td>3,681</td>
<td>556,051</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>3,591</td>
<td>343,302</td>
<td>3,646</td>
<td>555,982</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>99.58%</td>
<td>99.93%</td>
<td>99.05%</td>
<td>99.99%</td>
</tr>
</tbody>
</table>

The Better Payment Practice Code requires the Clinical Commissioning Group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Clinical Commissioning Group has achieved the set target to pay 95% of invoices within this requirement.

The volume of non-NHS invoices processed has decreased year-on-year as a result of the boundary change, effective 1 April 2017, whereby approximately 40% of Continued Healthcare, Funded Nursing Care and GP Locally Enhanced Services payments transferred to NHS Morecambe Bay CCG (MBCCG) slightly offset by an increase in volume of high value National Health Application & Infrastructure Services payments to GP practices as a result of the CCG taking on Primary Care Co-Commissioning from 1 April 2017. The value of NHS invoices processed has dropped as a result of reduced contract values with North West NHS providers reflecting the transfer of South Cumbria patients’ activity to MBCCG.
7. Operating leases

The Clinical Commissioning Group has entered into a small number of formal operating lease arrangements, relating to leased cars, none of which are individually significant. Specific lease terms vary by individual arrangement but are based upon standard practice for the type of arrangement involved. As a result of the boundary change on 1 April 2017, 7 staff car leases transferred to NHS Morecambe Bay CCG.

The Clinical Commissioning Group also has arrangements in place with NHS Property Services Ltd and Community Health Partnerships Ltd in respect of the utilisation of various clinical and non-clinical properties. Although formal signed contracts are not in place for these properties, the transactions involved do convey the right to use property assets. As a result of the boundary change on 1 April 2017, four properties transferred to NHS Morecambe Bay CCG.

The Clinical Commissioning Group has considered the substance of both arrangements under IFRIC 4 ‘Determining whether an arrangement contains a lease’ and determined that the arrangements are (or contain) leases. Accordingly the payments made in 2017 – 18 are disclosed as minimum lease payments in note 7.1.

While our arrangements with NHS Property Services Ltd and Community Health Partnerships Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed and consequently no disclosure, of future minimum lease payments for these arrangements, is made for buildings in note 7.2.

The Clinical Commissioning Group does not act as lessor.

7.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>Buildings £000</th>
<th>Other £000</th>
<th>2017 – 18 Total £000</th>
<th>2016 – 17 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>403</td>
<td>52</td>
<td>455</td>
<td>516</td>
</tr>
<tr>
<td>Total</td>
<td>403</td>
<td>52</td>
<td>455</td>
<td>516</td>
</tr>
</tbody>
</table>

7.2 Future minimum lease payments

<table>
<thead>
<tr>
<th>Payable:</th>
<th>Buildings £000</th>
<th>Other £000</th>
<th>2017 – 18 Total £000</th>
<th>2016 – 17 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>45</td>
<td>45</td>
<td>79</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>-</td>
<td>33</td>
<td>33</td>
<td>58</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>78</td>
<td>78</td>
<td>137</td>
</tr>
</tbody>
</table>
8. Intangible non-current assets

2017 – 18

<table>
<thead>
<tr>
<th>Description</th>
<th>Cost or valuation at 01 April 2017</th>
<th>Additions purchased</th>
<th>Cost/valuation at 31 March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer Software: Purchased</td>
<td>£000</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Amortisation 01 April 2017</th>
<th>Charged during the year</th>
<th>Amortisation 31 March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amortisation</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Net Book Value at 31 March 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchased</td>
<td>9</td>
</tr>
</tbody>
</table>

Total at 31 March 2018

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total at 31 March 2018</td>
<td>9</td>
</tr>
</tbody>
</table>

8.1 Economic lives

Computer software: purchased

<table>
<thead>
<tr>
<th>Description</th>
<th>Minimum Life (years)</th>
<th>Maximum Life (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Computer software: purchased</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

9. Trade and other receivables

<table>
<thead>
<tr>
<th>Description</th>
<th>31 March 2018 £000</th>
<th>31 March 2017 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>5,416</td>
<td>3,290</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>1,433</td>
<td>2,134</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>1,176</td>
<td>180</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>1,777</td>
<td>1,155</td>
</tr>
<tr>
<td>Non-NHS and Other WGA prepayments</td>
<td>1,122</td>
<td>470</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>-</td>
<td>132</td>
</tr>
<tr>
<td>VAT</td>
<td>25</td>
<td>45</td>
</tr>
<tr>
<td>Other receivables and accruals</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Total Trade &amp; other receivables</td>
<td>10,951</td>
<td>7,406</td>
</tr>
</tbody>
</table>

The great majority of trade is with NHS England and other NHS bodies. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.
9.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th>Period</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>6,895</td>
</tr>
<tr>
<td>By three to six months</td>
<td>473</td>
</tr>
<tr>
<td>By more than six months</td>
<td>1,026</td>
</tr>
<tr>
<td>Total</td>
<td>8,394</td>
</tr>
</tbody>
</table>

£866,677 of the amount above has subsequently been recovered post the statement of financial position date.

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2018 nor 31 March 2017.

9.2 Provision for impairment of receivables

No provision for impairment of receivables was made at 31 March 2018 (31 March 2017: nil) as all receivables were deemed recoverable.

The Clinical Commissioning Group evaluates its receivables age analysis on a regular basis for potential irrecoverable debt. The Clinical Commissioning Group assesses receivables for recoverability on an individual basis and to make provision where it is considered necessary. In assessing recoverability the Clinical Commissioning Group takes into account any indicators of impairment up until the reporting date. The overall level of credit risk is considered to be relatively low due to the proportion of the customer base which is comprised of NHS bodies and other central and local government bodies.

10. Cash

<table>
<thead>
<tr>
<th></th>
<th>31 March 2018</th>
<th>31 March 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April</td>
<td>20</td>
<td>2</td>
</tr>
<tr>
<td>Net change in year</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>Balance at 31 March</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

Made up of:

Cash with the Government Banking Service

|                           | 20 | 20 |

Cash as in statement of financial position

|                           | 20 | 20 |
11. Trade and other payables

<table>
<thead>
<tr>
<th>Description</th>
<th>Current 31 March 2018 £000</th>
<th>Current 31 March 2017 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>1,389</td>
<td>1,670</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>2,097</td>
<td>2,942</td>
</tr>
<tr>
<td>Non-NHS and other WGA payables: Revenue</td>
<td>1,446</td>
<td>1,492</td>
</tr>
<tr>
<td>Non-NHS and other WGA payables: Capital</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>14,307</td>
<td>15,675</td>
</tr>
<tr>
<td>Social security costs</td>
<td>-</td>
<td>80</td>
</tr>
<tr>
<td>Tax</td>
<td>-</td>
<td>83</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>20</td>
<td>187</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td><strong>19,268</strong></td>
<td><strong>22,129</strong></td>
</tr>
</tbody>
</table>

Other payables include £nil outstanding pension contributions at 31 March 2018 (£101,878 at 31 March 2017).


The Clinical Commissioning Group had no provisions as at 31 March 2018 nor at 31 March 2017.
Other Notes

13. Contingencies

The Clinical Commissioning Group had no contingencies as at 31 March 2018 nor at 31 March 2017 which could be quantified.

The following information is supplied relating to areas where it is not possible to give a reliable cost:

Unreported incidents
In common with many other healthcare providers, it is possible that claims and litigation could arise in the future due to incidents that have already occurred. The future expenditure which may arise from such incidents cannot be determined until such time as claims are made.

14. Commitments

The Clinical Commissioning Group had no contracted capital commitments nor non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2018 nor at 31 March 2017.

15. Financial instruments

15.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the Clinical Commissioning Group’s standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group’s internal auditors.

15.1.1 Currency risk
The Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Clinical Commissioning Group has no overseas operations and therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk
The Clinical Commissioning Group has no borrowings and therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk
Because the majority of its revenue comes from parliamentary funding, the Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note 9.

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

<table>
<thead>
<tr>
<th>Note</th>
<th>Loans and Receivables</th>
<th>Loans and Receivables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March 2018 £000</td>
<td>31 March 2017 £000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS</td>
<td>9</td>
<td>6,592</td>
</tr>
<tr>
<td>• Non-NHS</td>
<td>9</td>
<td>1,777</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Total at 31 March</td>
<td></td>
<td>8,391</td>
</tr>
</tbody>
</table>

15.3 Financial liabilities

<table>
<thead>
<tr>
<th>Note</th>
<th>Other</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31 March 2018 £000</td>
<td>31 March 2017 £000</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS</td>
<td>11</td>
<td>3,486</td>
</tr>
<tr>
<td>• Non-NHS</td>
<td>11</td>
<td>15,782</td>
</tr>
<tr>
<td>Total at 31 March</td>
<td></td>
<td>19,268</td>
</tr>
</tbody>
</table>

16. Operating segments

The Clinical Commissioning Group considers it has only one segment: commissioning of healthcare services.
17. Pooled budgets

The Clinical Commissioning Group operates two pooled funds in partnership with Cumbria County Council under section 75 of the Health Act 2006 (as amended). Both funds are hosted by Cumbria County Council and there has been no change to the operation of either funds.

The Better Care Fund (BCF) is a joint initiative between the NHS and Local Government to develop an integrated approach between health and social care. It is a single pooled budget to support health and social care services to deliver integrated services, based on plans developed and agreed between Cumbria County Council and the Clinical Commissioning Group.

The Learning Disability Specialised Commissioning Pooled Fund jointly commissions services to improve the general well-being and life chances of people of all ages with a learning disability.

The Clinical Commissioning Group’s shares of the income and expenditure (North Cumbria) handled by the pooled budget in the year to 31 March 2018 were:

<table>
<thead>
<tr>
<th></th>
<th>BCF</th>
<th>Learning Disability</th>
<th>2017 – 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(22,593)</td>
<td>(4,989)</td>
<td>(27,582)</td>
</tr>
</tbody>
</table>

The Clinical Commissioning Group’s shares of the income and expenditure (Cumbria wide: North & South) handled by the pooled budget in the year to 31 March 2017 were:

<table>
<thead>
<tr>
<th></th>
<th>BCF</th>
<th>Learning Disability</th>
<th>2016 – 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(37,502)</td>
<td>(7,687)</td>
<td>(45,189)</td>
</tr>
</tbody>
</table>
### 18. Related party transactions

Details of related party transactions with individuals are as follows:

During the year none of the Department of Health Ministers, Clinical Commissioning Group Governing Body members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Clinical Commissioning Group, other than the members set out below.

#### 2017 – 18

<table>
<thead>
<tr>
<th>Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workington Health Ltd (Dr N McGreevy)</td>
<td>1,205</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS North of England Commissioning Support Unit (Stephen Childs)</td>
<td>2,480</td>
<td>340</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Brampton Medical Practice (Dr M Alban)</td>
<td>3,802</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Carlisle Healthcare GP Practice (Dr A Edwards, Dr C Patterson, Dr R Westgate)</td>
<td>7,024</td>
<td>-</td>
<td>113</td>
<td>-</td>
</tr>
<tr>
<td>Westcroft House Surgery (Dr C Heasman)</td>
<td>652</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Distington Surgery (Dr H Horton)</td>
<td>1,217</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>James Street group Practice (Dr N McGreevy)</td>
<td>1,096</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Eden Medical Group (Dr S Rossi)</td>
<td>1,797</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Castlegate Surgery (Dr S Dessert)</td>
<td>2,290</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Castlehead Medical Practice (Dr P Hemmingway)</td>
<td>1,333</td>
<td>-</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Appleby Health Centre (Dr A Liston)</td>
<td>770</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Seascale Health Centre (Dr E Miles)</td>
<td>1,473</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>The Lakes Medical Practice (Dr R Preston)</td>
<td>1,191</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

#### 2016 – 17

<table>
<thead>
<tr>
<th>Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workington Health Ltd (Dr N McGreevy)</td>
<td>1,152</td>
<td>8</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>NHS North of England Commissioning Support Unit (Stephen Childs)</td>
<td>5,275</td>
<td>484</td>
<td>-</td>
<td>72</td>
</tr>
</tbody>
</table>
18. Related party transactions (continued)

Transactions are between the Clinical Commissioning Group and the declared organisation, not the individual, and form part of the Clinical Commissioning Group’s normal activities.

Workington Health Ltd, a consortium of GPs from five GP practices in Workington, runs Workington Primary Care Centre (WPCC). WPCC, launched in October 2014, provides same day urgent appointments for patients of those practices and also provides a walk-in minor injuries services for patients from those practices and elsewhere alongside other services including an electrocardiogram and wound clinic and a frail elderly assessment team.

The Clinical Commissioning Group also considers NHS North of England Commissioning Support Unit (NECSU) a related party as its Managing Director, Stephen Childs, was appointed Chief Executive of the CCG on 19 September 2016 on a part-time basis to 31 March 2018. NECSU supplies commissioning support services to the Clinical Commissioning Group.

Following the boundary change on 1 April 2017, the CCG revised its clinical leadership arrangements replacing locality GP leads with Integrated Care Community (ICC) GP leads whereby ICCs include groups of GPs serving the local population. As a result of also taking on full delegated commissioning arrangements, the CCG considers the GP Practices of the ICC GP leads to be related parties.

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

- Cumbria Partnership NHS Foundation Trust
- NHS Business Services Authority (NHS Pension Scheme)
- NHS England (including North of England Commissioning Support Unit)
- North Cumbria University Hospitals NHS Trust
- North West Ambulance Service NHS Trust
- Northumbria Healthcare NHS Foundation Trust
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Wrightington, Wigan & Leigh NHS Foundation Trust

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Cumbria County Council and HMRC.

19. Events after the end of the reporting period

There are no events after the reporting period which will have a material effect on the financial statements of the Clinical Commissioning Group.

20. Impact of IFRS

Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during 2017 – 18 nor 2016 –17.