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Appendix 1: Annual Accounts

Appendix 2: Audit Report and Opinion
Statement from the Accountable Officer and Chair

Welcome to the NHS Darlington Clinical Commissioning Groups (CCG) 2016/17 annual report. This year we have continued to work with our local communities to improve health services, patient experiences and clinical outcomes.

This report details our performance throughout 2016/17 including our financial performance, governance and how we work with our partner organisations across the health and social care sector to achieve our aims.

The performance report describes our objectives and strategies as a commissioning organisation and our successes in improving the healthcare of our communities.

By working together with our providers and partners in the local health economy of Darlington, we are transforming the way health services are provided. Our multi-disciplinary teams (MDTs) have changed the way we care for older people with a joint approach to managing health and social care.

The ‘Darlington Blueprint’ clearly sets out our vision for health services in 2020, moving urgent care into the hospital and improving access to GPs is a key part of that vision. We are already seeing real achievements towards a patient-centred approach to providing care in the community or at home, improving patient and carer experience and preventing unnecessary admissions to hospital. We have seen a steady reduction in the number of unplanned admissions and we aim to ensure this trend continues.

It also describes our involvement in two key transformation programmes, Sustainable Transformation Plan (STP) and the Better Health Programme.

The report also shows areas where our performance can be improved such as; cancer waiting times and waiting times for treatment in an emergency department.

We continue to foster close working relationships with the voluntary and community sector but recognise there is still more work we could do to enhance this. To do so we have strengthened our Community Council, enabling us to listen to the voice of the patient, ensuring this helps to inform and shape our transformation plans.

The financial section of this report shows that our resources have been appropriately and efficiently managed throughout the year and we have invested in a range of services including, MDTs and Urgent Care. We have moved the urgent care (walk-in) service from Doctor Piper House in Darlington town centre to Darlington Memorial Hospital, alongside the Emergency Department and also improved access to general practice by funding evening and weekend appointments.
Whilst Darlington Clinical Commissioning Group and Hartlepool and Stockton-On-Tees Clinical Commissioning Group have informally been working together since May 2015. From the 1 May 2016 we took the first step to bring together a shared management arrangement by my appointment as single Accountable Officer (known as the Chief Officer).

We strongly believe that this collaboration will not only support the delivery of our statutory responsibilities but in addition help to deliver the transformational challenges and aspirations for our respective communities. The collaboration is intended to create two successful and sustainable organisations through shared learning and development.

We have a hugely positive working relationship with Primary Healthcare Darlington (PHD) which is a true collaboration of all 11 GP practices working together for the benefit of patients and together we have delivered a range of services under the Prime Ministers Challenge Fund, improving access to general practice. GPs in Darlington are working together in new and innovative ways and this greater sharing of clinical expertise is improving the primary care and community services we offer to patients.

We would like to take this opportunity to thank all of our staff and partners who have helped us to achieve our goals this year and our local communities who have helped identify local priorities and help shape our response to those. Further information about NHS Darlington CCG is available on our website www.darlingtonccg.nhs.uk

Ali Wilson Accountable Officer                      Dr Andrea Jones, Chair

30 May 2017
Performance Overview
The purpose of the overview section is to enable you to understand the CCG, our purpose, our objectives and any associated risks to the achievement of those objectives. It also tells you how the CCG has performed during the year and should enable the lay user to have an overview of the organisation without the need to look further into the Annual Report.

About Us
NHS Darlington Clinical Commissioning Group (CCG) is a member organisation, comprising 11 GP practices. We were established on 1 April 2013 following a comprehensive reorganisation of the NHS as part of the Health and Social Care Act 2012. In 2016/17, we had a total annual budget of £164 million which we received from NHS England.

We are the NHS organisation responsible for commissioning (planning and buying) the majority of health services on behalf of our local population and from 1 April 2015 we have also been responsible for commissioning primary care (GP) services in partnership with NHS England. We are also one of the smallest CCGs in the country, with 11 member practices spread across a compact borough.

Our vision
Our vision is to ensure that the health services we commission from providers (such as County Durham and Darlington NHS Foundation Trust) are of the highest quality and are good value for the money we spend on your behalf.

Our strategic vision that has provided the focus for our work during 2016/17 has been:

*To commission healthcare that will improve health outcomes, reduce health inequalities and ensure fair and equitable access to high quality, safe, patient-centred services.*

Our aims
Our strategic aims are to:
• improve the health status of the people of Darlington;
• secure the right services in the right place for the people of Darlington;
• invest in primary care and services;
• secure meaningful engagement with people.

To be effective we are addressing the needs of the changing age profile of the population of Darlington and managing our resources effectively. We are doing this by working in partnership with our clinicians and involving our local communities, ensuring they have a voice.
**Our priorities**

Our 11 family GP practices serve a population of 107,318 patients, many of which face significant health challenges. Deprivation is higher than average and about 20.6% (4,100) children live in poverty.

Health profiles for Darlington (published September 2016) tell us that the health of people in Darlington is varied compared with the England average. About 21% (4,100) of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 11.8 years lower for men and 9.4 years lower for women in the most deprived areas of Darlington than in the least deprived areas.

**Child health**

In Year 6, 20.2% (233) of children are classified as obese. The rate of alcohol-specific hospital stays among those under 18 was 76.2*, worse than the average for England. This represents 17 stays per year. Levels of GCSE attainment, breastfeeding initiation and smoking at time of delivery are worse than the England average.

**Adult health**

The rate of alcohol-related harm hospital stays is 708*, worse than the average for England. This represents 730 stays per year. The rate of self-harm hospital stays is 231.4*, worse than the average for England. This represents 240 stays per year. The rate of smoking related deaths is 311*, worse than the average for England. This represents 190 deaths per year. Rates of sexually transmitted infections, people killed and seriously injured on roads and TB are better than average. The rate of long term unemployment is worse than average. The rate of violent crime is better than average.

Health priorities in Darlington include giving every child the best start in life, tackling alcohol-related harm, and promoting mental health and wellbeing.

* rate per 100,000 population

**Commissioning priorities**

In 2016/17 we continue to build upon the foundations of our first three years as a statutory body. We have consolidated the work we have done to achieve greater partnership working with the local authority and other partners in the health economy, with the aim being to improve the health of our local population and deliver high standards of patient care. Established against a backdrop of economic uncertainty we expect the next few years to be equally challenging, yet we are excited about the future opportunities we have to work with our key partners to improve health services in Darlington.

We are working in collaboration with Darlington Borough Council, County Durham and Darlington NHS Foundation Trust, Tees, Esk and Wear Valleys NHS Foundation
Trust, and primary care to deliver improved health and social care services that are sustainable for the future.

Collectively we have pledged to the following principles:

- We will work collectively as a collaboration of commissioners and providers;
- The interests of the patient are paramount and at the centre of what we do;
- Because we recognise a Darlington health economy, individual organisational interest will not get in the way of improvements for the patient;
- Where improvements adversely affect our partners, we will manage the impact as well as the improvement;
- Transitional change can require periods of contractual stability in order to realise long term improvements;
- Good practice and examples of best care and support will be spread for the benefit of all;
- Our population, patients and staff will be proud of what the health and social care system provides;

Our commissioning intentions allow us to formally notify our patients, carers, stakeholders and the general public of our plans as well as seeking to deliver the ‘2020 Vision for Health and Social Care in Darlington’, NHS England’s ‘Five Year Forward View’ and ‘Next Steps for co-commissioning’ along with the Dalton Review, all of which will inform and focus our strategic direction and priorities.

Darlington Unit of Planning
There is also a Darlington Unit of Planning. The Unit of Planning was established to set common goals and work closely together to develop services in Darlington that will help people live longer, healthier lives. The group comprises Darlington CCG, Darlington Borough Council, and various NHS health and social care partners. The unit shares an ‘Ambition for Excellence’ that delivers right care, in the right place, at the right time and with no waste. The Unit of Planning is key to the delivery of our vision that will be delivered over the following five years.

Our Achievements 2016/17

Working across our local health and social care system
We work with a broad range of stakeholders including healthcare service providers, neighbouring CCGs, Healthwatch organisations, Darlington Borough Council as well as community and voluntary organisations to ensure a joined up approach to the
provision and resourcing of healthcare in our community. We know that by working closely with partner organisations who have similar priorities and challenges to ourselves we can achieve so much more.

**Darlington Care Blueprint**
The CCG developed the Darlington Care Blueprint supported by an infographic to outline the CCGs 2020 vision and response to the Five Year Forward View. The blueprint sets out the CCGs plans for new models of care. The infographic provides a visual representation of how local health services work with the patient at the centre.

We are able to use this digitally across the service with an attached narrative to share our vision for future services including information about our plans for community hubs, care co-ordination centre, the discharge management team, care planning and the use of technology. An outline of our plans for future services as part of the blueprint can be seen on 29 under our plans for 2017/18.

**Two year operational plan**
The CCG has developed a two year operational plan as part of our response to the Five Year Forward View. Our joint management structure with Hartlepool and Stockton Clinical Commissioning Group sees us coming together this year to produce an ambitious shared delivery plan along with a shared performance framework across the two Clinical Commissioning Groups (CCGs); however as both CCGs remain separate Statutory Bodies, the subsequent operational plans will also remain separate, albeit with strong similarities.

In Darlington we are committed to a health service that provides high quality and safe care to all local people that meets our growing challenges and helps us reduce the inequality that exists across our communities.
This two year plan articulates how we will deliver transformation at scale and pace in order to deliver the requirements of the ‘Five Year Forward View’. Building on the progress already made during 2016/17 and focusing on the following areas;

- Further strengthening of our partnership working with all providers and other CCGs across our STP footprint in order to understand the shared opportunities and wider impact of our respective plans
- Continue to build on our history of working in partnership to drive improvements in the health and wellbeing of our local population
- Detailing the quarter on quarter benefits of the transformation programmes we plan to deliver and the expected outcomes

In June 2016 a vision of “meeting our communities needs now and for future generations, with consistently better health and social care delivered in the best place” was set at STP level. This was supported by a clear articulation of the challenges associated with an overreliance on hospital based services. To do nothing is not an option.

Our plan is ambitious, and will deliver a transformed system for our workforce and local population. We want to see everyone get healthier, but we want the health of the most vulnerable around us to be as good as that of the most fortunate. A finite budget and increasing demand will need us to make choices about the services we commission. Initially this will be focused on reducing unnecessary demand and reducing waste and inefficiency, whilst maintaining quality services. These are the challenges we must face up to. “We” being the GP practices, the patients, the community, the providers of services and other partner organisations we work with. “Good health is everyone’s business”. This will lead to better patient outcomes with shorter hospital stays, improved access to GPs and a financially sustainable system.

These important points are at the heart of our strategic outcomes. These are difficult to achieve. We must have the confidence to take the difficult decisions. We must do the right things, in the right way, at the right time to meet the needs of the people.

Reflecting that of the STP we will deliver a shift towards improving ‘population health’ - moving from fragmentation to integration in care delivery, but also tackling the wider determinants of the health and wellbeing of our population. Working together as a Health and Care system enables us to focus on early intervention and prevention, integration, reconfiguration of hospital based services, and technology.

**STP vision for 2020**

To date we have relied more on hospital based care than in other parts of the country. We want to strengthen care delivered outside of hospital so that neighbourhoods, communities and individuals are able to take more control of their health and maintain independence for longer, whilst preventing or delaying the need for more services in acute and community care.

We have ambitious plans to strengthen services delivered in primary care, attracting more GPs to the area and growing the work force, developing new roles that can support the primary care team to manage their workload, improve integration with
social care and expand services that were previously provided in a hospital setting. The new model will enhance proactive care planning and delivery for patients at risk of hospital admission that require wider service support.

We will increase the number of services that are delivered outside of hospital settings. We will be developing health and social care hubs each covering a population of 30,000 to 50,000 people. Health and care organisations will work together in developing new models of care taking responsibility for the health and care of the population budget. This new way of working will enable us to reduce the number of people that require admission to hospital. When people require hospital admission they can often stay in hospital longer than is necessary so we are working closely as health and social care partners to improve support for patients leaving hospital, so that they can be discharged quickly when it is medically safe to do so. We recognise that we need a strong focus on creating sustainable nursing and residential care provision.

We plan to strengthen links between health and social care commissioners. Plans are being developed to integrate commissioning functions where it makes sense to do so and we want to build and encourage the development of the voluntary sector so they can support patient care in the community, ensuring health and social care services are used effectively.

We will increase the number of patients and service users who have access to a Personal Health Budget enabling greater choice and control over their healthcare and the support they receive. These principles apply for both physical and mental health and service users with a learning disability. The improvements in services in our neighbourhoods and communities will impact on the way that our hospital based services will be delivered.

In response to the vision of the STP and the focus on primary and community care, we have started to develop local plans that focus on the bottom two tiers of the STP vision, as identified in the diagram below. local GP practice services and integrated community hubs. This is where we feel we can make local improvements to primary and community care, whilst supporting and working to achieve the identified overall vision of the STP. Local plans are aligned to the STP vision and have been developed to ensure that they support the wider STP proposed changes to higher complexity care.

**Working with member practices and clinicians**

The CCG took on fully delegated commissioning of primary medical services with effect from 1 April 2016.

Darlington’s local GP Federation is called Primary Healthcare Darlington (PHD), which is a collaboration of all 11 GP practices in the town working together for the benefit of patients

It was established following a successful bid in wave one of the Prime Ministers Challenge Fund in April 2014. PHD has been responsible for delivering a range of
pilot services under the Challenge Fund to improve access to general practice. This year we have secured additional funding from the Department of Health to continue to offer more GP appointments in Darlington, provided by PHD. There are pre-bookable GP and nurse appointments available during evening and weekends.

The service is open on a Saturday 8am-2pm, Sunday 9am-1pm, Monday to Thursday 6.30-9.00pm and Friday evening 6.30-8.30pm. The service is available to all patients registered with a Darlington GP practice and patients can make an appointment by calling their GP practice or NHS 111.

**Healthy New Towns**

Darlington was selected as one of 10 demonstrator sites in England for the Healthy New Towns initiative in March 2016 bringing together a collaboration between Darlington Borough Council, local health partners including Darlington CCG and County Durham & Darlington Foundation Trust and local developers. The aims of the programme are:

- To develop new and more effective ways of shaping new towns, neighbourhoods and strong communities that promote health and wellbeing, prevent illness and keep people independent;
- To show what is possible when we rethink how health and care services could be delivered, linking into the New Models of Care programme, by adding to the learning about how health and care services could be integrated to provide better outcomes

The Healthy New Town (HNT) programme in Darlington is initially focussing on the east side of the town because it poses significant health challenges compared to other parts of the town and it also poses significant opportunities for regeneration and new housing developments that can be designed taking on board Darlington’s healthy design principles. It is hoped that the collaborative work can contribute to reducing issues like higher premature mortality rates and higher levels of worklessness by encouraging healthier ways of living and increasing levels of exercise, better connectivity to the rest of the town and jobs, and working with health services to provide better planned care in the community, particularly for those with multiple long term conditions and/or who are frail elderly or who have complex needs. The programme also aims to harness the benefits of technology to assist residents to self-manage and maintain their independence, where they can be supported to do so, to make better use of clinicians’ skills and time and improve patient experience

Some early benefits delivered from the programme include: extensive regeneration work ongoing at the Red Hall estate in the heart of the eastern growth zone with investments into housing stock, improvements going into the environment such as improved walk/cycle ways; improved play park provision, a bikeability scheme linked
to the primary school, community engagement work with the local community, preparation work for the first of the new developments to be delivered to healthy new town design principles, Darlington under-nutrition luncheon club initiative, in reach of learning and skills opportunities to the Red Hall estate and delivery of Holiday Hunger Club.

Grant monies has been secured to continue the initiative for another two years so there are further roll out plans being developed including assessing how best to provide integrated health and care services to local communities and behaviour change programmes including improved access to exercise and sport. Plus the roll out of the digital platform to enable more patients to be able to be remotely monitored, allowing them to take more control and be more knowledgeable about their condition but with support and the development of teleconsulting opportunities between clinicians and with patients, again to assist with self-management.

The aim is to learn what impact these various initiatives have on people’s health and wellbeing and apply this learning both elsewhere in Darlington but also feed into the wider national healthy new towns programme.

**Health and wellbeing strategy**

In order to improve health and reduce inequalities, the CCG continues to work closely with a number of partners across the Borough. The CCG is represented in a range of partnerships, some are statutory and others are affiliations or networks of partner organisations for a specific issue or community.

The CCG as a ‘Responsible Authority’ is a member of the Local Safeguarding Children’s Board (LSCB), Safer Adults Partnership Board (SAPB), and Community Safety Partnership (CSP). The CCG has been a key member of the Darlington Health and Wellbeing Board since its establishment in shadow form. The Health and Wellbeing Board promotes integration and partnership working between health, social care and other agencies and is just one example of reciprocal cross partnership working.

Dr Andrea Jones is Vice Chair of the Darlington Health and Wellbeing Board. The Health and Wellbeing Strategy, ‘One Darlington: Perfectly Placed ‘sets the direction for the various organisations working together within the Darlington Strategic Partnership and the Health and Wellbeing Board. The CCG Chief Officer is a member of the Health &Wellbeing Board and the minutes of the Board come to the CCG Governing Body. The Director of Public Health and the Director of Children’s and Adult services also attend Governing Body.

As part of the consultation on the annual report a copy of the draft annual report was provided to the Chair of the Darlington Health and Wellbeing Board for comments. Their responses and any issues have been incorporated into the annual report.
The Health and Wellbeing Strategy has eight key outcomes, the CCG contributes to some elements more than others, nevertheless its contribution is recognised by partners as significant.

- Children with the best start in life - the CCG commission’s midwifery services and a range of other care services which contribute to this outcome. The CCG worked in partnership with the Council and NHS England to see a smooth transition of the 0-19 Public Health responsibilities to the Council in 2015 and have continued to embed the Healthy Child Programme.

- A safe and caring community - the CCG is a Responsible Authority on the Community Safety Partnership and ratified the revised Community Safety Plan, ‘One Darlington: Perfectly Safe’ in 2015-2020. The ‘safeguarding’ responsibilities of the CCG in relation to both children and adults is reflected in the description of the relevant Boards.

- More people active and involved - there are 2 aspects to this outcome one is a focus on addressing the key risk factors that contribute to the life expectancy gap, the other is on community connectedness, community facilities and assets and neighbourhood regeneration. The CCGs communication and engagement strategy reflects its responsibilities for engagement with a diverse range of groups in the population. The community council for patients, public and carers was refreshed in 2015/16 in order to ensure we have a wide range of community champions connected to a diverse range of sectors of the community.

- More people healthy and independent - a development of the above outcome, a focus on tackling health inequality and the work to develop new models of care, as described in the Vision 2010 and the Better Care Fund schemes of work.

- More businesses and more jobs - the NHS 5 Year Forward View urges CCGs to engage with local economic strategies and act as partners in the economic growth of the place. The CCG is keen to further develop mechanisms to contribute via its involvement in the Darlington Strategic Partnership. The Darlington Strategic Partnership is a broad network including the CCG, Council, Police, Fire and Rescue, community and voluntary service representatives and business leaders.

- More people caring for our environment - whilst the focus of this element of the Health and Wellbeing Strategy is on environmental aspects of the Borough, the CCG has a role to play in making sure that NHS Sustainability Strategy takes account of local environmental plans. The evidence base is growing for the links between sustainable transport, walking, cycling safely and green spaces and health improvement.

- Enough support for people when needed - the CCG makes a strong contribution to this element of the Health and Wellbeing Strategy, for example the Long Term Conditions collaborative and its focus in 2015 on respiratory illness; the Better Care Fund which has a focus on those who are most at risk of admission to hospital or high users of urgent and emergency care services; the Good Friends volunteering
project, and the work the CCG is leading across the Region on Muscular Skeletal conditions.

A place designed to thrive - this outcome is about creating the environmental and infrastructure needed to deliver most of the other outcomes. This includes the arts and cultural offer too

The CCG provides regular updates to the Health and Wellbeing Board (HWBB) on key areas of delivery and assurance and has led or jointly led number of HWBB development sessions for example the 2020 vision and the Darlington Blue print development session.

The Darlington Strategic Partnership is a broad network including the CCG, Council, Police, Fire and Rescue, community and voluntary service representatives and business leaders. The Sustainable Community Strategy ‘One Darlington: Perfectly Placed’ is also the Health and Wellbeing Strategy for the Board.

The CCG is a partner organisation in a range of other networks, with an issue or thematic focus, e.g. Mental Health Network, Children and Young People’s Joint Commissioning Group and Darlington Ageing Well Network (DAWN).

Commissioning Safe and Effective Care

Better Care Fund
The Better Care Fund (BCF) creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services. The BCF has enabled innovative approaches introduced in 15/16 to be developed, and new initiatives to be developed, all in the interests of reducing unnecessary hospital stays.

Our partnership, comprising Darlington GPs, Darlington Borough Council, NHS Darlington Clinical Commissioning Group (CCG), Darlington Memorial Hospital, Tees, Esk and Wear Valleys NHS Foundation Trust and Darlington’s voluntary sector has continued its close working together to make sure older people get appropriate care to stay safe and healthy at home, avoiding unplanned stays in hospital.

The fund, totalling £8,014,001, is made up so:

<table>
<thead>
<tr>
<th>Summary of Total BCF Expenditure</th>
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<tr>
<td>Acute</td>
<td>£298,400</td>
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<tr>
<td>Mental Health</td>
<td>£418,672</td>
</tr>
<tr>
<td>Community Health</td>
<td>£3,281,124</td>
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<tr>
<td>Continuing Care</td>
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</tr>
<tr>
<td>Primary Care</td>
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<td>Social Care</td>
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<tr>
<td>Other</td>
<td>£1,518,726</td>
</tr>
<tr>
<td>Total</td>
<td>£8,014,001</td>
</tr>
</tbody>
</table>
The vision for the fund remains in line with the wider vision for health and social care in Darlington:

“By 2020 there will be a sustainable health and social care economy in Darlington that places citizens at the centre of the model and which builds strategies and services around them. Personal responsibility, prevention of harm, self-management of conditions, prompt access to primary care and easy access to acute services will form a continuum of provision in Darlington, with some, more specialist services, provided elsewhere.”

Delivered by

- Health and social care services designed round the individual, across current organisational boundaries
- Increased support to enable individuals to look after themselves
- Focus – organisation and individual - on prevention
- Maximised use of partners’ resources including skills, expertise, property and other assets
- Minimised duplications and waste in service delivery processes
- Understood and managed demand
- Full integration of service delivery with community and Voluntary, Community and Social Enterprise (VCSE) sector
- Data shared appropriately and safely in the interests of individuals

These objectives have been delivered through five key strands of work this year. Hospital to Home, Safe at Home, Long Term Conditions, GP-based Multi-Disciplinary Teams, and Social Prescribing.

Performance-wise, emergency admissions to hospital continue largely at similar levels to previous years, but we can see the impact of targeted activity in relation to older people’s admissions to hospital from care homes, which continue to fall; without BCF the overall emergency admissions would be even larger. Permanent admissions to residential care are on track to achieve a new low, and Delays in Transfers of Care (enabling people fit to leave hospital, to do so) remain lower than target.

Under Hospital to Home, a central strand has been the jointly commissioned review of intermediate care services across Darlington. This will inform the future development of this central service, key to unlocking discharge and supporting people at home.

Hospital to Home also encompasses “Discharge to Assess”, being undertaken as part of CDDFT’s Better Health Programme, intended to better manage the speedy discharge of people no longer in need of hospital services but who require support to return to their usual place of residence.

Safe at home is concerned with helping people outside of the “high risk of emergency hospital admission” cohort remain at lower risk, supported at their normal place of residence to maximise their independence, through a range of interventions including new technology.
Where the normal place of residence is a care home, a national case study has highlighted the benefits of the work done in Darlington to bring Community Matrons into care homes, including improved patient health outcomes and experiences, staff satisfaction and reduced hospital admissions. This indicates the close working relationship between all partners in Darlington.

Reducing the number of permanent admissions to 24 hour residential care continues, and the rollout this year (following a successful pilot) of Just Checking Assessment Tool in Adult Social Care will provide reliable evidence of individuals’ independence, as well as where support might be needed.

The Long Term Conditions project came to a scheduled close in November as planned, with project close reports and follow-on actions being received by the CCG.

The GP-based multi-disciplinary team is now undergoing review to both build on its strengths and on the learning that has accrued, and will be extending its reach beyond frail elderly to those people who make a significant impact on our services without significant benefit to their health and wellbeing. It is also adjusting its format to fit with the emerging Care Hubs approach being implemented under the regional Better Health Programme’s “New Models of Care”.

A social prescribing model has been scoped this year and a test bed is in place for 17/18. This provides a structured process to enable both social workers and GP’s/practice staff to refer people to a team of care navigators. That team will support them to access to community-based services and activities to help address social isolation, improve self-management of conditions, or improve overall wellbeing. This one year ‘test-bed’ will generate demand and impact data sufficient to ensure the full design of a social prescribing model for tender at quarter 3 17/18 is shaped for Darlington.

GP support to care homes in Darlington

In September 2013 Darlington CCG launched a pilot programme that involved GP practices becoming aligned to nursing and residential care homes throughout Darlington. The aim of the pilot was to enhance the quality of health provision for residents of participating Darlington nursing and residential care homes by delivering improved patient access to primary and community medical services. A secondary aim was to reduce the number of emergency admissions and the number of A&E attendances by these residents.

Eight practices provide additional support to 21 care homes across Darlington. We are working with patients, families, care homes and practices to encourage registration of patients to the link GP practice whilst maintaining patient choice. No-one will be forced to move however it is hoped to be able to support patients in making the right choice for them and their care and being able to offer a regular GP contact, as it is known that this improves outcomes and quality of life. The project has been evaluated and the CCG Executive are considering the evaluation report and recommendations in March 2017, regarding the future of the project.
Prescribing
The decision to prescribe is the most common intervention in the NHS. Darlington CCG work collaboratively with other health professionals and social care providers to deliver evidence-based cost effective use of medication to maximise patient outcomes from medication prescribed to them. This is facilitated through the North Region Treatment Advisory Group, County Durham and Darlington Area Prescribing Committee, and its shared formulary process with secondary care along with individual funding request processes for medication, and County Durham and Darlington Drug and Therapeutics Clinical Advisory Group.

2016-17 has been the most challenging year yet for Darlington CCG from a QIPP perspective and medicines cost pressures have come from increased use of direct oral anticoagulants (DOACs), new medicines for type 2 diabetes and increased prescribing of pregabalin for neuropathic pain. Much of this is due to appropriate adherence to new NICE guidance. There has been significant growth in the use of PbR-excluded “high-cost drugs” by secondary care providers again as a result of newly published NICE clinical guidance and technology appraisals; however the utilisation of biosimilar infliximab and etanercept has mitigated against these cost increases to some extent.

All CCG member practices receive practice-based prescribing support which includes audit work to support implementation of NICE guidance and medication related issues in general practice, support to encourage prescribing decisions in line with the County Durham and Darlington formulary and monitoring and analysis of prescribing patterns. The practice team have reported prescribing savings of £274,824 in-year due to ensuring patients are prescribed the most cost-effective medication, including utilising cost-effective alternative products for pregabalin and strong opioid patches.

Locally developed clinical system protocols support decision making at the point of prescribing, based on clinical effectiveness and cost-effectiveness, and regular newsletters and memos, the formulary and medicines optimisation websites are also available to support clinicians. Clinical engagement of healthcare professionals is key to the delivery of the medicines optimisation agenda and longer term strategy. All Darlington practices are invited to send members to the CCG Prescribing Subcommittee which meets on a bi-monthly basis and leads on local implementation of medicines related issues and provides guidance to local prescribers.

Practices now receive quarterly prescribing reports tailored to their practice to outline their performance against budget, cost growth and prescribing cost pressure areas by BNF section. Assurance around the safe management of controlled drugs is provided to the CCG via quarterly prescribing reports, and medication incident reports are provided quarterly to the prescribing subcommittee.
**Urgent Care**

In September 2015 the CCG agreed the Country Durham and Darlington Urgent Care Strategy and committed to ensure the local urgent care pathway is implemented in line with the principles agreed within this strategy. This together with further developing our ambition to secure high quality services outside of hospital has been a key area of work described in the Darlington 2020 vision. The main focus of the model is the availability of a range of community based services including pharmacy, promotion of self-care, NHS 111, GP Paramedic Support, extended primary care joined up with secondary community care services providing a timely and effective service to patients who are quickly and safely directed to access the relevant service to meet their presenting health needs. For those with urgent needs they will be quickly and safely directed to attend an urgent care service and those will serious or life threatening health conditions will be quickly, safely and effectively assessed and treated in an Emergency Department.

**County Durham and Darlington Local A&E Delivery Board**

The County Durham and Darlington Local A&E Delivery Board (LADB) replaces the System Resilience Group (SRG) and acts as a forum where partners from across the health and social care economy together to discuss strategic aims, objectives and a whole system approach in relation to improving A&E performance. This transformation was mandated by NHS England in their correspondence to Clinical Commissioning Group (CCG) Accountable Officers in July 2016 following a review of SRGs which identified the need for local leadership structures to focus specifically on Urgent and Emergency Care, and to be attended at the Executive level by member organisations. The County Durham and Darlington LADB was formed in September 2016 with Sue Jacques, Chief Officer, County Durham and Darlington Foundation Trust (CDDFT) as Chair and Stewart Findlay Chief Clinical Officer, DDES CCG as Vice Chair to deliver the national A&E Improvement Plan.

The LADB takes a whole system approach to improve A&E performance. Primarily this is about recovery of the 4 hour target but the LADB is also working with Sustainable Transformation Plan (STP) groupings and the Urgent and Emergency Care Network (UECN) on the longer term delivery of the Urgent and Emergency Care Strategy.

As part of the A&E Improvement Plan, the Emergency Care Improvement Programme (ECIP) Team carried out an intensive whole system diagnostic in November 2016. As a consequence four key priority areas for improvement across the system have been identified:

a) Leadership  
b) Assessment prior to admission  
c) Doing today’s work today
d) Discharge to assess

A dedicated Lead from the ECIP Team will work with system leads across the County to implement the agreed priorities and high impact recommendations over the next 12 months. A LADB Operations Group has been set up with membership made up of the designated leads for specific aspects of taking forward and implementing the ECIP recommendations.

Urgent and Emergency Care Vanguard

All NHS organisations in the North East are part of the North East Urgent and Emergency Care Network. In 2016/17 the network received £2.9m from NHS England’s New Care Models programme to implement various schemes across the North East.

Some of these schemes included:

- **Respond** - simulation training package for mental health crisis care which rolled out across the region following its successful launch in September. Its aim is to transform professional responses to mental health crisis through better collaboration and knowledge
- **Under 5 app (NHS child health)** – the app gives easy to understand guidance on childhood illnesses and recognising when your child is unwell, as well as advice on when and where to seek treatment
- **Behavioural analysis** - A key element of the network’s approach is undertaking high quality market research to understand the views and behaviours of patients and NHS staff in relation to urgent and emergency care services
- **Great North Care Record** - The Great North Care Record (also known as MIG – Medical Interoperability Gateway) aims to bring the region up to a common standard of information-sharing, saving time and improving patient safety. The MIG enables real-time access to key primary care patient information at the point of care (emergency departments, GP out of hours services, mental health trusts, NHS 111 and the ambulance service)
- **Flight deck** - a real-time application displaying the current status of emergency care across the region as well as predicting the like scenario four to twelve hours ahead
- **Clinical hub** - the clinical hub involves Emergency Department consultants working within the hub on Monday and Friday 6–10pm and Saturday and Sunday 8am– 4pm to provide enhanced clinical assessment of patients who would otherwise be directed to their nearest Emergency Department

Co-location of the Urgent Care Centre

As part of the work being taken forward to integrate the urgent and emergency care pathway, the CCG working in conjunction with County Durham and Darlington NHS Foundation Trust has co-located 24/7 Urgent Care at Darlington Memorial Hospital that is
delivering Urgent Care and Emergency Department services side by side.

Our vision is to provide a fully integrated that will provide local people with equitable access to high quality, safe and effective urgent and emergency care services at the right time and in the right place.

**Tackling Winter Pressures**
As a North East region, all CCGs have worked together to develop a regional marketing campaign for winter. This work was developed using a social marketing approach using the insight developed through the behavioural analysis as part of the North East Urgent and Emergency Care Network.

The campaign used ‘plasticine people’ will help to highlight good self-care, raise awareness of the expert advice available free at every pharmacy in the region, and promote the new NHS Child Health app, which helps parents of under-fives look after their children’s health.

The campaign started on 14 November, to coincide with National Self-Care Week and will continue until the end of March 2017.

The CCG also supported the Stay Well this Winter campaign which was launched by NHS England and focused on people aged 65 years and over or people with long-term health conditions and their carers, family and friends to take specific actions to stay well over the winter, including seeking advice from a pharmacist at the first signs of illness and having the flu jab.

**Frail Elderly**
Our prime focus in our work with the Frail Elderly remains to improve the patient and carer experience and improve outcomes for our patients.

Community Matrons and GPs aligned to a number of care homes in Darlington continue to work together to implement care plans and manage daily concerns to ensure residents are supported in the best way possible in their place of their choice, with emergency attendances and admissions continuing to reduce from these identified care homes through proactive care planning. To support this work we are seeking to make more use of assistive technology in care homes so we can earlier identify the onset of infection and provide proactive intervention to avoid an unnecessary unplanned admission to hospital.

Monthly practice MDT meetings continue to be held, focused on frail elderly patients and managing their needs in an expert forum. A small number also now involve a Community Pharmacist on a pilot basis to determine how they can further support high risk patients.

The Adult Transitions of Care team continue to work in Darlington Memorial Hospital to facilitate early supported discharge of patients. This is in conjunction with a GP working in DMH on a Saturday and Sunday to identify patients who can be discharged back to their own home or to a Community Bed with support. This is continuing to reduce length of stay and reduce delayed transfers of care.
Alongside this, work continues with County Durham and Darlington Foundation Trust to further streamline the discharge process and ensure discharge planning starts on admission to ensure patients can return to their usual place of residence as soon as they are medically fit to do so via a ‘discharge to assess’ model which is in its infancy, identifying people who no longer need to stay in hospital and putting in place plans to return patients to their own homes wherever possible. This is supported by a rapid response service, provided by the local council which identifies patients who require short term intensive support to allow them to be discharged home.

Darlington CCG continue to commission community step-down beds where patients are transferred to from an acute bed when they are medically fit but may not yet be capable of returning to their own home due to needing an increase support package. This has reduced the number of patients being discharged to Richardson Community Hospital, which we know is a long way for relatives to travel when visiting.

**Dementia**

We have worked with Durham County Council, North Durham CCG, Durham Dales, Easington and Sedgefield CCG and Tees, Esk and Wear Valley NHS Trust to plan how we can provide the best care possible now and in the future for people with dementia. Following a public consultation in 2014 to gather people’s views, we agreed a 2014 – 2017 Dementia strategy to improve services throughout the community. We have now reviewed the County Durham and Darlington Dementia Strategy for 2014-2017 and from the recommendations within developed a future County Durham and Darlington Dementia Strategy for 2017-2020. Our priorities over the next three years need to be agreed by the CCGs and the Health and Wellbeing boards for Durham County Council and Darlington Borough Council.

The County Durham and Darlington Dementia Strategy 2017-2020 document will be available on the CCG website. The Dementia Strategy Implementation Group meets bi-monthly and membership has developed since its inception and this wide representation enables it to maximise the opportunities to help meet the National Dementia Strategy objectives. Dementia Diagnosis Rates have continued to improve with all CCGs in County Durham successfully exceeding the national target.

The CCG’s in County Durham and Darlington are leading the way with an Improving Value in Dementia Care (a co-design approach) project. This is five year study involving Commissioners, North of England Commissioning Support, local stakeholders and staff from Oxford University, London School of Economics and Bradford University. The aim of the study is to develop practical strategies that will improve care for those living with dementia and those who support them without increasing costs.

**End of Life Care**

There has been significant focus over the last year to support the delivery of high quality, timely, effective, individualised services for patients with end of life care
needs, support for their families and support for staff to provide these services. The County Durham and Darlington End of life steering group’s service improvement work continues. The End of Life Group has agreed a new work plan based on the Ambitions 2015-2020 document aimed at delivering person centred, accessible and quality services. St Teresa’s have now rolled out the Rapid response service which delivers high quality, well-coordinated, flexible and responsive palliative nursing care in the community at short notice, to patients at home, including care homes and sheltered housing, whose needs can be met by rapid, short term intervention in the end of life stage of their illness.

**Diabetes**

A review of diabetes services across County Durham and Darlington in 2013/14 revealed a number of challenges with continuing with the current ways of working. There are rising costs of prescribing, little integration between GP Practices, specialist Consultants, Diabetes Specialist Nurses and Community Services and we are experiencing both locally and nationally increasing numbers of patients being diagnosed with diabetes. Engagement feedback concluded that patient wanted more support to self-manage their condition and a more flexible and joined up diabetes service. Similarly Consultants, GP’s and Nurses advised they wanted to support patients to self-care more and provide a more integrated service.

Using all of this information, a new Integrated Diabetes Model was developed during 2015 and during 2016/17 work has taken place to put this new approach to diabetes care into practice around County Durham and Darlington. This is happened in stages and is planned to start being delivered in Darlington during 2017/18.

The new model will see care being delivered to all but the most complex diabetes patients within a GP Practice setting with skilled diabetes GP’s and Practice Nurses, supported by specialist Consultants and Diabetes Specialist Nurses. The overall aims of the new integrated diabetes model is to provide a genuinely integrated approach between primary and secondary care, reducing local variation in the quality of diabetes care and management of patient blood glucose levels facilitating improved health outcomes for patients and working towards a financially sustainable pathway of care by achieving savings, such as reducing cost per patient, that are to be reinvested back into the model to further improve health outcomes for people with, or at risk of developing diabetes.

**Respiratory Disease Programme 2015 - 2017 a catalyst for change**

Jointly funded by the Academic Health Science Network (AHSN) and the CCG this project has been running since 2015, with an end date of June 2017. Work has been carried out over the last few years in the care of patients with respiratory disease in Darlington with a view to the future. The Darlington Respiratory Team (DART) has been able to come together to develop pathways of care, which have successfully signposted people with chronic respiratory disease, ensuring greater consistency across practices. The project has been able to focus on and give support to Practices in the following areas; standardisation of management and review of
patients with COPD and Asthma and below are some of the key features of the project:

- Visits continue in each practice to include support with sharing best practice in Respiratory clinics, assistance with audit work, update sessions for GPs for Spirometry interpretation and COPD/Asthma management updates- as per local respiratory Network guidelines
- Respiratory Nurse interest group meeting held two monthly to allow forum for Respiratory Interested Practice Nurses to come together and stay updated in COPD and Asthma management and can share best practice.
- Respiratory Practice Nurse in each practice is conducting audits to identify good practice in respiratory management and highlight areas for improvement in their own work environment.
- A Breathlessness pathway has been developed and shared with all clinicians in the CCG to help ensure a more consistent diagnostic approach
- Asthma emergencies in general practice educational session delivered
- Patient feedback is currently being collected
- Spirometry competencies have been assessed in each Practice and there will be a Spirometry Quality Audit conducted

**Long Term Condition Collaborative**

Long term conditions project came to a close in November 2016, with work continuing as ‘business as usual’ in the partner organisations. Funding for an incentive scheme for practices to put care plans in place for patients with 1-3 LTC and 4+ LTC has been carried forward into BCF but care planning isn’t coming on stream in GP Practices until April 2017.

The main achievements for this project which should have the biggest impact on improving patient care and experience and shortening the pathway are: the cross skilling of the community and specialist nursing teams at CDDFT; Implementation of the breathless algorithm for Primary Care; and Health Coach Training across all sectors. The project had good collaboration at both Project Board and Chief Officer level and had good sponsorship.

**Darlington CCG leads North of England Regional Back Pain Programme**

Darlington CCG is the lead commissioner for the North of England Regional Back Pain Programme. This is a regional initiative with clinical commissioners, providers and health professionals from the north east of England that has been selected by the Health Foundation, an independent health care charity, to be part of its new national £3.5 million improvement programme, ‘Scaling Up’ Improvement.

The pathway aims to improve the management of patients who have lower back pain or radicular pain, implementing an evidence-based, comprehensive care pathway that integrates care from the GP surgery through to the specialists in hospital. NHS Darlington CCG and NHS Hartlepool and Stockton-on-Tees CCG launched the pathway in April 2016 as part of Wave 1 of the Health Foundation supported Programme. Wave 1 followed on from the ‘early implementer areas’ South Tees and Hambleton, Richmond and Whitby CCGs, who launched the pathway on 3 August
2015 following a period of awareness raising and education with local health professionals in all areas.

Those people who may go on to have more disabling problems are provided with the correct interventions at the right time which can significantly prevent their problems from becoming chronic and the consequent effect it has upon their overall wellbeing.

**Mental Health**

As outlined in our two year operational plan our ambition is to ensure early diagnosis, treatment and ongoing support for people with dementia and their carers through good access to services and information promoting independence for as long as possible; Improve the overall quality, responsiveness and equity of access for people presenting with an acute mental illness; Ensure that mental health provision is able to meet all levels of complexity as locally as possible, to meet the needs of the population; Build resilience across the adult population to minimise the impact of mental illness and promote well-being in local people; Better understand our population to meet the needs of local people across our locality areas (STP).

Our agreed actions are to;

- Explore dementia registers to identify severity to ensure services are commissioned around need
- Early Intervention Psychosis – undertake comprehensive pathway assessment to ensure service is compliant with NICE Guidance
- Undertake review of out of area treatment packages to ensure care is repatriated where appropriate.
- Undertake review of IAPT service with a view to improving overall pathway thresholds, access, waiting times & recovery rates.
- Further enhance the mental health primary care offering to improve mental health service provision at this threshold
- Carry out comprehensive review of MH Liaison Services against ‘core 24’ standards and propose action plan to ensure service meets all required standards and changes are implemented where required

Due to the prevalence of disease and long term illnesses coupled with high levels of deprivation individuals are more susceptible to developing mental health problems in our footprint. Recognising within our footprint there are a significant number of armed forces personnel and veterans and families who may require enhanced mental health support, therefore it is essential more is done to ensure early identification and support to access care is in place.

**Crisis Care Concordat**

Darlington CCG have signed up to the Crisis Care Concordat which is a multi-partner agreement to work together to improve care for patients in crisis. The Concordat is across County Durham and Darlington and looks at a range of issues including improvements in information sharing, improvements in the crisis pathway, improving pathways for those who use emergency services frequently.
No Health without Mental health
Darlington CCG works closely with Darlington Council and partner organisations in the voluntary sector to deliver the national strategy No Health without Mental Health. This requires close working with Public Health and social care colleagues to deliver improvements such as improving training in non-medical interventions and improving resilience in the community. In 2016/17, the CCG has invested in a recovery college model to continue to support mental health recovery in Darlington.

Improving Access to Psychological Therapies (IAPT)
This is a talking therapy service aimed at those with lower level and moderate depression and anxiety as an alternative to medication. There are specific national requirements within the service such as how long people should wait for their first appointment and checks to ensure that the majority of people consider themselves to be recovered. Darlington CCG commissions two services under the Improving Access to Psychological Therapies ‘umbrella’. The first is a standard IAPT service delivered by Talking Changes, the second a counselling service delivered by Insight. Essentially this gives patients a choice of therapy in addition/or as a replacement to medication.

Nationally the service has four key targets:-

• 15% of the prevalent population with a condition enter therapy.
• 50% of those entering therapy achieve a defined recovery.
• 75% of those finishing therapy have a referral to treatment time of 6 weeks
• 95% of those finishing therapy have a referral to treatment time of 9 weeks

Darlington CCG has delivered the above targets for the majority of the year for which data is available at time of going to print (up to the end of February 2017). The proportion of people moving to recovery was missed by 2.8 percentage points in February but was achieved for all other months. All other targets were achieved all year. This is a reflection of the work undertaken in 2015/16 to bring the counselling data in with the IAPT service data to reflect the full service provision for Darlington.

The CCG is currently reviewing the IAPT service provision in line with the 5 Year Forward View for Mental Health (5YFVMH). The 5YFVMH requires CCGs to expand IAPT services to cover a broader proportion of the general population and also to focus specifically on patients who have depression and anxiety associated with long term physical health conditions such as diabetes and COPD. How this will be commissioned, contracted and provided is yet to be decided as there is a patient consultation underway at time of going to press which will inform the direction of travel.
Parity of esteem
Parity of esteem means valuing mental health equally with physical health. The CCG has maintained its commitment from 2014/15 in relation to funding for Mental Health. The commitment was to ensure that mental health budgets benefited from the same levels of growth as other budgets. We also ring-fenced our mental health budgets to ensure continued investment in mental health services.

Liaison Psychiatry
This area is a high priority nationally. Many people who attend A&E have mental health problems which need to be addressed quickly alongside any physical health issues. The government has required CCGs to commission a liaison psychiatry team to work in 50% of A&E departments nationwide, 24 hours a day, by 2020. This service already exists in Darlington Memorial Hospital and is available to patients at peak times. However, the CCG will be working with the Foundation Trust to extend the service to be 24 hour and also to work in the wards alongside discharge teams.

The assertive outreach and crisis teams provide person centred care to adults with learning disabilities and associated mental health needs within the community. The team work in partnership with these individuals, their families and carers to provide assessment and treatment in the community to minimise and prevent hospital admission. The teams, all led by one team manager, include charge nurses, staff nurses, associate practitioners and support workers. Internal referrals to the service are accepted from the integrated teams. Crisis referrals to the service are accepted from the emergency duty team.

Darlington Children and Young People’s Mental Health and Wellbeing Plan
In September 2015 the CCG approved a final transformation plan and this has been ‘Assured’ by NHS England. This released the funding to be invested directly into Children and Young People Mental Health Services in Darlington. The Review Panel commented on the strength of the submission, the plan was identified as an ‘exemplar’ plan. The plan will significantly reshape the way services for children and young people with mental health needs are commissioned and delivered across all agencies over the next 5 years in line with proposals put forward in Future in Mind.

Darlington’s updated Operational Plan is a framework to improve the emotional wellbeing and mental health of all children and young people across Darlington over five years. The aim of the plan is to make it easier for children, young people, parents and carers to access help and support when needed and to improve mental health services for children and young people. The plan sets out a shared vision, high level objectives, and an action plan which takes into consideration areas of interest specific to Health and Local Authority.

Strong leadership and accountability arrangements across the CCG, Local Authority and voluntary sector have been established through a Joint Commissioning Group specifically for children and young people’s mental health services. A multiagency
safeguarding hub has been established. A 24 hour, 7 day a week crisis and liaison service for children and young people has been introduced with an Intensive Home Treatment service to stop children and young people being admitted to hospital for treatment wherever possible.

A multi-faceted anti stigma campaign has been ran in Darlington during 2016/17. This launched on mental health awareness week in May and continued to February 2017. It has included press advertisements, a social media campaign and bus shelter posters (designed by college students).

Schools have benefitted from 3 work streams to build resilience in children and young people and help prevent poor mental health. These are youth mental health first aid training, mindfulness in schools and a peer support grant fund. 64 funded places have been provided for youth mental health first aid and all schools have been offered the chance to train teachers to deliver mindfulness in school to pupils. This has ensured capacity building and therefore sustainability of the project.

Named 0-19 workers have been established within each Health Visitor and School Nurse team to support those in need.


Learning Disabilities Transformation
Why Change is needed.

The current experience for people with learning disabilities within the footprint is very varied. This is, in part, apparent by looking at the data but also by listening to the stories of service users, families, providers and commissioners. However, there are many challenges in understanding the true picture because of a lack of consistent data across the whole system. We understand pockets of activity such as for patients inpatient settings, but on the whole we have poor visibility of what people’s needs are, how they are currently being met (or not), and what issues they are encountering.

• Data shows that although a proportion of patients in specialist learning disability inpatient settings require this type of care, many of them could be managed in the community. The data also shows that people often stay in inpatient settings for longer than necessary, with some people admitted for very long periods of time (up to 25 years).

• The pace of transformation in respect of the community infrastructure is paramount in facilitating the safe reduction in inpatient beds across the locality. Without the matched level of investment and resource the demand on inpatient beds will continue to be a pressure. This is further influenced by the changes in commissioning across NHSE Specialised Services, which will see less treatment
programmes being delivered in secure settings and more patients being managed in the community. The transfer of patients through the rehabilitation pathway will require the CCG to ensure that the necessary settings are available to safely respond to patients with associated behavioural and forensic needs.

*Cancer Services*

We continue to achieve high standards with regard to meeting cancer waiting time targets. We are proud of these performance figures, but also recognise that opportunities exist to improve the outcomes of those affected by cancer in Darlington. To support this process, a review of cancer services has been started and is initially focusing on improvements regarding the earlier diagnosis and quicker treatment of lung cancers, and increasing local outcomes for colorectal cancers. The review is working across primary and secondary care to develop these improvements, so that patients are diagnosed, treated and supported more effectively and have better outcomes.

The aim of the review is to improve the outcomes for those affected by cancer and ensure that the CCG’s future commissioning plans are sustainable, of high quality, and consistent with changing national requirements to ensure we are able to deliver:

• improved outcomes for people affected by cancer in Darlington through the commissioning of effective and efficient cancer services provision in the area;

• increased quality of services for people affected by cancer and improving patient experiences of cancer services throughout their journey; and

• improved outcomes in Darlington relating to <75 years mortality rates

*IT/digital*

As part of the CCG’s Local Digital Roadmap we are currently working on the development of an Integrated Digital Care Record. We have taken a 3 phase approach to this:

• The 1st phase was to implement the Medical Interoperability Gateway (MIG) in the out of hours GP service. This would enable the service to view 10 data sets from the patients GP record with the patients consent. This is now in place and being used.

• The 2nd phase is to implement the MIG in urgent and emergency care settings for example A&E, Mental Health crisis teams and emergency social care teams. To implement this we are linking with the North East Urgent and Emergency Care Vanguard and intend to have this in place by December 2016 ready for the winter period.

• The 3rd phase is to be able to share appropriate health and care information across all providers and to be fed from all systems. One of the benefits of this system would be to support the patient flow across broader geographies and we are linking with the Great North Care Record to implement this phase. To
support the implementation of the MIG we are going to use the Information Sharing Gateway (ISG) tool for the information sharing agreements. This will replace the existing paper based processes and we believe it will reduce the administrative burden on both health and care providers.

We have recently implemented the simple telehealth system ‘Florence’ in the respiratory Hospital at Home service. The mobile phone text based tool should support patients in being able to manage their respiratory condition and build confidence in being able to self-manage. The tool should also support the service in providing patient care and free up resources to focus on patients that require more detailed care. The pathway the system uses has been jointly developed with the service and the patients to ensure it is most effective. Patients are now being setup and registered onto the system and we are following the progress closely to inform the further roll out of the system across other service areas.

Our Plans for 2017/18 and beyond
As previously mentioned this year the CCG has produced the Darlington Care Blueprint setting out our vision of what services will look like in 20/20, meeting the vision set out in the Five Year Forward View. Our new models of care outlined below aim to further integrate services, working together to co-ordinate care and make services less confusing to patients.

Community hubs

11 GP practices serve the Darlington population of 106,000. Our GP practices will be brought together into groups of 3 or 4 practices called ‘community hubs’ so they can share their skills to match the needs of Darlington residents. Community hubs allow patients to benefit from the knowledge and expertise of local GPs and other practitioners within their hub, and reduce the need for unnecessary attendance at hospital. GP practices will still run as they do now, but sometimes you may be asked to attend another GP practice to receive your care.

Care co-ordination centre

The public have told us accessing services is confusing when they are unwell. In future, the Care Co-ordination Centre we are planning, will provide a single point of access for the public, allowing people to attend and be seen by the most appropriate health services. The centre will have an overview of all health services and teams working across Darlington, including professional teams working in hospitals and the community. This will ensure patients are seen appropriately whether that is being assessed in hospital or staying at home with effective community support.
**Discharge management team**

Patients can often stay in hospital longer than is necessary. We are working closely with health and social care colleagues to improve support for patients leaving hospital, so they can be discharged quickly when it is medically safe to do so. Ideally patients will be discharged to their own home or for a short while in a rehabilitation bed within the local community, as research tells us patients recover quicker at home.

**Care planning**

We’re developing care plans that can be completed with patients (or their carers) with long term or complex health needs. Care plans will ensure their views, priorities and preferences are recorded. This will include how the patient wishes to be cared for should their circumstances change. The care plan will be shared with, and visible to, health and social care staff who are caring for the patient. This will reduce the need to repeat conversations and record details with several professionals.

**Mental Health - Future State/Ambition for 2020/21**

24/7 urgent and emergency health response, an all-age mental health liaison service in emergency departments and in-patient wards, multi-agency suicide prevention plan in order to reduce suicides by 10% Mental health is everywhere and the health needs of our population are increasing. We are looking to build high quality services and a highly skilled workforce that not only delivers value for money and are financially sustainable, but that provide more of our population with early interventions and increased access to treatment across all of our communities.

The success of the improvement areas under the Mental Health Five year Forward View will mean that vastly more people, of all ages, will have access to high quality, timely mental health treatment and earlier intervention, specific to their needs and improvements in health and wellbeing to increase opportunities for people affected by mental health and close the mortality gap. Scheme specific benefits will be seen in terms of service improvements in: (1) Health & Wellbeing, (2) Care & Quality, and (3) Finance & Efficiency.

**Learning Disability - Future State/Ambition for 2020/21**

Our ambition is for the footprint is to be as good as anywhere in the world to live for people with a learning disability and / or autism and a mental illness or behaviour that challenges. This vision was developed by all partners and stakeholders, including people with a learning disability, families and carers. By developing community infrastructure, supporting workforce development, avoiding crisis, earlier intervention and prevention the North East and Cumbria will be able to support people in the community so avoiding the need for hospital admission. The North East
and Cumbria Learning Disability Transformation Plan and the Yorkshire Transforming Care Plan aims include less reliance on in-patient admissions, developing community support and alternatives to inpatient admission, prevention and early intervention, avoidance of crisis and better management of crisis when it happens to create better more fulfilled lives.

Benefits

• Less reliance on in-patient admissions, delivering a reduction in avoidable admissions to inpatient learning disability services and delivery of a commissioned bed reduction trajectory by 2020.
• Developing community services and alternatives to inpatient admission
• Prevention, early identification and early intervention
• Increasing the number of annual health checks and health promotion/prevention programmes
• Avoidance of crisis and better management of crisis when it happens
• Better more fulfilled lives.
• Improved quality of life
• Improved service user experience

Sustainability and Transformation Plans (STP)

There are now 44 STP footprints across the country with NHS Hartlepool and Stockton-on-Tees CCG a part of the Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby plan

This plan will describe our shared local vision for 2021 regarding care both inside and outside our hospitals underpinned by better integration with local authority services in respect of prevention, early intervention and social care.

The first version was published at the end of November.

We now need to work together with partners to design the next steps such as:

• How we can better collaborate on prioritising prevention despite many financial cuts and other challenges
• Enabling the out of hospital sector to be stabilised and strengthened as demand grows
• Optimising the acute hospital sector to get the best quality within the resources it has

Better Health Programme

The Better Health Programme is about providing a consistently high standard of hospital care, in the right place at the right time, for the 1.1m people living in Durham Dales, Easington, Sedgefield, Darlington, Tees, Hambleton, Richmondshire & Whitby.
Experienced clinical staff from the local NHS – including hospital consultants and GPs - have been looking at how we do this, in discussion with their colleagues, stakeholders and patient representatives.

Some of the discussions have been around ensuring that people with serious or life threatening needs receive the right level of specialist care to maximise their chances of survival and a good recovery – even if it means going past the nearest hospital.

In July 2016 the programme announced that this could mean specialist emergency care being provided from fewer sites in the future. The programme is looking seriously at the development of proposals for how hospital services could be provided in the future to ensure they meet national standards and provide the best possible care to give patients, particularly those with life threatening conditions. Proposals could impact on each of the three hospitals in Darlington, Durham and Tees. There is public awareness that proposals could result in emergency centres (instead of the current three), one of which would offer highly specialist care for seriously ill or injured people.

Meanwhile the NHS Five Year Forward View set out a requirement for local NHS organisations to work with partner organisations on the development of Sustainability and Transformation Plans (STPs), which must focus on four areas for improvement:

- Preventing ill health and increasing self-care (this will mean a much greater focus on supporting people to stay)
- Health and care in communities and neighbourhoods (this will result in better access to local services and much more care being provided in communities and in people’s own homes to reduce avoidable hospital admissions and support people to stay independent)
- Quality of care in our hospitals (this will be delivered through the “Better Health Programme”)
- Use of technology in health care.

Health and care in communities and neighbourhoods
In the past, the majority of care was only provided in hospital. Thanks to improvements and changes, we can now manage many long-term health problems – such as heart or breathing problems, or diabetes – with fewer visits to hospital and fewer, shorter, hospital stays. Over the last few years, NHS organisations have worked together with local councils on services to support people to live as independently as possible.

What patients have been telling us
NHS staff have visited communities to talk about what the NHS does well, and where it could improve. Many people were concerned about access to their local doctor and the national and local shortage of doctors. We are working on plans to improve our recruitment of doctors, and to develop new roles to support them in caring for their
patients. We are also looking at how GP practices and other services can work together more effectively. People were also concerned about access to mental health services, and felt that more support should be available locally. We asked people what issues we should consider when services need to change. They thought the most important issues were:

- Over the next few months, more work will be done to develop the draft STP plan, working with local councils and other partners including the voluntary sector, with the Better Health Programme continuing as an important part of the process.

- Another important theme was information and communication. People didn’t feel they understood the services that were available, which they should use, and when. This was a problem in urgent care and emergency care. They also expressed frustration at the frequent need to retell the background to their illness and care when they came across a new professional. People were surprised that hospitals did not have routine access to GP records that would provide this background – particularly in an emergency. They were supportive of the NHS sharing their records, where this would improve their care, and with safeguards and opt-outs in place.

Consultation is expected to begin in the Summer of 2017. To find out more about the Better Health Programme please email necsu.betterhealthprogramme@nhs.net. To find out more about the STP in Durham Dates, Easington, Sedgefield, Darlington, Tees, Hambleton, Richmondshire & Whitby please email necsu.stp@nhs.net.

A summary booklet explaining the STP can be found on the www.nhsbetterhealth.org.uk website under the header ‘About Better health’.

**North East Urgent and Emergency Care Network**

All NHS organisations in the North East are part of the North East Urgent and Emergency Care Network. In 2016/17 the network received £2.9m from NHS England’s New Care Models programme to implement various schemes across the North East.

Some of these schemes included:

- **Respond** - simulation training package for mental health crisis care which rolled out across the region following its successful launch in September. Its aim is to transform professional responses to mental health crisis through better collaboration and knowledge.
- **Under 5 app (NHS child health)** – the app gives easy to understand guidance on childhood illnesses and recognising when your child is unwell, as well as advice on when and where to seek treatment.
- **Behavioural analysis** - A key element of the network’s approach is undertaking high quality market research to understand the views and
behaviours of patients and NHS staff in relation to urgent and emergency care services

- Great North Care Record - The Great North Care Record (also known as MIG – Medical Interoperability Gateway) aims to bring the region up to a common standard of information-sharing, saving time and improving patient safety. The MIG enables real-time access to key primary care patient information at the point of care (emergency departments, GP out of hours services, mental health trusts, NHS 111 and the ambulance service)
- Flight deck - a real-time application displaying the current status of emergency care across the region as well as predicting the like scenario four to twelve hours ahead
- Clinical hub - the clinical hub involves Emergency Department consultants working within the hub on Monday and Friday 6–10pm and Saturday and Sunday 8am– 4pm to provide enhanced clinical assessment of patients who would otherwise be directed to their nearest Emergency Department

Key issues and risks
During 2016/17 the CCG has been managing a number of identified issues and risks, all of which have been actively managed. As part of the implementation of the joint management structure for Darlington and HaST CCG’s, both CCG’s risk registers were fully reviewed in Q4 2016/17 to ensure that all risks are up to date. There are no risks out of exception due to this review of the risks in place and the next step is to review with the executive both CCG’s ‘risk appetite’ and reassess all residual risks against this defined appetite. A comparison was been undertaken of the two risk registers and a number of risks are replicated across both CCGs as would be expected.

The key risks themes on the CCG’s risk register relate to clinical engagement, winterbourne, deprivation of liberties, public engagement, financial position and delivery, working with commissioning partners particularly local authorities and performance issues with regards to constitutional standards.

As at the end of the year, the CCG was actively managing 24 corporate risks. All of these risks have key controls identified against them and also the delivery of both external and internal assurance regarding these risks. They also include mitigating actions where appropriate and are subject to an action plan. The Governing Body discussed the CCG’s risk register on 30 March 2017 confirming that they agreed that all risks were being actively managed and appropriate mitigations were in place. However, the CCG’s risk register is a dynamic document and is constantly subject to update and change in order to reflect the nature of the risks the CCG faces.

A number of new risks were identified during 2016/17 and added to the CCG’s corporate risk register and these are detailed below:

- Failure to meet constitutional standards.
- Limited Intermediate Care / Community Bed Capacity in Darlington.
• Primary care unable to maintain quality of services delivered. Significant workload shift from secondary care to primary care affecting the way in which primary care are able to manage needs of the registered Population
• CCG have responsibilities in respect of SEND requirements and currently do not meet the standards
• Risk of judicial DoLs. Assessment of number of potential cases across County Durham and Darlington is 90 cases of which 10 have been considered to be urgent.
• Primary care Workforce sustainability. There are recognised challenges in GP recruitment and practice nurse recruitment in the face of national shortages.
• Looked after Children might not receive timely Initial health assessments on entering looked after system. CDDFT and Darlington Borough council are not meeting the standard of IHAs being completed within 20 working days.
• CCG does not deliver the Sustainability and Transformation Plan due to conflicting partner priorities and negative perception
• Failure to procure commissioning support services to ensure delivery of CCG statutory duties.
• Financial and reputational risks in relation to the primary care commissioning agenda as the CCG is now fully delegated. Relationships and engagement with member practises decline due to CCG being responsible

During the year three risks were classified as high (red risks):

• Ability to deliver 2016/17 financial plan.
• Failure to meet constitutional standards.
• CCG experiences higher than planned premises costs due to current arrangements for funding void space

During 2016/17, all three risks are being constantly reviewed and reported to the CCG’s Governing Body, and controls and actions are in place.

The Darlington Governing Body Assurance Framework has also been reviewed and all strategic objectives have aligned strategic risks and these have been mapped to the CCG improvement and assessment framework 2016/17. The Assurance Frameworks were presented to the Audit and Risk Committee’s on 7th March 2017 and Governing Body on 30th March 2017.

**Going Concern**
The accounts within this report have been prepared on the going concern basis. 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 CCG 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.

**Performance summary**
Measuring our performance helps us to ensure our services are delivered to a quality standard and provide value for money. The CCG has internal processes in place to manage performance against the range of indicators including a mechanism to work with internal and external colleagues to identify areas of risk, and implementation of action plans to mitigate these. This ensures improvements in performance are delivered.

Throughout the year, reports are provided to our Governing Body setting out our performance against the agreed local and national measures. This ‘Quality, Performance and Finance Report’ describes how, in partnership with our providers, we are meeting the CCG’s commitment to ensure that the commissioning decisions and actions we take improve healthcare for the people of Darlington and ensure patients receive the highest quality of care.

NHS England has a statutory duty to make an annual assessment of each CCG’s performance. It meets this duty through its CCG Improvement and Assessment Framework and CCG performance dashboard.

The Five Year Forward View, NHS Planning Guidance, and the Sustainability and Transformation Plans (STPs) for each area, are all driven by the pursuit of the “triple aim”: (i) improving the health and wellbeing of the whole population; (ii) better quality for all patients, through care redesign; and (iii) better value for taxpayers in a financially sustainable system.

In Darlington we have worked with our partners and stakeholders to ensure that the health and wellbeing of patients remained a priority and to improve performance against national and local targets and the requirements of the NHS Constitution.

**Performance against NHS Constitution targets**

**Referral to treatment**
Patients have the legal right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral.

Year to date CCG performance to January 2017 for referral to treatment incomplete pathways treated within 18 weeks is above target, reporting 93.3% against the 92% threshold.

No patients should be waiting more than 52 weeks for treatment. Darlington CCG has reported zero breaches up to January 2017. This is an improved position compared to the previous year, where two cases were recorded in 2015/16.

**Diagnostic test waiting times**
No more that 1% of patients should wait over 6 weeks for a diagnostic test.

Darlington CCG has achieved this target for 10 consecutive months in a row from April 2016 through to January 2017. For diagnostic tests the latest available 2016/17 performance is 0.40% of Darlington patients waiting over six weeks.

The target was also met by the main provider, County Durham and Darlington NHS Foundation Trust (CDDFT) reporting 0.04% in January 2017.

This is a vast improvement in comparison to 2015/16 data, where Darlington CCG failed this indicator for 7 months out of 12.

This shows that the action plans put in place by the CCG and the Trust throughout 2015/16 have impacted and sustained performance.

**Cancer waiting times**

Darlington CCG has met the year-to-date to Jan-17 targets for six out of the nine categories for cancer waiting times. Performance against the 2 week wait, 2 week wait breast symptomatic and Cancer 62 day wait for urgent GP referral are the 3 areas that are reported under target.

Performance for the 62 day wait urgent GP referral category remains the main concern, currently reporting the year-to-date position as 74.2% against the 85% target. This standard has remained non-compliant in every month April 2016 through to January 2017.

Patient level breach analysis is being undertaken to try and identify any trends within the breach reasons which can then inform further actions with the Trusts. Although there are some capacity issues there are an increasing number of complex pathways which seriously impact Trusts ability to achieve the target. Performance continues to be monitored through contract meetings and the CCG performance framework.

**Ambulance response times**

All ambulance trusts are expected to respond to 75% of immediately life threatening calls within eight minutes. The performance of the North East Ambulance Service YTD to Feb-17 against this indicator is reported as 62.6%.

Where onward transport is required, 95% of life-threatening calls will receive an ambulance vehicle capable of transporting the patient safely within 19 minutes of the request for transport being made. The performance of the North East Ambulance Service YTD to Feb-17 against this indicator is reported as 89.3%.

A comprehensive action plan is in place which is monitored through the Contract Management Board along with the Clinical Quality Review Group. The action plan is broken down into three main areas/themes:
• Demand
• Capacity
• Efficiency

The action plan will deliver incremental improvements on performance over the coming year.

Healthcare associated infection
Reducing healthcare associated infection remained a key challenge for the CCG and the local NHS throughout the year.

• MRSA (methicillin resistant Staphylococcus Aureus)
There is a zero tolerance of MRSA which means that all commissioner and provider targets are zero. The CCG have reported 2 cases in year, 1 in June 2016 and 1 in October 2016.

• Clostridium difficile
The YTD position to 16th March 2017 for the CCG shows 19 cases in total against a trajectory of 17, the CCG was therefore over its annual target.

Accident and emergency (A&E) performance

Provider organisations have a number of targets in relation to emergency care. One key target is that 95% of patients should wait no longer than four hours for treatment in an emergency department. Although this is not one of the CCG’s constitutional indicators, it is unfortunately an area where performance against the target has not been achieved due to it not being met by the CCGs main provider, County Durham and Darlington NHS Foundation Trust.

The Trust achieved the target in Q2, but was non-compliant in Q1 and Q3. Performance has further declined in January 2017, a trend experienced both at a regional and national level as a result of increased pressures and rise in demand for emergency care. Performance is expected to improve in February and March 2017 and we anticipate that CDDFT will achieve the indicator in Q4.

A number of proactive steps have been put in place to help prepare for surges, and ensure robust arrangements for reviewing and challenging performance.

The CCG is not complacent about the performance of our providers as this seriously impacts on the experience of our local population. Whilst we expect that the final 16/17 performance to be an improvement from 15/16 the challenges have been so great that we have not seen the improvements we wish to see. This will be an area of continued focus for 2017/18 with plans in place to improve delivery during the year.

6 Clinical Priority Areas
The Forward View and the planning guidance set out national ambitions for transformation in 6 clinical priority areas:

• mental health
• dementia
• learning disabilities
• cancer
• maternity
• diabetes

The CCG progress against these areas is reported to NHSE through quarterly updates on the Improvement and Assessment Framework. Further information on CCG performance on these measures can be found at https://www.nhs.uk/service-search/performance-indicators/organisations/ccg-better-care

The current CCG performance against each of these indicators is set out below:

**Mental health**

<table>
<thead>
<tr>
<th>Organisation Information</th>
<th>Initial Assessment: Mental Health</th>
<th>Improving Access to Psychological Therapies: recovery rate</th>
<th>People with 1st episode of psychosis starting NICE-recommended treatment within 2 weeks of referral</th>
<th>Children and Young People’s Mental Health Services - Transformation</th>
<th>Crisis Care and Liaison Mental Health Services - Transformation</th>
<th>Out of area placements for acute mental health inpatient care - transformation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Darlington CCG</strong></td>
<td>Dr Piper House, King Street, Darlington, DL3 8UL</td>
<td>Tel: 01325 384271</td>
<td>See on NHS Choices</td>
<td>Greatest need for improvement</td>
<td>42.5% of people who finished treatment moving to recovery</td>
<td>83.3% of 6 people with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral</td>
</tr>
</tbody>
</table>
### Dementia

<table>
<thead>
<tr>
<th>Organisation Information</th>
<th>Initial Assessment: Dementia</th>
<th>Estimated diagnosis rate for people with dementia</th>
<th>Dementia care planning and post-diagnostic support</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Darlington CCG</td>
<td>Top performing</td>
<td>76.6% of the estimated number of people with dementia have a recorded diagnosis</td>
<td>79.8% of patients with dementia whose care plan has been reviewed in the preceding 12 months</td>
</tr>
</tbody>
</table>

---

### Learning disabilities

<table>
<thead>
<tr>
<th>Organisation Information</th>
<th>Initial Assessment: Learning Disabilities</th>
<th>Reliance on specialist inpatient care for people with a learning disability and/or autism</th>
<th>Proportion of people with a learning disability on the GP register receiving an annual health check</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Darlington CCG</td>
<td>Needs improvement</td>
<td>90 per million registered population</td>
<td>49% of people on the GP Learning Disability Register that received an annual health check during 15/16</td>
</tr>
</tbody>
</table>

---
### Cancer

<table>
<thead>
<tr>
<th>Organisation Information</th>
<th>Initial Assessment: Cancer</th>
<th>Cancers diagnosed at early stage</th>
<th>People with urgent GP referral having 1st definitive treatment for cancer within 62 days of referral</th>
<th>One-year survival from all cancers</th>
<th>Cancer patient experience</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Darlington CCG</strong></td>
<td>Needs Improvement</td>
<td>54.8% of patients diagnosed at an early stage</td>
<td>77.8% of people treated within 62 days</td>
<td>67.1% one-year survival</td>
<td>8.7</td>
</tr>
</tbody>
</table>

- Needs Improvement is the average score given by patients asked to rate their care on a scale from 1 to 10 (10 being best).

### Maternity

<table>
<thead>
<tr>
<th>Organisation Information</th>
<th>Initial Assessment: Maternity</th>
<th>Neonatal mortality and stillbirths</th>
<th>Women's experience of maternity services</th>
<th>Choices in maternity services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Darlington CCG</strong></td>
<td>Needs improvement</td>
<td>7.3 stillbirths and neonatal deaths per 1000 births. A similar rate to most other CCGs</td>
<td>86.3 is the score out of 100 based on six survey questions. A similar score to most other CCGs</td>
<td>67.3 is the score out of 100 based on six survey questions. A similar score to most other CCGs</td>
</tr>
</tbody>
</table>

- Needs improvement is the average score given by patients asked to rate their care on a scale from 1 to 10 (10 being best).
Diabetes

Performance analysis

CCG performance is reviewed by NHS England to ensure that CCGs are delivering quality outcomes for patients, both locally and as part of the national standards. The following pages set out areas performing particularly well and some that still require improvement.

Indicators described include:

- A&E four hour waits
- Ambulance Response times
- Ambulance handovers
- Cancer waiting times
- Reduction in avoidable emergency admissions
- Healthcare associated infections (MRSA and Clostridium difficile)
- Referral to treatment times
- Friends and Family Test

The indicators are set out in the following layout:
Urgent Care Performance

Four Hour Waits in Accident & Emergency:

In 2016/17, 6.8% of people who required A&E services waited over 4 hours to be seen. This is the same as 2015/16.

Ambulance Response Times:
We commission ambulance services from North East Ambulance Service NHS FT (NEAS) and specify that they comply with operational standards.
During 2016/17, 20.9% of patients who required an ambulance urgently because their condition was considered immediately life threatening waited over 8 minutes for an ambulance to arrive. This is a 7.9 percentage points decrease from 2014/15. The CCG is 4.1 percentage points above standard.

During 2016/17, 30% of patients who required an ambulance urgently because their condition was considered immediately life threatening waited over 8 minutes for an ambulance to arrive. This was 4.0 percentage points more than 2015/16.
In 2016/17, 17.0% of people who required a fully equipped ambulance to attend urgently but did not have a condition considered immediately life threatening waited over 19 minutes for the ambulance to arrive. This is a 3.3 percentage point increase from last year.

Cancer Waiting Times

During 2016/17, 8.0% of patients waited more than two weeks for an outpatient appointment when referred by their GP urgently with suspected cancer. This was an increase from 2015/16 when 7.7% of patients waited more than two weeks for an outpatient appointment.
In 2016/17, 7.9% of patients who were referred urgently for an outpatient appointment with breast symptoms waited more than two weeks for an outpatient appointment. This is an increase of 0.8 percentage points from last year.

During the year 2016/17, 2.0% of patients who were diagnosed with cancer waited over 31 days for treatment to commence, an increase of a 0.5 percentage point from 2014/15. Darlington CCG has been over standard for three consecutive years.
In 2016/17, 1.7% of people diagnosed with cancer waited over 31 days for surgery to commence. The CCG has been over standard for three consecutive years.

98.8% of patients diagnosed with cancer received drug treatment within 21 days.
95.9% of patients who were diagnosed with cancer waited less than 31 days for radiotherapy to commence.

During the course of 2016/17, 26.0% of patients who were diagnosed with cancer waited over 62 days for treatment to commence, following an urgent referral from their GP. This is 0.8 percentage points increase from 2015/16.
During the year 2016/17, 6.9% of patients who were diagnosed with cancer waited over 62 days for treatment to commence following referral from an NHS screening service. This is 2.2 percentage points decrease from last year.

In 2015/16, all patients who were diagnosed with cancer waited over 62 days for treatment to commence, following a consultant’s decision to upgrade the priority of the patient.
Reduction in Avoidable Emergency Admissions

Between 2015/16 to 2016/17 there was an increase of 85 per 100,000 population Emergency Admissions for Darlington CCG.

Healthcare Associated Infections

All CCGs have objectives for HCAIs set by NHS England. There is a zero tolerance of MSRA (Methicillin resistant Staphylococcus Aureus), which means that all commissioners and provider targets are zero.
There has been a slight decrease in cases of C. difficile among Darlington CCG patients.

**Mixed-Sex Accommodation**

Under the NHS constitution, providers of NHS funded care are expected to eliminate mixed sex accommodation.

There were no breaches of the mixed sex accommodation standard in Darlington CCG in the last four years.

**Referral to Treatment**

During the year 2016/17, 14.4% of patients admitted for elective treatment started treatment after more than 18 weeks. This is an increase of 4.8 percentage points from last year.
In 2016/17, 3.4% of patients who received treatment and did not require admission to hospital waited more than 18 weeks for treatment. This is a 1.2 percentage point increase from 2015/16. The CCG has been above standard for the last three years.

At the end of 2016/17, 6.8% of patients who continued to wait for treatment waited in excess of 18 weeks for their treatment, 1.5 percentage points more than last year. The CCG remains above standard for three years now.
During the last year, 27 patients admitted for non-urgent consultant-led treatment received their treatment after more than 52 weeks.

**Friends and Family Test**

The friends and family test is intended to be a simple metric against which to measure patient experience.

**FFT Inpatients Response:**

Response rates for Inpatients were well above national target during 2016/17.
FFT Inpatients %age Recommended:

The satisfaction score was below the national target for three consecutive years.

FFT A&E Response:

Response rates were above standard throughout 2016/17.

FFT A&E %age Recommended:

2015/16 and 2016/17 results brings the CCG at national target.
Financial Performance

The financial accounts have been prepared under a Direction issued by NHS Commissioning Board under the National Health Service Act 2006 (as amended).

Robust systems of financial governance and financial management monitored by the CCG’s Finance Committee have ensured that financial risks were appropriately identified and managed during the year enabling the delivery of all financial targets.

Financial Allocations

CCGs are set resource limits on an annual basis and must contain their expenditure within these limits. Separate resource limits are set for revenue and capital expenditure, with revenue expenditure limits further split between programme spend and running (management and administrative) costs:

- Programme Budget Allocation – funding for direct healthcare expenditure. The CCG allocation for programme spend was £162 million;
- Running Cost Allowance – funding for the administrative costs of running the CCG. The CCG allocation for running costs was £2.3 million.

Financial targets and performance for the year

In accordance with NHS England financial planning guidance, the CCG is required to deliver a surplus of at least 1% (£1.77 million) of available resources.

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs’ 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Darlington CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £1.592m. This additional surplus will be carried forward for drawdown in future years.

Due to prudent financial planning and management, the CCG’s financial performance in 2016/17 has delivered the planned surplus as was the case for 2015/16.

The CCG has a number of financial duties under the NHS Act 2006 (as amended). Our performance against these duties is included in note 23 of the full annual accounts which are published with this report.
The CCG’s results in 2016/17 are set out in the table below with further detail included in note 23 of the full annual accounts.

<table>
<thead>
<tr>
<th>Target</th>
<th>Outcome Delivered</th>
<th>Target Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliver surplus on revenue budgets of at least 1% plus uncommitted funding of 1%</td>
<td>Surplus of £3.4m on revenue allocation of £164.5m</td>
<td>✓</td>
</tr>
<tr>
<td>Maintain Running Costs within allowance</td>
<td>Running cost spend of £2.3m against allowance of £2.3m</td>
<td>✓</td>
</tr>
<tr>
<td>Maintain Capital spending within capital resource</td>
<td>No capital resource allocated to the CCG and no spend incurred</td>
<td>✓</td>
</tr>
<tr>
<td>Ensure cash spending is within the cash limit set</td>
<td>Cash managed within available resources</td>
<td>✓</td>
</tr>
</tbody>
</table>

The chart below indicates how the CCG’s funding was split across the services we commission:

During the year, the CCG funded a number of service developments and improvements including:

- multi-disciplinary teams comprising health, social care and voluntary sector to support patients who are at high risk of hospital admission;
- provision of enhanced GP and Community Matron support to residential homes in Darlington
- a community lymphoedema service
- a nine bedded unit to provide step down care and convalescence for patients who have received hospital treatment
- development of a female primary care continence pathway to ensure patients receive the right care, at the right time and at the right place
Compliance with Better Payment Practice Code

The CCG signed up to the Better Payment Practice Code (BPPC) in 2013/14. The code requires the CCG to aim to pay all valid invoices within 30 days of receipt of a valid invoice, or the due date if later.

The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of the CCG’s compliance with the code are shown in note 5.1 to the Financial Statements.

<table>
<thead>
<tr>
<th>Non NHS</th>
<th>NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>95.0%</td>
</tr>
<tr>
<td>Target</td>
<td>95.0%</td>
</tr>
<tr>
<td>Result by Number</td>
<td>98.6%</td>
</tr>
<tr>
<td>Result by Number</td>
<td>99.0%</td>
</tr>
<tr>
<td>Result by Value</td>
<td>96.7%</td>
</tr>
<tr>
<td>Result by Value</td>
<td>99.9%</td>
</tr>
</tbody>
</table>

Performance against the target is monitored by the CCG on a monthly basis with performance maintained at over 95% of invoices paid within 30 days of receipt measured against both total invoice value and overall volume of invoices.

Looking Forward

The coming years will present significant financial pressures to Darlington CCG as the need for health services is expected to grow faster than our funding. It is clear that the existing models and pattern of service provision are unlikely to sustain service quality and reasonable access in the light of foreseeable financial settlements.

In order to secure the continuity of high quality healthcare services for the population of Darlington, we plan to manage system wide service transformation across the Darlington, Durham and Tees via the Better Health Programme integrating this work with the North East wide Urgent & Emergency Care Vanguard, the North East & Cumbria LD Transformation programme and our local service development plans. This is an established programme involving our partners in Local Government, Health Education England, NE Ambulance Service, GP organisations and the Voluntary Sector.

The Better Health Programme has two main elements:

- A major planned acute reconfiguration driven by standards, outcomes and workforce
- A major investment in more appropriate lower cost care in a non-acute settings

The health and social care leadership team is committed jointly to developing options, based on work involving 100+ clinicians, with full public engagement, enabling consultation to take place in autumn 2016 for planned commencement of implementation in 2017.
Following on from 2015/16, the Better Care Fund (BCF), a single pooled budget of £7.3 million across the CCG and local authority designed to enable transformation in integrated health and social care will also be a key enabler for Darlington.

**Sustainable Development**

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012).

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

As part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020 using 2013 as the baseline year.

**Modelled Carbon Footprint**
The majority of the environmental and social impacts are through the services we commission. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2014/15. More information available here: [http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx](http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx)

Resulting in an estimated total carbon footprint of 32 tonnes of carbon dioxide equivalent emissions (tCO₂e). The majority of this impact is from the services we commission.

<table>
<thead>
<tr>
<th>Category</th>
<th>% CO₂e</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy</td>
<td>79%</td>
</tr>
<tr>
<td>Travel</td>
<td>20%</td>
</tr>
<tr>
<td>Procurement</td>
<td>1%</td>
</tr>
<tr>
<td>Commissioning</td>
<td>0%</td>
</tr>
</tbody>
</table>
Policies
In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.
### Area

<table>
<thead>
<tr>
<th>Area</th>
<th>Is sustainability considered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commissioning (environmental)</td>
<td>Yes</td>
</tr>
<tr>
<td>Commissioning (social impact)</td>
<td>Yes</td>
</tr>
<tr>
<td>Suppliers’ impact</td>
<td>Yes</td>
</tr>
<tr>
<td>Business Cases</td>
<td></td>
</tr>
<tr>
<td>Travel</td>
<td>No</td>
</tr>
</tbody>
</table>

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). We will be putting together an SDMP in the near future for consideration by the Governing Body.

### Partnerships

As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

### Travel

We can improve local air quality and improve the health of our community by promoting active travel – to our staff, through our providers and to the patients and public that use the services we commission.

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO₂e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness.

### Energy

<table>
<thead>
<tr>
<th>Category</th>
<th>Mode</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business Travel</strong></td>
<td>miles</td>
<td>565</td>
<td>919</td>
<td>3,148</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>0.21</td>
<td>0.34</td>
<td>1.14</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Staff commute</strong></td>
<td>miles</td>
<td>10,099</td>
<td>12,488</td>
<td>11,527</td>
<td>18,252</td>
</tr>
<tr>
<td></td>
<td>tCO₂e</td>
<td>3.73</td>
<td>4.59</td>
<td>4.17</td>
<td>6.60</td>
</tr>
</tbody>
</table>

### Energy

<table>
<thead>
<tr>
<th>Resource</th>
<th>Use (kWh)</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas</td>
<td>0</td>
<td>226,472</td>
<td>75,264</td>
<td>21,821</td>
<td></td>
</tr>
<tr>
<td>Oil</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Coal</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td>0</td>
<td>246,243</td>
<td>106,531</td>
<td>40,232</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resource</th>
<th>tCO₂e</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas</td>
<td>0</td>
<td>48</td>
<td>16</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Oil</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Coal</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Electricity</td>
<td>0</td>
<td>153</td>
<td>61</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>
### Green Electricity Use

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>kWh Use</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>tCO₂e</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Energy CO₂e</td>
<td>0</td>
<td>200</td>
<td>77</td>
<td>25</td>
</tr>
</tbody>
</table>

### Total Energy Spend

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>£</td>
<td>-</td>
<td>-</td>
<td>£</td>
<td>-</td>
</tr>
</tbody>
</table>

### Carbon Emissions - Energy Use

![Carbon Emissions Chart]

- **Gas**
- **Oil**
- **Coal**
- **Electricity**
- **Green Electricity**

### Waste

<table>
<thead>
<tr>
<th>Waste</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recycling/reuse (tonnes)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>tCO₂e</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Other (tonnes)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>tCO₂e</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Landfill (tonnes)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>tCO₂e</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Total Waste (tonnes)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% Recycled or Re-used</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Waste tCO₂e</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
Finite resource use - Water

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mains m³</td>
<td>698</td>
<td>629</td>
<td>661</td>
<td>252</td>
</tr>
<tr>
<td>tCO₂e</td>
<td>0.64</td>
<td>0.57</td>
<td>0.60</td>
<td>0.23</td>
</tr>
<tr>
<td>Water &amp; Sewage Spend</td>
<td>£</td>
<td>-</td>
<td>£</td>
<td>-</td>
</tr>
</tbody>
</table>

Improve quality

Commissioning for Quality and Innovation (CQUIN)
CQUIN is a scheme which supports providers to innovate care delivery resulting in improvements to the quality of care. The CQUIN framework enables commissioners to reward excellence by linking a proportion of a providers income to the achievement of national and local quality improvement goals. The CCG CQUIN schemes for 2016/17 were centred on developing and improving staff health and wellbeing initiatives; improvements to Sepsis care in both emergency and inpatient
care settings; improved management of the use of Antibiotics through antibiotic stewardship and improvements to Paediatric; Diabetes and Dementia care. The schemes are outcome based and are monitored quarterly by the CCG against agreed targets. The schemes are compliant with the CCGs commissioning priorities.

**Serious Incidents (SIs)**
Healthcare systems and processes can have weaknesses which can lead to errors. Responding appropriately when things go wrong is a key part of the way that the NHS aims to continuously improve services. The CCG is responsible for gaining assurance that when serious incidents occur; either within the providers or within the CCG; there are measures in place which safeguard patients; and that incident investigations are undertaken to ensure that lessons learnt are shared and embedded in improvements to practice.

The incident investigations and outcomes are reviewed by the CCG. The CCG has robust governance processes in place which monitor the serious incidents through a combined County Durham and Darlington CCG serious incident panel. This panel is led by the CCG Executive Nurses who ensure that sufficient rigor has been applied to the investigation. Serious incident reports and action plans are reviewed and signed off during these panels once appropriate assurances have been gained by the CCG. The CCG also monitors serious incident themes and trends across the year and works with providers to manage and improve any emerging themes. These are subject to debate and scrutiny both during the serious incident panel and during the Quality Review Group meetings held with key providers regularly throughout the year.

**Infection control**
The CCG Infection Prevention and Control Team (IPCT) works through effective leadership, education and training and surveillance of alert organisms. The IPCT has carried out surveillance of healthcare associated infections (HCAI) and root cause analysis on all pre-72 hour clostridium difficile and pre-48 hour MRSA bacteraemia cases. Lessons learnt from all HCAI are discussed at significant event meetings within general practice and at County Durham and Darlington Health and Social Care HCAI group.

Training has been offered and delivered to a range of staff including medical, nursing, health and social care and administration. Unannounced visits to care homes have identified areas of infection control standards and practices which require improvement in some homes. Support has been provided to make improvements and information shared with other health and social care professionals.

The team has been available to work with architects, staff within general practice and relevant associates to ensure that any new builds and refurbishments meet the required infection control standards and taken part in assurance visits to provider
organisations to observe standards and make recommendations for improvement where necessary. Many challenges remain across health and social care and it is important that the CCG remains focused in ensuring that Infection Prevention and Control is seen as part of patient safety wherever care is delivered. For further information please see the full Infection Prevention and Control annual report.

**Safeguarding**

Multi-agency partnership working is essential to support the CCG’s robust approach to safeguarding and is a key priority to keep adults and children safe.

The CCG is a member of the Local Safeguarding Adults Partnership Board (LSAPB) and associated sub-groups in Darlington. This ensures the CCG meets its statutory requirement in accordance with the Care Act 2014 and provides assurance that the CCG is up-to-date with developments around changes to multi-agency procedure, training and communication, and the ongoing development of a performance framework.

The LSAPB Board ensure that lessons learned from Safeguarding Adult Reviews, internal management reviews and domestic homicide reviews are embedded in practice. A member of the safeguarding team chairs the associated learning and improvement subgroup.

Throughout the year, the Safeguarding Adults Team have been actively involved in strategy meetings related to incidents commissioned by health and those associated with primary care. They also attend information sharing meetings which are held with adult social care, infection control and the Care Quality Commission (CQC). Meetings are bi-monthly and allow a route for intelligence gathering and joining up of concerns which can then be acted upon. As well as being an arena for sharing good practice, the meetings also have addressed key areas of concern regarding commissioned services.

Throughout the year, the safeguarding team, as well as offering advise as required to primary care have visited a number of practices to ensure they are up to date with their safeguarding requirements.

The CCG is a member of the Local Safeguarding Children’s Board (DLSCB) and the associated sub-groups in Darlington. This ensures that the CCG meets its statutory requirements in accordance with Working Together 2015 and provides assurance that the CCG is compliant in meeting legislative changes to maintain quality of practice in relation to the application of multi-agency procedures, training, communication and the performance framework. The roles for Safeguarding are combined with Looked after Children’s responsibilities with expectation to ensure compliance for meeting the statutory requirements for this group of vulnerable children.
The LSCB ensure that lessons learned from Safeguarding Children’s Serious Case Reviews and Learning Lessons Reviews are embedded in practice. A member of the safeguarding team chairs the associated learning and improvement children’s group.

Throughout the year the Designated Nurses Safeguarding and Looked after Children have contributed to the commissioning service specifications and decommissioning of services involving children. The Designated Nurse provides strategic involvement, input and direction for health contribution to multi –agency strategic meetings for Domestic Abuse, Child Sexual Exploitation, Female Genital Mutilation, commissioner assurance visits, Multi-Agency Safeguarding Hub ( MASH).

The Designated Nurse has continued to support the interim Named GP lead for Safeguarding with support to practices for advice and current legislative and local practice changes, contribution to safeguarding audit and training. In addition the Designated Nurse has supported the Named GP with the contributions from Primary Care for two learning lessons reviews.

Compliance has been provided both to NHS England Assurance Framework Audit North for Safeguarding standards.

The Chief Nurse also represents the CCG at Darlington Children’s improvement board, set up following the local authority OFSTED inspection and report in 2015.

**Patient and Public Involvement**

Listening to, and engaging with local people is one of the CCG’s key priorities. We have pledged to carry out meaningful engagement by signing up to a ‘Patients Charter’. The charter places meaningful engagement with patients, carers and the public at the centre of its work, to inform, develop and prioritise its work in commissioning health services on behalf of the local population.

The five-point Charter was developed with the help of the CCG’s Community Council and focuses on the following themes:

- **Meaningful voices** – patient and public involvement and engagement (PPIE) will be fully embedded in the design and delivery of our services;
- **Leadership** – there is executive level responsibility for PPIE;
- **Proactive engagement** – PPIE will be innovative and meet organisational objectives;
- **Collaboration** – building on existing links with local interest groups and organisations
- **Celebration** – recognising the contribution and influence of patients, carers and the public.

Working closely with Healthwatch Darlington, the independent consumer champion for health and social care in Darlington, we have made good progress this year in engaging with local patients, their families and carers but we recognise that we can still improve upon this.
Community Council
We continue to promote the Community Council via the website so that people can express an interest in applying throughout the year. Members of the council also carry out the role of community champions working with the CCG as a key mechanism for active engagement and involvement in CCG commissioning activity and decisions. The meeting agendas are shaped by CCG business items where input from the community council is a key mechanism for communications and engagement.

Website
Our website www.darlingtonccg.nhs.uk helps us to engage with our local population and is regularly updated with news and important corporate information.

Social media
We are keen to enter into two-way dialogue with local people and our Twitter account @darloccg not only allows us to share information about our work, but allows us to directly engage with our growing band of over 2,401 followers.

Media relations
We work closely with local, regional and sometimes national media to get our message across. We are keen to publicise our successes and good news stories, but we also work with the media to explain why we make decisions and provide an honest and transparent response when we are scrutinised or challenged about any aspect of our commissioning role.

Governing Body
The public are welcome to attend and observe our Governing Body meetings. Following the meetings, there is an opportunity for members of the public to ask questions. Meeting dates and papers are available to view on the CCG website or paper copies are available on request by contacting the CCG Headquarters at Dr Piper House.

Media relations
Pro-active press releases are issued to local media as part of the communications and engagement strategy and statements issued on a re-active basis responding to media enquiries.

Local authority publications
The CCG uses Darlington Borough Council’s magazine ‘One Darlington’ that goes to every household in Darlington to regularly promote the positive work the CCG is doing to improve health outcomes in the community.

Equality and Diversity
NHS Darlington CCG complies with the Equality Act 2010, the Public Sector Equality Duty and the Health and Social Care Act 2012. We have demonstrated our commitment to taking Equality, Diversity and Human Rights into account in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work as evidenced below:
Equality Duties

The Equality Delivery System 2 (EDS2)

We have implemented the Equality Delivery System (EDS2) framework and have been using the tool to support the mainstreaming of equalities into all our core business functions to support us in meeting the Public Sector Equality Duty (PSED) and to improve our performance for the community, patients, carers and staff with protected characteristics that our outlined within the Equality Act 2010.

This has been an opportunity to raise equality in service commissioning and gain insight into the local population’s diverse health needs and we have reviewed and updated our Equality Objectives to reflect this.

The Audit and Risk committee and Governing Body approved plans detailing actions we will take to ensure that individuals, communities and staff are treated equitably. Progress against these action plans is reported to the Audit and Risk committee on a quarterly basis.

Workforce Race Equality Standard (WRES)

In accordance with the PSED and the NHS Equality and Diversity Council agreeing measures to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace, the CCG has shown due regard to the Workforce Race Equality Standard (WRES).

We have collated staff data as outlined within the updated WRES reporting template for 2016. We aim to improve workplace experiences and representation at all levels for black and minority ethnic staff.

Equality Analysis

Our Equality Impact Assessment (EIA) Toolkit has been implemented into core business processes to provide a comprehensive insight into our local population, patients and staff’s diverse health needs.

The tool covers all equality groups offered protection under the Equality Act 2010 (Race, Disability, Gender, Age, Sexual Orientation, Religion/Belief, Marriage and Civil Partnership and Gender Re-assignment) in addition to Human Rights and Carers.
Our EIA process ensures that we can consider the impact or effect of our policies, procedures and functions on the population we serve. For any negative impacts identified we will take immediate steps to deal with such issues as part of the Action Plan set out in the tool to make sure equity of service delivery is available for all as well as the opportunity to continuously monitor progress against challenges identified to monitor and reduce inequality for our local population.

The tool also now includes checks in relation the Accessible Information Standard to aid compliance with the Standard when commissioning services to ensure that information is provided to all service users and patients in a way they can understand.

Our staff has been offered interactive training on how to complete the document as well as process guidance within the EIA itself.

**Reducing health inequality**

NHS Darlington CCG has regard to the need to reduce inequalities between patients in accessing health services for our local population.

We understand our local population and local health needs, through the use of joint strategic needs assessments (JSNAs) and we collate additional supporting data including local health profiles as well as qualitative data through our local engagement initiatives which aim to engage hard to reach groups.

Our CCG serves a population of 107,318 patients, many of which face significant health challenges.

Deprivation is higher than average and about 20.6% (4,100) children live in poverty. Life expectancy is 11.8 years lower for men and 9.4 years lower for women in the most deprived areas of Darlington than in the least deprived areas of the town (2015). Health profiles for Darlington tell us that improvements in child health are needed, including achieving a healthy weight. The rate of alcoholic-specific hospital stays for under 18s was 84.8 (per 100,000 population), worse than the England average. Levels of breastfeeding and smoking at time of delivery are also worse than the England average.

Adult obesity is greater than average, are the rate of hospital stays resulting from alcohol and self-harm. Smoking related deaths are also a health issue in Darlington. The North East has the second highest rate of alcohol related deaths for men and women in England. Tackling alcohol related health harm is a real challenge and is one of our key priorities along with giving every child the best possible start in life and promoting mental health and wellbeing.
Poor adult nutrition and low levels of physical activity contribute to higher rates of obesity, diabetes and blood pressure.

Through our Equality Analysis process we carry out evidence based service reviews impacting the risks for our protected groups when reviewing and developing our services. Our EIA tool is developed to make these considerations at the beginning of the decision making process and throughout all of the appropriate stages of work.

The EIA is embedded into our governance process and sign off from the Governing Body is required for monitoring and completion.

We work in partnership with local NHS Trusts as well as local voluntary sector organisations and community groups to identify the needs of the diverse local community we serve to improve health and healthcare for the local population.

We seek the views of patients, carers and the public through individual feedback/input, consultations, working with other organisations and community groups, attendance at community events and engagement activity including patient surveys, focus groups and Healthwatch.

As the local commissioners of health services, we seek to ensure that the services that are purchased on behalf of our local population reflect their needs. We appreciate that to deliver this requires meaningful consultation and involvement of all our stakeholders. We aim to ensure that comments and feedback from our local communities are captured and, where possible, acted upon and give local people the opportunity to influence local health services on their terms and enable people to have their say using a variety of methods; from completing surveys to attending events and providing feedback either online, via post, text or telephone. We invite people to be involved as little or as much as they like, enabling them to help shape and influence the way NHS health services are commissioned.

This year, through our Commissioning Support Unit, we have continued to work closely with other local NHS organisations to support the regional working that has been a legacy of the Equality, Diversity and Human Rights Regional Leads Meetings. Also nationally we have been awarded NHS Employers E&D Partner status for 2016/17.

Further information can be found at:

Health Profiles: www.healthprofiles.info
Public Health England – Local Health: http://www.localhealth.org.uk
Governance

Equality and Diversity is governed and reports into the Audit and Risk committee and the Governing Body. The Governing Body ensures we are compliant with legislative, mandatory and regulatory requirements regarding equality and diversity, develops and delivers national and regional diversity-related initiatives within the CCG, provides a forum for sharing issues and opportunities, functions as a two-way conduit for information dissemination and escalation, monitors progress against the Equality Strategy and supports us in the achievement of key equality and diversity objectives.

Ali Wilson
Accountable Officer
30 May 2017
ACCOUNTABILITY REPORT

Corporate Governance Report

Members Report

Member practices

In 2016/17 the CCG was made up of 11 member practices which are:

<table>
<thead>
<tr>
<th>Blacketts Medical Practice 63-65 Bondgate Darlington County Durham DL3 7JR</th>
<th>Felix House Surgery Middleton Lane Middleton St George County Durham DL2 1AA</th>
<th>Orchard Court Surgery Orchard Road Darlington County Durham DL3 6HZ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carmel Medical Practice Nunnery Lane Darlington County Durham DL3 8SQ</td>
<td>Parkgate Surgery Park Place Darlington County Durham DL1 5LW</td>
<td>Rockcliffe Court Hurworth Place Darlington County Durham DL2 2DS</td>
</tr>
<tr>
<td>Clifton Court Medical Centre Victoria Road Darlington County Durham DL1 5JN</td>
<td>Moorlands Surgery 139a Willow Road Darlington County Durham DL3 9JP</td>
<td>Whinfield Surgery Whinbush Way Darlington County Durham DL1 3RT</td>
</tr>
<tr>
<td>The Surgery Denmark Street Darlington County Durham DL3 0PD</td>
<td>Neasham Road Surgery 186 Neasham Road Darlington County Durham DL1 4YL</td>
<td></td>
</tr>
</tbody>
</table>

Members Assembly

The Members Assembly is the mechanism through which the individual member practice representatives come together for collective decision-making as a member organisation. This ensures active participation by each member practice in the functions of the CCG in accordance with its constitution, standing orders and scheme of reservation and delegation. Each practice nominates a representative of the practice to participate in meetings.

Governing Body and Director Profiles

Andrea Jones, Chair

Originally from Leeds, Andrea qualified as a doctor from the University of Newcastle, and started work as a GP in 1990. As Chair of the Darlington CCG, her role includes overall responsibility of the Governing Body and engagement of clinicians, the public, patients and key stakeholders.

Alison Wilson, Interim Accountable Officer (to 30th April 2016) Chief Officer (from 1st May 2016)

Ms Wilson has worked in the public sector for more than 30 years, the last ten of
those on Teesside. Ali has many years’ experience in health services commissioning working at Board level. This is informed by a background that includes health services research, service improvement, medical education, and in hospital and general practice based clinical practice. Ali was one of the country’s first Master’s nurse practitioner graduates. As a former Fulbright Fellow in the University of Minnesota, USA, Ali maintains a keen interest in patient and public participation, the focus of her Fulbright experience.

**Martin Phillips, Chief Officer (to 30th April 2016)**
Martin joined the NHS in 1984 as a graduate working in Sunderland. He has accumulated almost 30 years of experience in the North East, working in a range of operational, planning and commissioning roles. He took the CCG through the assurance process to become formally established.

**Alison MacNaughton-Jones, GP Chair Members Assembly**
Dr Macnaughton-Jones has worked at Rockcliffe Court Surgery practice for 10 years. This was initially as a salaried doctor and subsequently as a partner on the retirement of Dr Bagshaw. She has two young children who take up most of her free time! Her main interests are women’s health and family planning but she also leads on chronic disease management in the surgery. When not working or looking after children her interests are running (or ambling slowly) and looking after her menagerie of cats.

**Richard Harker, Quality Lead**
Richard was born and bred in Darlington and has been a GP for 28 years. His main interests are quality in general practice and performance assessments of doctors giving concern.

**Angela Galloway, Secondary Care Doctor**
Angela joined as an interim Secondary Care Doctor in December 2014 and took up the substantive post in September 2015. Angela was previously a Consultant Medical Microbiologist and I previously held Consultant posts in Merseyside, Durham and Newcastle.

**Michelle Thompson BEM, Lay Member for Patient and Public Involvement**
A volunteer who lost her sister to cancer then survived the disease herself, Michelle has pledged to ensure a strong voice for patients. She raises funds and awareness for Macmillan Cancer Support, and was recently appointed CEO of Healthwatch Darlington having previously been the chair of the organisation.

**John Flook, Governance Lay Member**
John has a wealth of NHS and financial expertise built up during his 20 years experience as Director of Finance and in non-executive roles across the North East.

**Andie Mackay, Lay Member**
Andie was a serving firefighter with over 27 years experience with the County Durham and Darlington Fire and Rescue Service. He now works for Stockton Borough Council as a Technical and Commercial Services Manager.
chairs the CCG and NHS England joint committee for commissioning primary medical care services.

**Lisa Tempest, Chief Finance Officer (up to 31st December 2016) and Director of Planning and Assurance (from 1st Jan 2017)**
Lisa joined the CCG from South Tees Hospitals NHS Foundation Trust, where she was Chief Operating Officer for the Community Services Division. Prior to joining the NHS in 2008, Lisa worked for BASF plc, National Power plc and Nike Inc.

**Graeme Niven, Chief Finance Officer (from 1st January 2017)**
Mr Niven is an experienced NHS Executive Director and has worked Teesside since 2003. He qualified as a Chartered Institute of Management Accountant in 1994. He was appointed as Chief Finance Officer for Hartlepool and Stockton-on-Tees CCG in April 2013 following a period as Chief Finance Officer Designate for the CCG. He has worked in the NHS for 32 years in varying roles including in a community and mental health provider, regional role and commissioning roles.

**Diane Murphy, Director of Nursing and Quality**
Diane has been nursing since 1981 and qualified as a registered nurse in 1984 and health visitor in 1991. She has worked in both acute and community settings both clinically and managerially and has many years’ experience in Clinical Governance, quality and patient safety and more recently has led large scale change and transformation. She is passionate about continuous improvement and ensuring the NHS provides efficient and high quality services to everyone.

**Karen Hawkins, Director of Commissioning and Transformation (from 1st Jan 2017)**
Karen has spent her entire career in public service, she took up the joint post of Director of Commissioning and Transformation across Hartlepool and Stockton-on-Tees and Darlington CCGs in December 2016. Before this she was Associate Director for Commissioning and Delivery for Hartlepool and Stockton-on-Tees CCG. Karen has a strong commissioning and contracting background and has held a variety of senior positions in the NHS, across both primary and acute care.

**Audit and Risk Committee**
An Audit and Risk Committee has operated throughout the year, chaired by John Flook, Lay member for audit and governance.

Other members of the Audit and Risk Committee are:

<table>
<thead>
<tr>
<th>Michelle Thompson</th>
<th>Lay Member (patient and public involvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Andie MacKay</td>
<td>Lay Member</td>
</tr>
</tbody>
</table>

Other committee structures are referenced fully in the Governance Statement and the Remuneration and Staff Report details members of the Remuneration Committee.
## Register of Interests

<table>
<thead>
<tr>
<th>Name</th>
<th>Position within or relationship with the CCG</th>
<th>Name of organisation and nature of its business</th>
<th>Position held / nature of interest</th>
<th>Personal interest</th>
<th>Date from</th>
<th>Date until</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Andrea Jones</td>
<td>Chair</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
<td>01/04/16</td>
<td>31/03/17</td>
</tr>
<tr>
<td>Ms Ali Wilson</td>
<td>Interim Accountable Officer (up to 30th April 2016) Chief Officer (from 1st May 2016)</td>
<td>Community Ventures (LIFT) Company - No payment received and represents NHS</td>
<td>Public Sector Directorship</td>
<td>Nil</td>
<td>01/04/16</td>
<td>31/10/16</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Academic Health Science Network - No payment received</td>
<td>Director</td>
<td>01/04/16</td>
<td>25/05/16</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member of Ad Astra Academy Trust - No payment received</td>
<td>Member</td>
<td>01/04/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group</td>
<td>Chief Officer</td>
<td>01/05/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS North East Leadership Academy</td>
<td>Chair</td>
<td>22/08/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td>Martin Phillips</td>
<td>Chief Officer (up until 30th April 2016)</td>
<td></td>
<td>Wife is employed as Paediatric Specialist Physiotherapist at CDDFT.</td>
<td>01/04/16</td>
<td>30/04/16</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chair of Darlington Harriers and Athletic Club</td>
<td></td>
<td>01/04/16</td>
<td>30/04/16</td>
<td></td>
</tr>
<tr>
<td>Mr Graeme Niven</td>
<td>Chief Finance Officer (from 1st January 2017)</td>
<td>NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group</td>
<td>Chief Finance Officer</td>
<td>Nil</td>
<td>01/01/17</td>
<td>31/03/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Ventures (LIFT) Company - No payment received and represents NHS</td>
<td>Public Sector Directorship</td>
<td>Nil</td>
<td>01/01/17</td>
<td>31/03/17</td>
</tr>
<tr>
<td>Name</td>
<td>Position within or relationship with the CCG</td>
<td>Name of organisation and nature of its business</td>
<td>Position held / nature of interest</td>
<td>Personal interest</td>
<td>Date from</td>
<td>Date until</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-------------------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Mrs Diane Murphy</td>
<td>Executive Nurse</td>
<td>NHS County Durham and Darlington Foundation Trust</td>
<td>Employee of CDDFT on secondment to DCCG</td>
<td>Nil</td>
<td>01/04/16</td>
<td>31/03/17</td>
</tr>
<tr>
<td>Dr Richard Harker</td>
<td>GP Quality Lead</td>
<td>Whinfield Surgery</td>
<td>GP Partner</td>
<td>01/04/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td>Dr Alison McNaughton-Jones</td>
<td>Chair Members Assembly GP and Practice Lead for Rockcliffe Court</td>
<td>Rockcliffe Court</td>
<td>GMS contract holder and joint owner of GP premises</td>
<td>01/04/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td>Dr Angela Galloway</td>
<td>Secondary Care Consultant</td>
<td>St Cuthbert’s Hospice, Durham</td>
<td>Trustee</td>
<td>01/04/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td>Mrs Michelle Thompson</td>
<td>Lay Member Patient and Public Involvement, Deputy Chair of Governing Body</td>
<td>Healthwatch Darlington</td>
<td>Chief Executive</td>
<td>01/04/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td>Mr Andie MacKay</td>
<td>Lay Member, Finance</td>
<td>Stockton-on-Tees Borough Council</td>
<td>Technical and Commercial Services Manager</td>
<td>Nil</td>
<td>01/04/16</td>
<td>31/03/17</td>
</tr>
<tr>
<td>Mr John Flook</td>
<td>Lay Member Audit And Governance</td>
<td>NHS Hartlepool and Stockton-on-Tees Clinical Commissioning Group</td>
<td>Lay Member - Finance</td>
<td>01/08/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS Hartlepool and Stockton-on-Tees CCG</td>
<td>Lay Member Governance</td>
<td>Nil</td>
<td>01/08/16</td>
<td>31/03/17</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS Professionals Ltd</td>
<td>Senior Non Executive Director</td>
<td>01/04/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sport England</td>
<td>Independent Member Audit Committee</td>
<td>01/04/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>British Orienteering</td>
<td>Board Member</td>
<td>01/04/16</td>
<td>31/03/17</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Position within or relationship with the CCG</td>
<td>Name of organisation and nature of its business</td>
<td>Position held / nature of interest</td>
<td>Personal interest</td>
<td>Date from</td>
<td>Date until</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Lisa Tempest</td>
<td>Chief Finance Officer (until 31st December 2016) Direct of Performance, Planning &amp; Assurance (from 1st Jan 2017)</td>
<td>NHS Hartlepool and Stockton-on-Tees CCG</td>
<td>Director of Performance, Planning &amp; Assurance</td>
<td>Sister employed by North Tees and Hartlepool Foundation Trust in a clinical capacity</td>
<td>01/01/17</td>
<td>31/03/17</td>
</tr>
<tr>
<td>Karen Hawkins</td>
<td>Director of Commissioning &amp; Transformation (from 1 Jan 2017)</td>
<td>NHS Hartlepool and Stockton-on-Tees CCG</td>
<td>Director of Commissioning &amp; Transformation</td>
<td></td>
<td>01/01/2017</td>
<td>31/03/17</td>
</tr>
</tbody>
</table>
Personal data related incidents
There have been no personal data related incidents or data security breaches identified in 2016/17 and no Serious Untoward Incidents relating to data security.

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
Darlington CCG fully supports the Government’s objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2017 is published on our website at www.darlingtonccg.nhs.uk
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 Chief Officer to be the Accountable Officer of the Clinical Commissioning Group.

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group’s assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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 Clinical Commissioning Group 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 ‘Manual for Accounts’ 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 ‘Manual for Accounts’ issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements.
- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:
- as far as I am aware, there is no relevant audit information of which the entity’s auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make himself or herself aware of any
relevant audit information and to establish that the entity’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

Ali Wilson
Accountable Officer
30 May 2017
Governance Statement

1. Introduction
NHS Darlington CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended). The clinical commissioning group’s statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG’s general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2016, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

2. Scope of responsibility
As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG’s policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out in my CCG Accountable Officer Appointment Letter.

I am also responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

3. Governance arrangements and effectiveness

3.1.1 The main function of the governing body is to ensure that the group 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.

3.1.2 The CCG has a Constitution based on the Department of Health’s Model Template. The Constitution was reviewed during 2016/17 in order to ensure it remained legally compliant and took into account any guidance provided and legal requirements put in place since its adoption. Review of the CCG’s Constitution confirms that it complies with the elements of the self-certification checklist, including:

- specifying the arrangements made by the CCG for the discharge of its functions;
- specifying the arrangements made by the CCG for the discharge of the functions of the Governing Body;
- the procedures to be followed by the CCG in making decisions;
• the arrangements it has made to secure that individuals to whom health services are being or may be provided pursuant to its commissioning arrangements are involved;
• arrangements made by the CCG for discharging its duties in respect of registers of interests and management of conflicts of interests;
• arrangements made by the CCG for securing that there is transparency about the decisions of the group and the manner in which they are made.

3.2 During 2016/17 the CCG has continued to operate with a governance structure which reflects guidance and best practice. In light of the implementation of a shared management structure for NHS Darlington CCG and NHS Hartlepool and Stockton-on-Tees CCG, the governance arrangements have been reviewed to ensure there was efficiency between the two organisations, whilst ensuring each delivered its statutory responsibilities including the requirement to have a Governing Body, Audit Committee and Remuneration Committee.

Also in 2016/17, the CCG was delegated responsibility from NHS England to undertake primary care commissioning and to this extent a Primary Care Commissioning Committee has been in operation.

For the period 1st April 2016 to 31st December 2016, the below governance structure was in place:

![Governing Structure Diagram]

For the period 1st January 2017 to 31st March 2017, the below governance structure was in place:

![Governing Structure Diagram]
3.3 Description of the established bodies and committees

3.3.1 The roles of each of the Clinical Council of Members, the Governing Body and its associated committees are set out broadly below.

3.3.2 Members Assembly

NHS Darlington CCG is a member organisation. The intentions and wishes of the Group will be determined and expressed by the Members Assembly. The Members Assembly comprises a representative of each member practice. The Members Assembly ensures that the Groups' activities retain a clear clinical focus, determine clinical strategy thereby assuring clinical ownership, assure member engagement as well as adopting standards of behaviour for its members in line with the Nolan principles of good governance in public life i.e. selflessness, objectivity, integrity, honesty, accountability, openness and leadership.

There have been five meetings of the Assembly during this year and the main areas covered include:

- approval of the CCG’s revised Constitution;
- agreement on appointment to Governing Body roles and timing of elections to the Governing Body for the CCG;
- CCG Financial Plans;
- Primary Care Co-commissioning; and
- Planning for 2017/18 including Sustainability and Transformation Plans.

The Members Assembly delegate approval of a range of functions to the Governing Body as set out in paragraph 3.3.3.

The Members Assembly undertook a review of its effectiveness as part of its review of the CCG Function at their meeting on 1 March 2017. The results of the
assessment of its own effectiveness are that it remains compliant with its terms of reference, which were reviewed at their meeting held in March 2017.

Membership of the Members consists of the healthcare professional nominated by each member practice to act on its behalf in dealings with the CCG and to represent that member practice at meetings of the Members Assembly.

Attendance at Members Assembly is shown in Figure 1: Members Assembly Attendance Record.

<table>
<thead>
<tr>
<th>Surname</th>
<th>Forename</th>
<th>Title</th>
<th>Practice</th>
<th>Members Assembly (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baines</td>
<td>Alistair</td>
<td>Dr</td>
<td>Felix House Surgery</td>
<td>3</td>
</tr>
<tr>
<td>Bartlett</td>
<td>Terri</td>
<td>Practice Manager</td>
<td>Parkgate Surgery</td>
<td>1</td>
</tr>
<tr>
<td>Crook</td>
<td>Karen</td>
<td>Practice Manager</td>
<td>Carmel Medical Practice</td>
<td>1</td>
</tr>
<tr>
<td>Foot</td>
<td>Victoria</td>
<td>Dr</td>
<td>Clifton Court Medical Practice</td>
<td>3</td>
</tr>
<tr>
<td>Harker</td>
<td>Richard</td>
<td>Dr</td>
<td>Whinfield Surgery</td>
<td>2</td>
</tr>
<tr>
<td>Harrison</td>
<td>Jodie</td>
<td>Dr</td>
<td>Neasham Road Surgery</td>
<td>1</td>
</tr>
<tr>
<td>Hirst</td>
<td>Cherrie</td>
<td>Practice Manager</td>
<td>Denmark Street Surgery</td>
<td>2</td>
</tr>
<tr>
<td>Hutchinson</td>
<td>Sally</td>
<td>Practice Manager</td>
<td>Neasham Road Surgery</td>
<td>3</td>
</tr>
<tr>
<td>Macnaughton-Jones</td>
<td>Alison</td>
<td>Dr</td>
<td>Rockcliffe Court Surgery</td>
<td>5</td>
</tr>
<tr>
<td>Michie</td>
<td>Andrew</td>
<td>Dr</td>
<td>Blacketts Medical Practice</td>
<td>3</td>
</tr>
<tr>
<td>Nevison</td>
<td>James</td>
<td>Dr</td>
<td>Denmark Street Surgery</td>
<td>4</td>
</tr>
<tr>
<td>Penney</td>
<td>Basil</td>
<td>Dr</td>
<td>Carmel Medical Practice</td>
<td>2</td>
</tr>
<tr>
<td>Ramos</td>
<td>Anna</td>
<td>Dr</td>
<td>Felix House Surgery</td>
<td>1</td>
</tr>
<tr>
<td>Riley</td>
<td>Amanda</td>
<td>Dr</td>
<td>Clifton Court Medical Practice</td>
<td>2</td>
</tr>
<tr>
<td>Shaw</td>
<td>Tony</td>
<td>Dr</td>
<td>Moorlands Surgery</td>
<td>2</td>
</tr>
<tr>
<td>Stevens</td>
<td>Richard</td>
<td>Dr</td>
<td>Orchard Court Medical Practice</td>
<td>5</td>
</tr>
<tr>
<td>Stewart</td>
<td>Liz</td>
<td>Practice Manager</td>
<td>Felix House Surgery</td>
<td>1</td>
</tr>
<tr>
<td>Tutin</td>
<td>Sarah</td>
<td>Nurse</td>
<td>Orchard Court</td>
<td>2</td>
</tr>
<tr>
<td>Umashankar</td>
<td>Gomathy</td>
<td>Dr</td>
<td>Blacketts Medical Practice</td>
<td>2</td>
</tr>
</tbody>
</table>

3.3.3 Governing Body

The Governing Body has the following functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations or in its Constitution. The Governing Body also has functions of the CCG delegated to it by the Council. Our Governing Body has responsibility for:
ensuring 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 (its main function);

- identifying strategic risks and developing an Assurance Framework;
- approving the commissioning strategy which takes into account financial targets and forecast limits of available resources;
- approving consultation arrangements for the CCG’s commissioning plan;
- engaging with partners and stakeholders;
- reviewing compliance with the public involvement Statement of Principles;
- approving the level of non-pay expenditure on an annual basis;
- approving reports showing the total financial allocations received and their proposed distribution including any sums to be held in reserve including regular updates on significant changes;
- receiving and reviewing reports on financial performance against budget and plan, including explanations for variances;
- receiving reports detailing actual and forecast expenditure and activity for contracts;
- receiving reports which outline the reasons for seeking tenders from firms not previously pre-qualified to provide goods/services;
- determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act;
- approving a timetable for producing the annual report and accounts; and
- approving any functions of the CCG that are specified in regulations.

The Governing Body has an agreed annual cycle of business which enables it to discharge the duties set out above. During 2016/17, the Governing Body has discharged it duties under the responsibilities above. The Governing Body met on eight occasions and has held all of its meetings in public with the exception of ‘In Committee meetings’ which discuss work in progress and items of a confidential nature prior to public disclosure at the earliest convenience. Full details of the membership and attendance of the Governing Body is included at Figure 2: Governing Body and Committee Meetings Attendance Record.

**Figure 2: Governing Body and Committee Meetings Attendance Record**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Governance, Audit and Risk Committee (5)</th>
<th>Quality, Performance and Innovation (9)</th>
<th>Quality, Performance and Finance Committee (1)</th>
<th>Finance Committee (8)</th>
<th>Governing Body (6)</th>
<th>Remuneration Committee (3)</th>
<th>Primary Care Commissioning Committee (6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Flook</td>
<td>Lay Member-Audit and Governance (from 1st August 2016)</td>
<td>5/5</td>
<td></td>
<td></td>
<td>6/6</td>
<td>3/3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Agendas are structured to deal with strategic, performance, quality assurance, risk and governance issues. The arrangements meet the requirements of best practice guidance in respect of risk management and ensure that a strong accountability framework has been established. They reflect the public service values of accountability, probity and openness and specify as Accountable Officer my responsibility for ensuring that these values are met within the CCG. The Governing Body duties are contained within the CCG’s Constitution, within the standing orders under meetings of the CCG, which is available on the CCG’s website.
Key areas that the Governing Body has focussed on during the year include:

- Receipt, review and approval of a range of strategies.
- Finance and Performance.
- Quality Performance including safeguarding.
- Governance and Assurance Performance.
- Better Care Fund development and plans.
- Better Health Programme/ Sustainability and Transformation Plans.
- CCG Operational Plan and Strategic Plans.

The Governing Body also receives confirmed minutes from each of its committees to enable the Governing Body to consider the work and effectiveness of the respective committee and to receive assurance relating to delivery of their aims and objectives.

During the year, the Governing Body undertook a process of ‘critique’ to review at each meeting the effectiveness of the meetings. This process ensures continuous learning and development to improve effectiveness. An external review of the CCG’s Governance arrangements has been undertaken in line with compliance requirement of the Corporate Governance Code.

3.3.4 Remuneration Committee
The committee is established to advise/recommend to the Governing Body the appropriate remuneration and terms of service for the Chief Officer and other staff paid through the Very Senior Manager Pay Framework. The committee also advises/recommends to the Governing Body remuneration for the role of Chair, remuneration and terms of service of Governing Body clinical representatives and any independent lay members and reviews any business cases for early retirement and redundancy. Full details of the membership and attendance of the Committee is included at Figure 2: Governing Body and Committee Meetings Attendance Record. The committee’s terms of reference are referenced within the CCG’s Constitution and are available on the CCG’s website. The committee considers its effectiveness on an ongoing basis and has produced an annual report of its work.

Key areas that the Committee have focussed on during the year include:

- Terms and Conditions and contracts for clinicians
- Terms and Conditions and contracts for executives
- Terms and Conditions and contracts for Lay Members
- Reporting of appraisals of Governing Body members
- Shared Management Structure and Shared Accountable Officer role

3.3.5 Audit and Risk Committee (Governance, Audit and Risk Committee until 31st December 2016)

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the committee provides the organisation with an independent and objective review of their financial systems, financial
information and compliance with laws, guidance, and regulations governing the NHS.

Full details of the membership and attendance of the Committee is included at Figure 1: Governing Body and Committee Meetings Attendance Record. The committee’s cycle of business includes review of the CCG Governing Body Assurance Framework and corporate risk register. The committee Chair is a lay member of the Governing Body and has no executive powers, other than those specifically delegated in its terms of reference. The committee’s terms of reference are referenced within the CCG’s Constitution and are available on the CCG’s website. Annually, the committee also carries out a self-assessment of its effectiveness which is undertaken with support from Internal Audit and the committee considered itself to be operating effectively.

The Audit and Risk Committee as part of its terms of reference provides an Annual Report of its work to the Governing Body. The most recent report available covers 2016/17. The principal purpose of the report is to give the Governing Body assurance as to the work carried out by the Committee. The Committee’s cycle of business enables it to carry out its key objectives necessary to support its assurances regarding the effectiveness of the organisation’s internal controls.

Significantly during the year through its cycle of business, the Audit and Risk Committee have received the following assurances:

- Internal Audit Progress Reports
- External Audit Progress Reports
- Chief Finance Officer Reports
- Head of Internal Audit Opinion
- Approval of Audit and Counter Fraud Plans
- Review of Risk Register and Assurance Framework
- Annual Report and Accounts

As part of the revised governance arrangements, responsibility for monitoring risk and governance has passed to this Committee from the Governance and Risk Committee

3.3.6 Quality Performance and Innovation Committee (ceased to meet as of 31st December 2016)

The duties of the Quality, Performance and Innovation Committee are driven by the priorities for the CCG and any associated risks or areas of clinical quality across commissioned services and primary care services. The Quality, Performance and Innovation Committee has an ambition of excellence in clinical quality, clinical effectiveness and patient experience, and to improve health outcomes and all associated risks or areas of quality improvement. It leads innovation and on embedding best practice principles in commissioned services, always acting with a view to securing continuous improvement in the quality of care and services. The Committee innovates and oversees research to deliver health gain, improved patient safety and a better experience for patients. The
committee supports the CCG to achieve organisational performance objectives, through reviewing performance in-year and implementing relevant any actions as required. The primary objectives of the Committee are to safeguard patients from harm, develop high quality services and foster a culture of safety.

The Quality, Performance and Innovation Committee met five times during the year and its work has included:

- Reviewed membership following consultation with member assembly, committee now includes a practice manager representative
- Regularly received full quality and performance reports for all providers identifying areas of concern for further exploration with the relevant provider in the relevant clinical quality review groups
- Received and reviewed annual reports for adult safeguarding and children’s safeguarding
- Received and reviewed locally benchmarking activity reports on GP practices
- Reviewed prescribing quality schemes
- Reviewed, updated and approved a range of key policies

3.3.7 Finance Committee (ceased to meet as of 31st December 2016)
The Finance Committee supports the CCG to achieve financial balance, including delivery of quality, innovation, productivity and prevention (QIPP) financial targets, delivery of the Groups Clear and Credible Plan and annual Delivery Plan and organisational financial performance objectives, through reviewing performance in-year and implementing any relevant actions as required.

The Finance Committee met five times during the year and its work has included:

- monitoring of financial performance to ensure that national financial targets were met
- monitoring of the QIPP plan and the identification of alternative schemes where planned schemes failed to deliver to ensure delivery of the planned QIPP saving
- Monitoring of the Financial Recovery plan to ensure in year financial balance was achieved and can be maintained in future years
- ensuring that financial risks were identified and appropriate controls and and action plans were put in place to mitigate financial loss to the CCG

3.3.8 Quality Performance and Finance Committee (started meeting 1st January 2017)
The purpose of the Committee is to provide assurance to the Governing Body of effective management of risk in relation to finance, contracts, performance and quality, including the delivery of Quality, Innovation, Productivity and Performance (QIPP). The Committee’s cycle of business includes overseeing that commissioned services are being delivered in a high quality and safe manner and performance is managed according to the agreed terms of the Service Level Agreements and Legally Binding Contracts and that appropriate corrective action is being taken to address areas of underperformance, including
changes to future contracts where necessary. Full details of the membership and attendance of the Committee is included at Figure 1: Governing Body and Committee Meetings Attendance Record. The Committee’s terms of reference are referenced within the CCG’s Constitution and are available on the CCG’s website.

One of the Quality, Performance and Finance Committee’s key responsibilities is to seek assurance that the CCG is commissioning safe care for patients and this is undertaken by monitoring provider performance and adherence to quality standards.

Significantly during the year through its cycle of business, the Quality Performance and Finance Committee and its associated sub-committees have considered the following issues;

- Quality monitoring reports on provider commissioned services, including the reporting of serious untoward incidents
- Provider reports in relation to complaints, claims and untoward incidents
- Provider Healthcare Acquired Infections
- Achievement of QIPP
- Performance Monitoring of Provider contracts
- Monitoring delivery of the 2016/17 financial plan
- Operational and Financial Plans
- Delivery of commissioning intentions

The committee reviews its effectiveness on an ongoing basis and has produced an annual report of its work.

3.3.9 Primary Care Commissioning Committee

The Committee has a primary purpose of commissioning primary medical services for the people of Darlington.

The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under Section 83 of the NHS Act, except those relating to individual GP performance management, which have been reserved to NHS England. This includes the following activities:

(a) GMS, PMS and APMS contracts, including:-
- the design of PMS and APMS contracts;
- monitoring of contracts;
- taking contractual action such as issuing breach/remedial notices;
- removing a contract;
(b) Directed Enhanced Services;
(c) Design of GP services as alternatives to the Quality Outcomes Framework [QOF];
(d) Approving practice mergers, boundary changes and list closures;
(e) Decision making on whether to establish new GP practices in an area;
(f) Making decisions on “discretionary” payment (e.g. returner/retainer schemes)
In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG, which will sit alongside the delegation and terms of reference.

3.3.10 Funding Panel
The Funding Panel, which is a collaboration between CCGs and is accountable to the CCG’s Governing Body, considers all Individual Funding Requests and decides whether or not to support individual requests on the basis of the information provided with the request to the committee. Requests will be assessed for access to treatment within the commissioning authority of the CCG and the membership through the delegation and reservation arrangements.

During the course of the year, it has developed and agreed protocols for accessing services or treatment outwith core commissioned services, either for NHS or non-NHS providers where a service level agreement or contract does not exist. The Governing Body has approved and keeps under review the terms of reference for the Funding Panel which includes information on the membership of the committee.

3.3.11 Better Health Programme Joint Committee
The Joint Committee of Clinical Commissioning Groups (hereafter referred to as the Joint Committee) is a joint committee of: NHS Darlington CCG, NHS Durham Dales, Easington and Sedgefield CCG, NHS Hambleton, Richmondshire and Whitby CCG, NHS Hartlepool and Stockton-on-Tees CCG, and NHS South Tees CCG with the primary purpose of arranging formal public consultation in relation to service reconfiguration.

The Joint Committee’s primary purpose is to arrange and undertake the formal public consultation and then make decisions on the issues relating to reconfiguration.

The role of the Joint Committee therefore shall be to carry out the functions relating to making decisions about future acute service configuration and service change, undertaking formal public consultation and making decisions on the issues which are the subject of the consultation in relation to the STP.

This includes the following key responsibilities:

- Determine the options appraisal process, including agreeing the evaluation criteria and weighting of the criteria
- Determine the method and scope of the engagement and consultation process
- Act as the formal body in relation to the public consultation with the Joint Overview and Scrutiny Committees established for it by the relevant Local Authorities
- Make any necessary decisions arising from a Pre-Consultation Business Case (and the decision to run a formal consultation process)
- Approve the Consultation Plan
• Approve the text and issues on which the views of the public are sought in the Consultation Document
• Take or arrange for all necessary steps to be taken to enable the CCGs to comply with their public sector equality duties
• Approve the formal report on the outcome of the consultation that incorporates all of the representations received in response to the consultation document in order to reach a decision
• Make decisions about future service configuration and service change, taking into account all of the information collated and representations received in relation to the consultation process. This should include consideration of any recommendations made by the Programme Board or views expressed by the Joint Health Overview and Scrutiny Committee or any other relevant organisations. It should also include consideration of the implications of the decisions in relation to potential risk to the sustainability and viability of the Foundation Trusts included in the remit of the Programme

3.3.12 Other committees on which the CCG is a partner
The CCG is a member of the Darlington Borough Council Health and Wellbeing Board and membership is in accordance with the Council’s governance arrangements. Together with all other CCGs across the North East and Cumbria, the CCG is a member of the Northern CCG Forum which is supported by a memorandum of understanding.

The CCG is also a statutory member on the Darlington Local Safeguarding Children Board, Darlington Borough Council Safeguarding Adults Board, and the County Durham-wide Safeguarding Vulnerable Adults Board. These bodies are led by our local authority partners.

The CCG has entered into joint arrangements with the CCGs in the North of England to determine commissioning for health gain policies and to review and approve individual funding requests, including conducting an appeals process. In accordance with the CCG’s Constitution, where the CCG has established a partnership with others, the CCG has provided details in its Scheme of Reservation and Delegation of the individual who has delegated authority to make decisions on its behalf, although the CCG retains responsibility for the decision. Please also see detail at 3.3.10.

Compliance with the UK Corporate Governance Code
3.4 We are not required to comply with the UK Corporate Governance Code. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG. Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice.

Discharge of Statutory Functions
3.5.1 During establishment, the arrangements put in place by the CCG and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with all the relevant
legislation. That legal advice also informed the matters reserved for the Members Assembly and Governing Body decisions and the scheme of delegation. No further guidance or legal advice has superseded this process.

3.5.2 In light of the 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 and those supporting structures provided by NECS provide the necessary capability and capacity to undertake all of the CCG’s statutory duties.

4. Risk Management arrangements and effectiveness

4.1.1 The Risk Management Framework provides a number of ways in which we identify and mitigate risks. We have an established corporate policy set which informs our knowledge, and guides our actions and behaviours. These policies ensure we conduct our business appropriately, comply with legal requirements and protect our patients and staff from avoidable harm. Policies included are a Risk Management Strategy and procedures, a Health and Safety Strategy, Policy and procedures and an Incident Management Policy.

4.1.2 A Risk Management Strategy is in place, which takes into account current guidance on risk management best practice and is consistent with the principles contained within the NHS England’s Risk Management Strategy and Risk Management Policy and Procedure issued in July 2013. The Risk Management Strategy sets out the CCG’s approach to the way in which, in general terms, risks are managed. This is achieved by having a thorough process of risk assessment in place, providing a useful tool for the systematic and effective management of risk, and informing and guiding staff as to the way in which all significant risks are identified and controlled.

4.1.3 Our staff also participate in mandatory training to support them to acquire the essential knowledge and skills to fulfil their roles. Throughout 2016/17, executive directors and senior manager leads have been held to account for the mandatory training compliance rates within their areas. Mandatory training requirements include Fire Safety, Equality and Diversity, Information Governance and Counter Fraud.

4.1.4 Executive directors and senior manager leads are assigned to each of our operational and strategic risks in line with their portfolio and are responsible for ensuring their effective assessment and management. They are held to account by the Governing Body and its sub-committees, namely the Audit and Risk Committee and the Quality, Performance and Finance Committee as well as more regular one-to-one line management arrangements. There is evidence of the Audit and Risk Committee challenging the assessment of risk and controls
and actions in place to manage risks, acting in accordance with their terms of reference to provide assurance to the Governing Body.

4.1.5 The Governing Body Assurance Framework (GBAF) enables the Governing Body to be sighted on the risks to the delivery of the organisation’s strategic objectives and to ensure that effective controls and assurance are in place. The Governing Body Assurance Framework was formally agreed at the Governing Body on 28 March 2017.

Risk Assessment

4.2.1 Risk is identified in accordance with the CCG’s Risk Management Strategy and risk management is embedded in the organisation via a number of mechanisms. Risk identification is undertaken in a number of ways, through horizon scanning by the executive team, through identification by sub-committees of the Governing Body, through identification and escalation by individual executive directors and also by the Governing Body.

4.2.2 Identified risks are included in the Corporate Risk Register which identifies current and prospective risks to the organisation. The Corporate Risk Register is initially reviewed by the Executive Committee and provided to the Governing Body. Strategic Risks are also reviewed by the Audit and Risk Committee in order to provide assurance to the organisation. Active steps are taken to ensure that it is regularly updated and updates are provided quarterly to the Audit and Risk Committee in line with the Constitution and scheme of delegation. In addition, all CCG policies and reports are assessed for risks and equality impact.

4.2.3 Furthermore, the incident reporting system identifies the risks that have already (or nearly) occurred from incidents or near misses. Our strategic planning system ensures that all organisational objectives are rated for risks to achievement of delivery; and our performance management system rates all objectives for risk to delivery. In addition, all Governing Body reports are assessed for equality impact and all reports are assessed to provide evidence of assurance for the Assurance Framework and/or mitigate risk included on the CCG’s Risk Register.

4.2.4 As at the end of the year, the CCG was actively managing 24 corporate risks. All of these risks have key controls identified against them and also the delivery of both external and internal assurance regarding these risks. They also include mitigating actions where appropriate and are subject to an action plan.

4.2.5 None of the risks have been assessed as impacting upon the CCG’s licence or governance, risk management and internal control processes. The Audit and Risk Committee discussed the CCG’s risk register on 7 March 2017 confirming that they agreed that all risks were being actively managed and appropriate mitigations were in place. However, the CCG’s risk register is a dynamic document and is constantly subject to update and change in order to reflect the nature of the risks the CCG faces.
5. Other sources of Assurance

Internal Control Framework

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

5.2 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.

5.3 Our system of internal control is detailed within our Constitution, in particular within the scheme of reservation and delegation, the CCG standing orders and the CCG’s prime financial policies. The following internal control mechanisms are in place within the CCG:

- A Governing Body which ensures 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.
- A committee structure, as described in section 4, in which each have a vital role in contributing to the establishment of an effective governance infrastructure and for both identifying and interpreting information relating to risks to the fulfilment of our objectives and vision; the safety of patient care; high quality commissioning; our role as an employer.
- An appointed Accountable Officer who is responsible (amongst other duties) for ensuring that the CCG fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money. By working closely with the Chair of the Governing Body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to assure the members (through the Governing Body) of the organisation’s ongoing capability and capacity to meet its duties and responsibilities.
- An appointed Chief Finance Officer who is responsible for (amongst other duties) overseeing robust audit and governance arrangements leading to propriety in the use of the CCG’s resources.
- Appointed internal and external auditors who also measure the effectiveness of internal control through their efforts. They assess whether the controls are properly designed, implemented and working effectively, and make recommendations on how to improve internal control which the CCG acts upon.
- Finally, all staff members are responsible for reporting operational problems, monitoring and improving their performance, and monitoring non-compliance with the corporate policies and various professional codes, or violations of policies, standards, practices and procedures. Their particular responsibilities are documented in their own objectives and role and responsibilities.
5.4 The CCG is responsible overall for its system of internal control, however it is reliant on others for provision of services and therefore their respective systems of internal control:

NECS - A number of functions of the CCG are carried out by the North of England Commissioning Support Unit under a service level agreement; however the CCG retains the delegated responsibilities as per its agreed Constitution. The services provided by the CSU are:

- Service Planning
- Service Reform
- Procurement and Market Management
- Provider Management
- Joint Commissioning
- Continuing Healthcare
- Medicines Optimisation
- Clinical Quality
- Governance including Risk Management and Incident Reporting
- Research and Development
- Commissioning Finance
- Financial Control
- Financial Accounting
- Business Information Services
- Business Information Services Information Communication Technology (ICT)
- Human Resources
- Organisation Development
- Communications and Engagement

Secondary User System (SUS) – national system, repository for the acute activity and is used to generate the financial charges to Foundation Trusts.

Payroll – provided by Northumbria Healthcare Foundation Trust, a payments system for staff salaries and travel expenses.

Prescribing spend – national system ran by Business Services Authority, payment mechanism to dispensing pharmacies for issuing GP prescriptions.

Electronic Staff Record (ESR) – national system ran by McKesson – records relevant information for employed staff and links to information used for payroll.

Procurement and creditor payment systems. National system ran by Shared Business Services – ordering of good and services, and payment of invoices.

General Ledger system – national system Oracle, providers’ financial management information and information for annual accounts.
5.5 Annual audit of conflicts of interest management

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

An annual internal audit of conflicts of interest has been carried out by the CCG’s internal auditors in accordance with the template audit framework. Reasonable assurance has been provided by the internal auditors to the CCG. Further areas for development identified by the audit included the provision of training to all members of staff and ensuring all members of the CCG has fully completed declarations of interest.

Information Governance (IG)

5.6 The CCG actively manages its data security risks through our Information Governance Framework and is assessed through our IG Toolkit work. The Governance and Risk Committee have received quarterly updates on progress against the IG Toolkit and the CCG achieved a satisfactory rating for level 2 of the IG Toolkit.

5.6.1 The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The CCG has in place a Senior Information Risk Owner (SIRO), (Graeme Niven, Chief Finance Officer) and a Caldicott Guardian (Diane Murphy, Director of Nursing and Quality).

5.6.2 We place high importance on ensuring that there are robust information governance systems and processes in place to help protect information. We have an Information Governance Framework in place comprising an approved strategy and a suite of approved policies and procedures in line with the Information Governance Toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

5.6.3 There are processes in place for incident reporting and investigation of serious incidents. This process outlines the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach. We are continuing to develop information risk assessment and management procedures and a programme is being established to fully embed an information risk culture throughout the organisation.

5.7 Data Quality
The CCG has an approved Data Quality Policy which clearly defines data and explains data standards and the importance of data validation. Assurance on
the quality of data is provided through the data quality procedures and policies put in place including NHS number compliance, pseudonymisation, compliance with new ISNs, Reference Cost Audits, Information Governance Toolkit data quality requirements. Data Quality requirements are also built into contract with providers and within the SLA in place with NECS. Any data provided to the Governing Body is verified by directors’ responsible for those areas before it is formally presented.

5.8 Business Critical Models
The Commissioning Support Unit holds all the business critical models that are used by the CCG. The CCG has received assurance that an appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report. Further assurance has been given that all business critical models have been identified and that information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.

5.9 Data Security
There have been no personal data related incidents or data security breaches identified in 2016/17 and no Serious Untoward Incidents relating to data security.

The CCG has submitted the Information Governance Toolkit and has been assessed as being 74% overall compliant, which confirms the organisation’s rating as overall ‘satisfactory’ in this regard. Significant assurance has been given in respect of the CCG’s Information Toolkit submission following a review by Internal Audit.

The CCG complies with its statutory duty to respond to requests for information. During the year, the CCG received 272 FOI requests under the Freedom of Information Act 2000 and 2 subject access requests under the Data Protection Act 1998. All the requests were responded to within the statutory timescales.

5.10 Third party assurances
As a result of the support service arrangements provided by NECS under a signed service level agreement, the CCG will receive a number of assurance reports covering the 1st April 2016 to 31st March 2017. These will be reviewed and form part of the overall head of audit opinion.

The CCG has received a Service Auditor Report from NECS covering the period 1st April 2016 to 30th September 2016.

The report covers control objectives in relation to those services provided to the CCG:

- Accounts Payable;
- Accounts Receivable;
- Treasury and Cash Management;
- Financial Ledger;
• Financial Reporting; and
• Payroll.

The Deloitte audit opinion was a qualified one, on account of five exceptions noted in the control environment. These exceptions related to review of payroll and financial ledger journals, authorisation of purchase orders, training for finance staff, and production of forecast outturn reports. Remedial action has been put in place by NECS to address these minor control exceptions. The report provides reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the year.

Work is currently ongoing to produce the second report covering the second half of the year, and at the time of producing this report, it had not been issued. In addition, Service Auditor Reports are currently awaited for business continuity and contract management. A separate report has been produced in the year covering Continuing Health Care processes.

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

6.1 The CCG has well developed systems and processes in place for managing its resources. The Quality, Performance and Finance Committee and Subsequent to that the Finance Committee has continuously monitored the financial position of the CCG throughout the year and highlighted risks to the Governing Body regarding the effective and efficient use of resources.

6.2 The Governing Body approved the CCG’s financial plans for 2016/17 and have received an updated financial position, as part of the Finance and Performance report, at each of their Governing Body meetings. This includes the opportunity to ask questions of the Executive relating to assurance of the delivery of the CCG’s financial objectives. By combining the finance and performance report into one report, this illustrates the wider considerations between cost and performance and allows challenge of the executive to be made. They have also actively sought assurance from the Quality, Performance and Finance Committee as well as from the Audit and Risk Committee via internal and external audit reports that the CCG is ensuring value for money in the use of its resources. In year performance is monitored by the CCG’s Finance Committee.

6.3 Central management costs, known as the CCG’s running cost allowance was £2.3 million for 2016/17. The CCG operated within the running cost allowance during the year.

6.4 As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means. In the event, the national position across the provider sector has been such that NHS England
has been unable to allow CCGs’ 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Darlington CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £1.592m. This additional surplus will be carried forward for drawdown in future years. Due to prudent financial planning and management, the CCG’s financial performance in 2016/17 has delivered the planned surplus as was the case for 2015/16.

6.5 Internal Audit reports have been undertaken in relation to financial management arrangements and performance reporting to NHS England, and financial planning and budget setting. Significant assurance has been provided in relation to these areas.

6.6 As part of their annual audit, the CCG’s external auditors are required to satisfy themselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources. They do this by examining documentary evidence and through discussions with senior managers. Their audit work is made available to and reviewed by the Audit and Risk Committee.

6.7 The CCG’s performance is routinely monitored by NHS England and this includes a well-led assessment, the most recent data of which is included in the table below:

<table>
<thead>
<tr>
<th>Organisation Information</th>
<th>Staff engagement index</th>
<th>Progress against workforce race equality standard</th>
<th>Effectiveness of working relationships in the local system</th>
<th>Quality of CCG leadership</th>
<th>Probit and corporate governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Darlington CCG</td>
<td>3.76</td>
<td>-0.15</td>
<td>68%</td>
<td>1</td>
<td>Fully compliant</td>
</tr>
</tbody>
</table>

The latest results available on my NHS are from Q2 2016/17. The year end results for the indicator will be available from July 2017 at [www.nhs.uk/service-search/scorecard/results/1175](http://www.nhs.uk/service-search/scorecard/results/1175)

7. Delegation of functions

This is covered under the section Third Party Assurances at 5.10
8. **Counter fraud arrangements**

8.1 The CCG is required to have counter fraud provision to meet its statutory financial reporting duties and in year financial reporting requirements and has in place clear counter fraud arrangements and access to appropriate, accredited counter fraud support.

8.2 The CCG meets these requirements within their resource constraints via a nominated and accredited LCFS (via service level agreement with Audit One) and policies and procedures which have been fraud proofed in conjunction with the LCFS. Fraud alerts are regularly circulated and followed up and links to our newsletter are periodically distributed. In addition an anti-fraud e-learning module has been successfully adopted. Efficiencies are achieved through centralisation of core services. Proactive work has been undertaken and is ongoing in respect of risks identified.

8.3 The Standards for Commissioners 2016/17 were posted on the NHS Protect website in March 2016 and the CCG noted some changes from last year, mainly the removal of the requirement to review providers’ organisational crime profiles. Working with the counter-fraud team, the CCG completed the Self-Review Tool (SRT) and submitted a completed return to NHS Protect by 31st May 2016 in accordance with the guidance. The CCG Audit and Risk Committee receives a report against each of the Standards for Commissioners on annual basis as part of the counter-fraud annual report.

8.4 Counter-Fraud has undertaken work this year in respect of the Bribery Act and Continuing Healthcare, and in addition assisted the CCG with their participation in the 2016/17 National fraud initiative (NFI).

8.5 The Chief Finance Officer of the CCG is the executive lead for counter-fraud matters. Any issue relating to tackling fraud, bribery and corruption is supported by the Chief Finance Officer who in accordance with the Counter-Fraud policy would reported such incidents to the Audit and Risk Committee. Additional days must also be purchased over and above the core days in the plan, in the event of any referrals or identification of any potential frauds. All such amendments to the plan will be discussed and agreed with the Chief Finance Officer in the first instance.

9. **Head of Internal Audit Opinion**

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

**The Head of Internal Audit 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:

1. Overall opinion;
2. Basis for the opinion;
3. Commentary.

1. Overall Opinion

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

2. Basis for 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.

3. 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>
</table>
| Design and operation of the Assurance Framework and supporting processes | The Governing Body Assurance Framework has been updated throughout 2016/17, and presented to both the Audit and Risk Committee and the Governing Body during the year.  
Our review of the CCG’s governance and risk management arrangements identified no issues of concern and was assigned ‘good assurance’. On this basis we are content that the Board Assurance |
<table>
<thead>
<tr>
<th>Opinion Area</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Framework provides a reasonable basis to support the CCG’s Annual Governance Statement.</td>
<td></td>
</tr>
<tr>
<td>Outturn of Internal Audit Plan</td>
<td>During the year 2016/17 we have undertaken our work in accordance with the Internal Audit annual plan. We have reported our findings to the Chief Finance Officer and Chief Officer (and other Executive colleagues where applicable). Our progress reports to the Audit and Risk Committee set out the areas covered by internal audit work during the year, our results and matters arising. All final reports issued during the year to date have been issued with an assurance level of either good or substantial; and no significant issues have been identified. The CCG should review our findings in order to satisfy itself that any significant control issues have been recognised and appropriately disclosed in its Governance Statement. At the time of compiling this report one draft report has been issued to management, and is being progressed in accordance with the Internal Audit Protocol. The report, relating to conflicts of interest, has been assigned reasonable assurance. This draft report has been considered as part of the Head of Internal Audit Opinion. Assignments in progress and where the audit field work has been satisfactorily completed have also been considered as part of this process. By way of commentary it should also be noted that there have been no ‘limited assurance’ final reports issued for 2016/17.</td>
</tr>
<tr>
<td>Brought forward Internal Audit assurances</td>
<td>A ‘significant assurance’ Head of Audit opinion was given for the year ended 31 March 2016, and there are no material outstanding matters brought forward that will impact on the Head of Audit Opinion for 2016/17.</td>
</tr>
<tr>
<td>Response to Internal Audit recommendations</td>
<td>There is a formal process in place to follow up on outstanding actions to address issues identified in internal audit reports. Progress against outstanding actions is reported in regular progress reports to the Audit and Risk Committee, with specific attention drawn to any actions where the target date has been deferred, or where no update has been received from officers within the CCG. There are no significant outstanding issues that impact upon the overall opinion.</td>
</tr>
<tr>
<td>Significant factors outside the work of internal audit</td>
<td>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</td>
</tr>
</tbody>
</table>
many of its functions, assurances from third parties are equally as important when the CCG is preparing its Annual Governance Statement. Although we have reviewed the third party reports available, we have not taken account of these in providing our overall Head of Internal Audit Opinion.

It is for the CCG to decide if any of the weaknesses identified in the issued reports should be included within the CCG’s Annual Governance Statement, and that they provide the CCG with sufficient assurance that these key controls were operating throughout the year.

10. **Review of the effectiveness of risk management and internal control**

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

10.1 *Capacity to handle risk*

10.1.1 As Accountable Officer, I have overall responsibility for:
- ensuring the implementation of an effective risk management strategy, including effective risk management systems and internal controls;
- the development of the corporate governance and assurance framework;
- meeting all the statutory requirements and ensuring positive performance towards our strategic objectives.

10.1.2 Each of the executive directors and senior manager leads of the CCG are responsible for:
- co-ordinating operational risk in their specific areas in accordance with the Risk Management Strategy;
- ensuring that all areas of risk are assessed appropriately and action taken to implement improvements;
- ensuring that staff under their management are aware of their risk management responsibilities in relation to the Risk Management Strategy;
- incorporating risk management as a management technique within the performance management arrangements for the organisation.

10.1.3 All managers within the CCG are responsible for implementing the risk management strategy within their span of control and for ensuring that staff understand and apply the relevant policy and strategy in relation to risk management. All staff within the CCG are responsible for assisting in the implementation of the Risk Management Strategy and for highlighting any areas of risk through the incident reporting procedures, a principal means through which the CCG manages risk and learns lessons.
10.1.4 The risk management process has been implemented in accordance with agreed policy by the Chief Finance Officer supported by the Corporate Governance and Risk Manager. Additionally, the Scheme of Delegation clearly sets out the individual level responsibilities held at director level in relation to risk management.

10.2 Review of effectiveness

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

10.2.2 The Governing Body Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its objectives have been reviewed.

10.2.3 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit and Risk Committee, and the Governance, Audit and Risk Committee, and plans to address weaknesses and ensure continuous improvement of the system are in place.

10.2.4 The Corporate Management Team also make a significant contribution to the overall effectiveness of the system. Each director and senior executive has provided an annual assurance statement which describes any significant issues and confirms the work undertaken to manage risk and comply with duties. Furthermore, it has enabled me as Accountable Officer to gain on-going assurance regarding compliance with statutory duties and risk.

10.2.5 The CCG commission and receive support from a number of systems and from a number of organisations. The CCG can seek assurance via a Service Auditor Report, and/or seeking internal audit assurance and/or placing its own internal controls. During the year, the Audit and Risk Committee has reviewed these risks and have provided assurance that systems are in place to minimise the risks and I have placed reliance on them to form this Annual Governance Statement.

- SUS
- NECS System
- Payroll
- Prescribing Spend
- ESR
- Procurement and Creditor Payments
- General Ledger

10.3 My review for 2016/17 is also informed by:
• Regular executive reporting to my executive team (senior executive meeting) and to the Governing Body and escalation processes through the Audit and Risk Committee.
• Third Party Assurance provided for the functions carried out on behalf of the CCG.
• NHS England Assurance processes.

11. Conclusion
My review confirms that NHS Darlington CCG has a sound system of internal control that supports the achievement of its policies, aims and objectives. Where weaknesses have been identified, actions have been put in place for 2016/17.

Ali Wilson
Accountable Officer
30 May 2017
Remuneration and Staff Report

Remuneration report

Remuneration Committee (not subject to audit):
The Remuneration Committee was established to advise the Governing Body about pay, other benefits and terms of employment for the Chief Officer and other senior staff, including the clinical staff of the CCG.

The Remuneration Committee is established in accordance with the CCG’s constitution, standing orders and scheme of delegation. The committee is made up as follows:

- Michelle Thompson, Lay Member (Patient and Public Involvement) - Chair of Remuneration Committee
- Andie MacKay, Lay Member
- Dr Andrea Jones, Chair of the Governing Body
- Dr Angela Galloway, Governing Body Secondary Care Consultant

The Remuneration Committee has delegated authority from the Governing Body to make recommendations on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG. The Chief Officer and the Chief Financial Officer have provided advice and guidance to the committee in relation to pay rates and terms and conditions for its clinical members, although they were specifically excluded from discussions in relation to their own pay rates and terms and conditions. Legal advice was also sought from Hempsons which was obtained in relation to contractual type for GP members of the Governing Body; this was obtained on a regional basis across the North East CCGs.

The remuneration for senior managers for current and future financial years is determined in accordance with relevant guidance, best practice and national policy.

Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to any senior managers during the year and there are no plans to make such payments in future years. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health.

Contracts of employment in relation to all senior managers employed by the CCG are permanent in nature and subject to six months’ notice of termination by either party.

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service, and under the NHS Pension Scheme Regulations for those who are members of the scheme. No awards have been made during the year to past senior managers.
For the purpose of this remuneration report, the definition of ‘senior managers’ is taken from the CCG Annual Reporting Guidance published by NHS England:

*Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Clinical Commissioning Group. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments. It is considered that the Governing Body voting members represent the senior managers of the CCG.*

It is considered that the Governing Body voting members represent the senior managers of the CCG.

**Darlington CCG Senior Officers 2016/17 Declarations of Interests (not subject to audit):**

These are included in the Accountability Report at page 74.
## Darlington CCG Senior Officers Salaries & Allowances 2016/17 (subject to audit):

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>2016/17</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Salary and Fees</td>
<td>Expense Payments (taxable)</td>
<td>Performance Pay and Bonuses</td>
<td>Long-term Performance Pay and Related Bonuses</td>
<td>All Pension Related Benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Bands of £5000)</td>
<td>(Rounded to the nearest £00)</td>
<td>(Bands of £5,000)</td>
<td>(Bands of £5,000)</td>
<td>(Bands of £2,500)</td>
</tr>
<tr>
<td>Dr Andrea Jones</td>
<td>Chair and Medical Director</td>
<td>90 - 95</td>
<td>0</td>
<td>90 - 95</td>
<td>0</td>
<td>90 - 95</td>
</tr>
<tr>
<td>Martin Phillips</td>
<td>Accountable Officer (1st April 2016 to 30th April 2016)</td>
<td>225 - 230</td>
<td>0.5 - 2.5</td>
<td>230 - 235</td>
<td>0</td>
<td>230 - 235</td>
</tr>
<tr>
<td>Ali Wilson</td>
<td>Accountable Officer (1st May 2016 onwards)</td>
<td>70 - 75</td>
<td>13</td>
<td>70 - 75</td>
<td>0</td>
<td>70 - 75</td>
</tr>
<tr>
<td>Lisa Tempest</td>
<td>Chief Finance Officer (1st April to 31st December 2016)</td>
<td>70 - 75</td>
<td>25 - 27.5</td>
<td>100 - 105</td>
<td>0</td>
<td>100 - 105</td>
</tr>
<tr>
<td>Graeme Niven</td>
<td>Chief Finance Officer (1st January onwards)</td>
<td>5 - 10</td>
<td>5</td>
<td>15 - 20</td>
<td>0</td>
<td>15 - 20</td>
</tr>
<tr>
<td>Jackie Kay</td>
<td>Assistant Chief Officer</td>
<td>240 - 245</td>
<td>17.5 - 20</td>
<td>260 - 265</td>
<td>0</td>
<td>260 - 265</td>
</tr>
<tr>
<td>Diane Murphy</td>
<td>Director of Nursing (Employed by County Durham and Darlington FT)</td>
<td>60 - 65</td>
<td>60 - 65</td>
<td>60 - 65</td>
<td>60 - 65</td>
<td>60 - 65</td>
</tr>
<tr>
<td>Dr Jenny Steel</td>
<td>Darlington GP Locality Lead</td>
<td>85 - 90</td>
<td>20 - 22.5</td>
<td>105-110</td>
<td>20 - 22.5</td>
<td>105-110</td>
</tr>
<tr>
<td>Karen Hawkins</td>
<td>Director of Commissioning and Transformation</td>
<td>5 - 10</td>
<td>15 - 17.5</td>
<td>20 – 25</td>
<td>15 - 17.5</td>
<td>20 – 25</td>
</tr>
<tr>
<td>Angela Galloway</td>
<td>Secondary Care Clinician</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Michelle Thompson</td>
<td>Lay Member</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Andie Mackay</td>
<td>Lay Member</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
</tr>
<tr>
<td>John Flook</td>
<td>Lay Member</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
</tr>
</tbody>
</table>
Notes:

Martin Philips took Voluntary Redundancy from the Chief Officer role which took effect the 30th April 2016.

The following Senior Officer is employed by Hartlepool and Stockton-on Tees CCG but has also worked for Darlington CCG for the full year, as interim Chief accountable officer until 30th April 2016, and as Chief Officer for the rest of the year as part of a 50/50 staff sharing arrangement. The salary for this role across the two CCGs is banded between £140,000 to £145,000.

Ali Wilson Chief Officer

The following Senior Officer is employed by Darlington CCG but has worked for Hartlepool and Stockton-on Tees CCG in a joint role from the 1st August 2016 as part of a 50/50 staff sharing arrangement.

John Flook Lay Member (Total salary banding £10k to £15k)
Andie Mackay Lay Member (Total salary banding £10k to £15k)

From the 1st January 2017, the following Senior Officers have worked as part of a shared management staff sharing arrangement across Hartlepool and Stockton-on Tees CCG and Darlington CCG. The salaries disclosed above reflect the remuneration for the period from the 1st January 2017 for Darlington CCG only.

Graeme Niven Chief Finance Officer (Total salary banding £95k to £100k)
Lisa Tempest Director of Performance, Planning & Assurance Lay Member (Total salary banding £90k to £95k)
Karen Hawkins Director of Commissioning & Transformation Lay Member (Total salary banding £80k to £85k)

Andrea Jones GP Chair Jones

2016-17 remuneration consists of £80,424 for Senior Manager roles (Chair and MSK) plus £10,746 for Regional Backpain role

Jenny Steel Darlington GP Locality lead
2016-17 remuneration consists of £65,700 for Senior Manager role plus £22,500 in Clinical Lead role

The remuneration shown in the table above for Jackie Kay includes the agreed package cost of £160,000 for compulsory redundancy. This was as a result of the joint management restructure between Darlington CCG and Hartlepool and Stockton-on-Tees CCG. The cost of £80,000 shown in the payments for loss of office reflect the 50:50 split of the full exit package across the two CCGs.

NHS Darlington CCG Senior Officers Salaries and Allowances 2015/16 (subject to audit):

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>2015/16</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Salary</td>
<td>Expense Payments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Bands of £500)</td>
<td>(Rounded to the nearest £00)</td>
</tr>
<tr>
<td>Dr Andrea Jones</td>
<td>Chair</td>
<td>90 - 95</td>
<td>20 - 22.5</td>
</tr>
<tr>
<td>Martin Phillips</td>
<td>Chief Officer</td>
<td>110 - 115</td>
<td>7.5 - 10</td>
</tr>
<tr>
<td>Lisa Tempest</td>
<td>Chief Finance Officer</td>
<td>115 - 120</td>
<td>35 - 37.5</td>
</tr>
<tr>
<td>Jackie Kay</td>
<td>Assistant Chief Officer</td>
<td>100 - 105</td>
<td>2.5 - 5</td>
</tr>
<tr>
<td>Dr Richard Harker</td>
<td>Quality Lead</td>
<td>25 - 30</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Gill Findley</td>
<td>Director of Nursing (Employed by DDES CCG and recharged 50% of time from 1st April 2015 to 11th May 2015)</td>
<td>5 - 10</td>
<td>45 - 47.5*</td>
</tr>
<tr>
<td>Diane Murphy</td>
<td>Director of Nursing (from 15th June 2015)</td>
<td>45 - 50</td>
<td>45 - 50</td>
</tr>
<tr>
<td>Angela Galloway</td>
<td>Secondary Care Doctor</td>
<td>5 - 10</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Michelle Thompson</td>
<td>Lay Member</td>
<td>10 - 15</td>
<td>10 - 15</td>
</tr>
<tr>
<td>Andie Mackay</td>
<td>Lay Member</td>
<td>10 - 15</td>
<td>10 - 15</td>
</tr>
<tr>
<td>John Flook</td>
<td>Lay Member</td>
<td>10 - 15</td>
<td>10 - 15</td>
</tr>
</tbody>
</table>

Note
* Included All Pension Related Benefits across employers
Payments for loss of office (subject to audit):

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2016/17</th>
<th>2016/17</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>Number</td>
<td>£</td>
</tr>
<tr>
<td>£50,001 to £100,000</td>
<td>1</td>
<td>80,000</td>
<td>-</td>
</tr>
<tr>
<td>Over £200,001</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>80,000</td>
<td>1</td>
</tr>
</tbody>
</table>

Analysis of Other Agreed Departures

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other agreed departures</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>£</td>
<td>Number</td>
</tr>
<tr>
<td>Voluntary redundancies including early retirement contractual costs</td>
<td>1</td>
<td>160,000</td>
</tr>
<tr>
<td>Contractual payments in lieu of notice</td>
<td>1</td>
<td>60,247</td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>220,247</td>
</tr>
</tbody>
</table>

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not the NHS Pensions scheme.

Pay Multiples (subject to audit):

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director 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 Darlington CCG in the financial year 2016/17 was £90,000 to £95,000 (2015/16: £90,000 to £95,000). This was 1.1 times higher (2015/16: 1.5 times higher) than the median remuneration of the workforce, which was £82,434 (2015/16: £61,291).

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

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band of Highest Paid Director’s Total Remuneration (£’000)</td>
<td>90 - 95</td>
<td>90 – 95</td>
</tr>
<tr>
<td>Median Total Remuneration (£)</td>
<td>82,434</td>
<td>61,291</td>
</tr>
<tr>
<td>Ratio</td>
<td>1.1</td>
<td>1.5</td>
</tr>
</tbody>
</table>

The reduction in the ratio between the median remuneration and the highest paid director reflects the increase in the median remuneration figure and reduction in banded remuneration of the highest paid director due to the joint management structure across Darlington and Hartlepool and Stockton-on-Tees CCGs.

There have been no other significant changes to remuneration of other staff within the CCG during the year. Due to the small number of staff employed by the CCG, the median remuneration can be impacted by relatively small changes.
### Darlington CCG Senior Officers’ Pension Benefits 2016/17 (subject to audit):

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</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 2017</th>
<th>Lump sum at pension age related to accrued pension at 31 March 2017</th>
<th>Cash Equivalent Transfer Value at 1 April 2016</th>
<th>Real increase in cash equivalent transfer value at 31 March 2017</th>
<th>Cash Equivalent Transfer Value at 31 March 2017</th>
<th>Employer’s contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Andrea Jones</td>
<td>Chair</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>0</td>
<td>0</td>
<td>203</td>
<td>16</td>
<td>219</td>
<td></td>
</tr>
<tr>
<td>Martin Phillips</td>
<td>Accountable Officer (1st to 30th April 2016)</td>
<td>0 - 2.5</td>
<td>0 – 2.5</td>
<td>40 - 45</td>
<td>0</td>
<td>837</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ali Wilson</td>
<td>Accountable Officer</td>
<td>0</td>
<td>0</td>
<td>50 - 55</td>
<td>155 - 160</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lisa Tempest</td>
<td>Chief Finance Officer (April to December 2016)</td>
<td>0 - 2.5</td>
<td>0</td>
<td>50 - 55</td>
<td>1207</td>
<td></td>
<td>4</td>
<td>1211</td>
<td></td>
</tr>
<tr>
<td>Graeme Niven</td>
<td>Chief Finance Officer (January to March 2017)</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>40 - 45</td>
<td>110 - 115</td>
<td>673</td>
<td>14</td>
<td>730</td>
<td></td>
</tr>
<tr>
<td>Jackie Kay</td>
<td>Assistant Chief Officer</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>567</td>
<td>567</td>
<td>44</td>
<td>4</td>
<td>611</td>
<td></td>
</tr>
<tr>
<td>Karen Hawkins</td>
<td>Director of Commissioning and Transformation (January to March 2017)</td>
<td>0 – 2.5</td>
<td>0 – 2.5</td>
<td>15 - 20</td>
<td>210 - 215</td>
<td>171</td>
<td>10</td>
<td>213</td>
<td></td>
</tr>
<tr>
<td>Diane Murphy</td>
<td>Director of Nursing (Employed by County Durham and Darlington FT)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
Cash Equivalent Transfer Values (subject to audit):

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 pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit 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 Cash Equivalent Transfer Values (subject to audit):

This reflects the increase in CETV effectively funded by the employer. It takes account of 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.

Off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months (not subject to audit):

| Number of existing engagements as of 31 March 2017 | 0 |
| Of which, the number that have existed: |
| for less than one year at the time of reporting | 0 |
| for between one and two years at the time of reporting | 1 |
| for between two and three years at the time of reporting | 0 |
| for between three and four years at the time of reporting | 0 |
| for four or more years at the time of reporting | 0 |

| Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year | 1 |
| 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 | 12 |
Pension liabilities
Details of the accounting for pension liabilities can be found in the accounting policies and pension costs notes in the CCG’s financial statements (notes 1.9 and 4.5 respectively). Further details of directors’ pension benefits can be found on 113.

Workforce Overview 2016/17

Details of staff numbers are included in note 3.2 of the financial statements.

Sickness Absence Data:

Details of sickness absence data are included in note 3.3 of the financial statements.

The CCG monitors its sickness absence and follows an approved policy.

Gender makeup of the CCG:

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Body members including all very senior managers</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>CCG employees (excluding Governing Body Members)</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

Staff policies and equal opportunities for staff
We can demonstrate fair and equitable recruitment, workforce engagement and employment terms and conditions to ensure levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work, and work rated as of equal value, being entitled to equal pay.
Expenditure on consultancy
There has been no expenditure on consultancy in 2016/17.

Two Tick Disability Symbol
The CCG has successfully renewed its accreditation as a Two Tick Disability employer for 2016/17. The symbol, awarded by Jobcentre Plus, demonstrates our commitment to employ, retain and develop the abilities of disabled staff.

As a Two Tick Disability Symbol employer we have displayed five commitments regarding recruitment, training, retention, consultation and disability awareness:

• To interview all disabled applicants who meet the minimum criteria for a job vacancy and to consider them on their abilities.
• To discuss with disabled employees, at any time but at least once a year, what both parties can do to make sure disabled employees can develop and use their abilities.
• To make every effort when employees become disabled to make sure they stay in employment.
• To take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work.
• To review these commitments each year and assess what has been achieved, plan ways to improve on them and let employees and Jobcentre Plus know about progress and future plans.

Ali Wilson
Accountable Officer
30 May 2017
Parliamentary Accountability and Audit Report

NHS Darlington CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at Appendix 1. An audit certificate and report is also included in this Annual Report at Appendix 2.
# Financial statements

## NHS Darlington CCG Financial Statements for the year ended 31 March 2017

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<tr>
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</tr>
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Statement of Comprehensive Net Expenditure for the year ended
31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2016/17 £000</th>
<th>2015/16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration costs and programme expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross employee benefits 3.1</td>
<td>1,078</td>
<td>660</td>
</tr>
<tr>
<td>Other costs 4</td>
<td>160,356</td>
<td>144,184</td>
</tr>
<tr>
<td>Other operating revenue 2</td>
<td>(255)</td>
<td>(236)</td>
</tr>
<tr>
<td>Net operating costs before interest</td>
<td>161,179</td>
<td>144,608</td>
</tr>
<tr>
<td>Investment revenue 7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other (gains)/losses 8</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Finance costs 9</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>161,179</td>
<td>144,608</td>
</tr>
</tbody>
</table>

Of which:

Administration costs

Gross employee benefits 3.1 | 800 | 479 |
| Other costs 4 | 1,469 | 1,874 |
| Other operating revenue 2 | - | - |
| Net administration costs before interest | 2,269 | 2,353 |

Programme expenditure

Gross employee benefits 3.1 | 278 | 181 |
| Other costs 4 | 158,887 | 142,310 |
| Other operating revenue 2 | (255) | (236) |
| Net programme expenditure before interest | 158,910 | 142,255 |

Total comprehensive net expenditure for the year | 161,179 | 144,608 |
### Statement of Financial Position as at 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 2017</th>
<th>31 March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>11</td>
<td>2,753</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>12</td>
<td>34</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td><strong>2,787</strong></td>
<td><strong>2,308</strong></td>
</tr>
<tr>
<td>Total assets</td>
<td><strong>2,787</strong></td>
<td><strong>2,308</strong></td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>13</td>
<td>(8,489)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td><strong>(8,489)</strong></td>
<td><strong>(10,859)</strong></td>
</tr>
<tr>
<td><strong>Total assets less total current liabilities</strong></td>
<td><strong>(5,702)</strong></td>
<td><strong>(8,551)</strong></td>
</tr>
</tbody>
</table>

**Financed by taxpayers’ equity**

<table>
<thead>
<tr>
<th></th>
<th>31 March 2017</th>
<th>31 March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity</strong></td>
<td><strong>(5,702)</strong></td>
<td><strong>(8,551)</strong></td>
</tr>
</tbody>
</table>

The notes on pages 5 to 21 of the Annual Report form part of this statement.

The financial statements on pages 1 to 21 of the Annual Report were approved and authorised for issue by the Governing Body on 30th May 2017 and signed on its behalf by:

Ali Wilson
Accountable Officer, NHS Darlington CCG
May 2017
### Statement of Changes In Taxpayers' Equity for the year ended 31 March 2017

<table>
<thead>
<tr>
<th></th>
<th>General fund</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2016</strong></td>
<td>(8,551)</td>
<td>(8,551)</td>
</tr>
<tr>
<td><strong>Changes in CCG taxpayers’ equity for 2016/17</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(161,179)</td>
<td>(161,179)</td>
</tr>
<tr>
<td><strong>Net recognised CCG expenditure for the financial year</strong></td>
<td>(161,179)</td>
<td>(161,179)</td>
</tr>
<tr>
<td>Net Parliamentary funding</td>
<td>164,028</td>
<td>164,028</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2017</strong></td>
<td>(5,702)</td>
<td>(5,702)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>General fund</th>
<th>Total reserves</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2015</strong></td>
<td>(7,456)</td>
<td>(7,456)</td>
</tr>
<tr>
<td><strong>Changes in CCG taxpayers’ equity for 2015/16</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(144,608)</td>
<td>(144,608)</td>
</tr>
<tr>
<td><strong>Net recognised CCG expenditure for the financial year</strong></td>
<td>(144,608)</td>
<td>(144,608)</td>
</tr>
<tr>
<td>Net Parliamentary funding</td>
<td>143,513</td>
<td>143,513</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2016</strong></td>
<td>(8,551)</td>
<td>(8,551)</td>
</tr>
<tr>
<td>Note</td>
<td>2016/17 £000</td>
<td>2015/16 £000</td>
</tr>
<tr>
<td>------</td>
<td>--------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Cash flows from operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(161,179)</td>
<td>(144,608)</td>
</tr>
<tr>
<td>(Increase) in trade and other receivables</td>
<td>11</td>
<td>(468)</td>
</tr>
<tr>
<td>(Decrease) / Increase in trade and other payables</td>
<td>13</td>
<td>(2,370)</td>
</tr>
<tr>
<td>Net cash outflow from operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(164,017)</td>
<td>(143,529)</td>
</tr>
<tr>
<td>Net cash outflow before financing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(164,017)</td>
<td>(143,529)</td>
</tr>
<tr>
<td>Cash flows from financing activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net funding received</td>
<td>164,028</td>
<td>143,513</td>
</tr>
<tr>
<td>Net cash inflow from financing activities</td>
<td></td>
<td>164,028</td>
</tr>
<tr>
<td>Net increase / (decrease) in cash and cash equivalents</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Cash and cash equivalents at the beginning of the financial year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>39</td>
</tr>
<tr>
<td>Cash and cash equivalents at the end of the financial year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>34</td>
<td>23</td>
</tr>
</tbody>
</table>
1 Accounting Policies

NHS England has directed that the financial statements of CCGs 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 2016/17 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 CCGs, 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 CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG 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.

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

1.2 Accounting Convention

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

1.3 Acquisitions and Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006, the CCG 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 CCG is in a “jointly controlled operation”, the CCG recognises:

- the assets the CCG controls;
- the liabilities the CCG incurs;
- the expenses the CCG incurs; and,
- the CCG’s share of the income from the pooled budget activities.

If the CCG is involved in a “jointly controlled assets” arrangement, in addition to the above, the CCG recognises:

- the CCG’s share of the jointly controlled assets (classified according to the nature of the assets);
- the CCG’s share of any liabilities incurred jointly; and,
- the CCG’s share of the expenses jointly incurred.

1.6 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

In the application of the CCG’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.

1.6.1 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 CCG’s accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- determining whether income and expenditure should be disclosed as either administrative or programme expenditure;
- determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets; and
- determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare.

1.6.2 Key Sources of Estimation Uncertainty

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

- the assumptions applied in the estimation of activity not yet invoiced, including partially completed treatment spells as at the Statement of Financial Position date;
- the estimate of potential future liabilities in respect of continuing healthcare services; and
- to estimate an accrual for two months of prescribing expenditure based on the ten months of actual charges received from the Prescription Pricing Division.

1.7 Revenue

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

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

1.8.1 Short-term Employee Benefits

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

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

1.8.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pension 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 CCG 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 CCG commits itself to the retirement, regardless of the method of payment.

1.9 Other Expenses

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

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

1.10 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.

1.10.1 The CCG 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.

1.11 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the CCG’s cash management.
Notes to the financial statements (continued)

1. Accounting policies (continued)

1.12 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (2015/16: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (2015/16: minus 1%)
- Timing of cash flows (over 10 years): Minus 0.80% (2015/16: plus 0.80%)

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

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

1.13 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which the CCG 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 CCG.

1.14 Non-clinical Risk Pooling

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG 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.

1.15 Continuing healthcare risk pooling

In 2014/15, a risk pool scheme was been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Any claims after the 31 March 2013 are managed as part of the CCGs normal business. Under the scheme, CCGs contribute annually to a pooled fund, which is used to settle the claims.

1.16 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 CCG, 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 CCG. 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. Accounting policies (continued)

1.17 Financial Assets

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

Financial assets are classified into the following categories:
- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and
- Loans and receivables.

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

All CCG assets have been classified as loans and receivables.

1.17.1 Loans and Receivables

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the CCG 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.

1.18 Financial Liabilities

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

1.18.1 Other Financial Liabilities

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

1. Accounting policies (continued)

1.19 Value Added Tax

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

1.20 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 that individual cases are handled.

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

1.21 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016/17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH group bodies)
- IFRS 15: Revenue for Contracts with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016/17, were they applied in that year.

2. Other Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Admin £000</th>
<th>2016/17 Programme £000</th>
<th>2016/17 Total £000</th>
<th>2015/16 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient care services to other bodies</td>
<td>-</td>
<td>255</td>
<td>255</td>
<td>236</td>
</tr>
<tr>
<td>Total other operating revenue</td>
<td>-</td>
<td>255</td>
<td>255</td>
<td>236</td>
</tr>
</tbody>
</table>

Programme revenue is revenue received that is directly attributable to the provision of healthcare or healthcare services.

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

Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.
### 3. Employee benefits and staff numbers

#### 3.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Total</th>
<th>2016/17 Permanent</th>
<th>2016/17 Other</th>
<th>2015/16 Total</th>
<th>2015/16 Permanent</th>
<th>2015/16 Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>£651</td>
<td>£651</td>
<td>-</td>
<td>£398</td>
<td>£392</td>
<td>£6</td>
</tr>
<tr>
<td>Social security costs</td>
<td>£59</td>
<td>£59</td>
<td>-</td>
<td>£34</td>
<td>£34</td>
<td>0</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>£68</td>
<td>£68</td>
<td>-</td>
<td>£47</td>
<td>£47</td>
<td>0</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>£300</td>
<td>£300</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gross employee benefits expenditure</td>
<td>£1,078</td>
<td>£1,078</td>
<td>-</td>
<td>£800</td>
<td>£800</td>
<td>-</td>
</tr>
</tbody>
</table>

#### 3.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Number</th>
<th>2016/17 Permanently employed</th>
<th>2016/17 Other</th>
<th>2015/16 Number</th>
<th>2015/16 Permanently employed</th>
<th>2015/16 Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>13</td>
<td>13</td>
<td>-</td>
<td>12</td>
<td>12</td>
<td>-</td>
</tr>
</tbody>
</table>

None of the above people were engaged on capital projects (2015/16: none).

#### 3.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Number</th>
<th>2016/17</th>
<th>2015/16 Number</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>48</td>
<td>213</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>11</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average working days lost</td>
<td>4.5</td>
<td>23.7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The staff sickness absence data for 2016/17 is based on the 12 months ended 31 December 2016 (2015/16: 12 months ended 31 December 2015).

No staff retired early on ill health grounds during the financial year (2015/16: none).

#### 3.4 Exit packages agreed in the financial year

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Compulsory redundancies</th>
<th>2016/17 Other agreed departures</th>
<th>2016/17 Total</th>
<th>2015/16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compulsory redundancies Number</td>
<td>£80,000</td>
<td>£220,247</td>
<td>£300,247</td>
<td>£160,000</td>
</tr>
<tr>
<td>Over £200,001</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>£80,000</td>
<td>£220,247</td>
<td>£300,247</td>
<td>£160,000</td>
</tr>
</tbody>
</table>

**Analysis of Other Agreed Departures**

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voluntary redundancies including early retirement contractual costs</td>
<td>-</td>
<td>160,000</td>
<td>-</td>
</tr>
<tr>
<td>Contractual payments in lieu of notice</td>
<td>-</td>
<td>60,247</td>
<td>60,247</td>
</tr>
<tr>
<td>Total</td>
<td>£220,247</td>
<td>£220,247</td>
<td>-</td>
</tr>
</tbody>
</table>

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not the NHS Pensions scheme.
Notes to the financial statements (continued)

3. Employee benefits and staff numbers (continued)

3.5 Pension costs

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

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP 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 CCG of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

3.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at www.nhsbsa.nhs.uk/pensions.

For 2016/17, employer’s contributions of £67,485 (2015/16: £68,416) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The Scheme’s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of Note 3.1.
### 4. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2016/17 Admin £000</th>
<th>2016/17 Programme £000</th>
<th>2016/17 Total £000</th>
<th>2015/16 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>416</td>
<td>278</td>
<td>694</td>
<td>247</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>384</td>
<td>-</td>
<td>384</td>
<td>413</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>800</td>
<td>278</td>
<td>1,078</td>
<td>660</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>1,015</td>
<td>776</td>
<td>1,791</td>
<td>2,192</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>-</td>
<td>98,312</td>
<td>98,312</td>
<td>97,515</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>-</td>
<td>303</td>
<td>303</td>
<td>205</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>-</td>
<td>26,124</td>
<td>26,124</td>
<td>23,722</td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>137</td>
<td>-</td>
<td>137</td>
<td>162</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>4</td>
<td>301</td>
<td>305</td>
<td>657</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>35</td>
<td>-</td>
<td>35</td>
<td>7</td>
</tr>
<tr>
<td>Establishment</td>
<td>23</td>
<td>17</td>
<td>40</td>
<td>17</td>
</tr>
<tr>
<td>Transport</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Premises</td>
<td>152</td>
<td>415</td>
<td>567</td>
<td>463</td>
</tr>
<tr>
<td>Impairments and reversals of receivables</td>
<td>-</td>
<td>12</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>Audit fees</td>
<td>49</td>
<td>-</td>
<td>49</td>
<td>54</td>
</tr>
<tr>
<td>Other non statutory audit expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Internal audit services</td>
<td>30</td>
<td>-</td>
<td>30</td>
<td>-</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>-</td>
<td>18,352</td>
<td>18,352</td>
<td>18,097</td>
</tr>
<tr>
<td>Pharmaceutical services</td>
<td>-</td>
<td>93</td>
<td>93</td>
<td>94</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>-</td>
<td>13,737</td>
<td>13,737</td>
<td>2</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>15</td>
<td>74</td>
<td>89</td>
<td>80</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>3</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Education and training</td>
<td>5</td>
<td>12</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>CHC Risk Pool contributions</td>
<td>-</td>
<td>359</td>
<td>359</td>
<td>898</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>1,469</td>
<td>158,887</td>
<td>160,356</td>
<td>144,184</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>2,269</td>
<td>159,165</td>
<td>161,434</td>
<td>144,844</td>
</tr>
</tbody>
</table>
5.1 Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2016/17</th>
<th>2016/17</th>
<th>2015/16</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£000</td>
<td>Number</td>
<td>£000</td>
</tr>
<tr>
<td>Non-NHS Payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the year</td>
<td>8,034</td>
<td>42,200</td>
<td>6,767</td>
<td>23,762</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>7,921</td>
<td>40,827</td>
<td>6,637</td>
<td>23,310</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>98.59%</td>
<td>96.75%</td>
<td>98.08%</td>
<td>98.10%</td>
</tr>
<tr>
<td>NHS Payables</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade invoices paid in the year</td>
<td>1,708</td>
<td>104,704</td>
<td>1,420</td>
<td>102,006</td>
</tr>
<tr>
<td>Total NHS Trade invoices paid within target</td>
<td>1,691</td>
<td>104,559</td>
<td>1,411</td>
<td>101,969</td>
</tr>
<tr>
<td>Percentage of NHS Trade invoices paid within target</td>
<td>99.00%</td>
<td>99.86%</td>
<td>99.37%</td>
<td>99.96%</td>
</tr>
</tbody>
</table>

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

5.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no payments made in respect of late payments of commercial debts in 2016/17 (2015/16: none).

6. Income Generation Activities

The CCG does not undertake any income generation activities (2015/16: none).

7. Investment revenue

There was no investment revenue in 2016/17 (2015/16: none).

8. Other (gains) and losses

There were no other (gains) and losses in 2016/17 (2015/16: none).

9. Finance costs

There were no finance costs in 2016/17 (2015/16: none).
Notes to the financial statements (continued)

10. Operating Leases

10.1 As lessee

The CCG 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.

The CCG occupies property owned and managed by NHS Property Services Limited. The charges shown in note 10.1.1 from NHS Property Services Limited are intended to reflect the cost of occupancy, or void space, attributable to the CCG. During 2015/16, this was calculated on a cost recovery basis by NHS Property Services Limited. For 2016/17 this charging mechanism changed with charges from NHS Property Services Limited now based on market rents.

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

10.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Buildings</td>
<td>Other</td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td>Minimum lease payments</td>
<td>567</td>
<td>1</td>
<td>568</td>
<td>454</td>
</tr>
<tr>
<td>Total</td>
<td>567</td>
<td>1</td>
<td>568</td>
<td>454</td>
</tr>
</tbody>
</table>

10.1.2 Future minimum lease payments

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Payable:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
</tbody>
</table>
11. Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>1,018</td>
<td>317</td>
<td>1,746</td>
<td>-</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>166</td>
<td>45</td>
<td>107</td>
<td>-</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>1,387</td>
<td>45</td>
<td>45</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>70</td>
<td>107</td>
<td>16</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA prepayments</td>
<td>69</td>
<td>16</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>37</td>
<td>50</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provision for the impairment of receivables</td>
<td>(12)</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>VAT</td>
<td>18</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other receivables</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Trade and other receivables</strong></td>
<td>2,753</td>
<td>2,285</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The great majority of trade is with other NHS bodies, including other CCGs as commissioners for NHS patient care services. As CCGs are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary.

11.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th>Time Period</th>
<th>31 March 2017</th>
<th>31 March 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>

The CCG did not hold any collateral against receivables outstanding at 31 March 2017 (31 March 2016: none).

11.2 Provision for impairment of receivables

<table>
<thead>
<tr>
<th>Year</th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2016</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>(Increase) in receivables impaired</td>
<td>(12)</td>
<td>-</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2017</strong></td>
<td>(12)</td>
<td>-</td>
</tr>
</tbody>
</table>

The CCG has reviewed all receivables to determine whether an impairment value is required. In determining the recoverability of a receivable, the CCG considers any change in credit quality of the receivable from the date credit was initially granted up to 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.
12. Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2016/17 £000</th>
<th>2015/16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April</td>
<td>23</td>
<td>39</td>
</tr>
<tr>
<td>Net change in year</td>
<td>11</td>
<td>(16)</td>
</tr>
<tr>
<td><strong>Balance at 31 March</strong></td>
<td><strong>34</strong></td>
<td><strong>23</strong></td>
</tr>
</tbody>
</table>

**Made up of:**
- Cash with the Government Banking Service | 34 | 23 |
- **Cash and cash equivalents as in Statement of Financial Position** | 34 | 23 |

The CCG held £nil cash and cash equivalents at 31 March 2017 on behalf of patients (31 March 2016: £nil).

13. Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 2016/17 £000</th>
<th>Non-current 2016/17 £000</th>
<th>Current 2015/16 £000</th>
<th>Non-current 2015/16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>1,436</td>
<td>-</td>
<td>2,634</td>
<td>-</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>270</td>
<td>-</td>
<td>1,152</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>1,738</td>
<td>-</td>
<td>2,899</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>4,781</td>
<td>-</td>
<td>4,121</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and Other WGA deferred income</td>
<td>58</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social security costs</td>
<td>7</td>
<td>-</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Tax</td>
<td>10</td>
<td>-</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Other payables</td>
<td>189</td>
<td>-</td>
<td>37</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Trade and Other Payables</strong></td>
<td><strong>8,489</strong></td>
<td>-</td>
<td><strong>10,859</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

| Total current and non-current        | **8,489**            | **10,859**               |

At 31 March 2017, the CCG had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2016: none).

Other payables include £87k in respect of outstanding pension contributions at 31 March 2017 (31 March 2016: £12k).


There were no provisions to recognise in the financial statements at 31 March 2017 (31 March 2016: none).

15. Contingencies

There were no contingent assets or liabilities at 31 March 2017 (31 March 2016: none).
Notes to the financial statements (continued)

16. Commitments

There were no contracted or non-cancellable contracts entered into by the CCG at 31 March 2017 which are not otherwise included in these financial statements (31 March 2016: none).

17. Financial instruments

17.1 Financial risk management

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

As the CCG 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 CCG 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 CCG in undertaking its activities.

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

17.1.1 Currency risk

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

17.1.2 Interest rate risk

The CCG has no borrowings and has only limited powers to borrow funds from government for capital expenditure, subject to affordability as confirmed by NHS England. The CCG therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

Because the majority of the CCG’s revenue comes from parliamentary funding, the CCG 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.

17.1.4 Liquidity risk

The CCG is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.
17. Financial instruments (continued)

17.2 Financial assets

<table>
<thead>
<tr>
<th>Receivables:</th>
<th>Loans and Receivables 2016/17 £000</th>
<th>Total 2016/17 £000</th>
<th>Loans and Receivables 2015/16 £000</th>
<th>Total 2015/16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016/17</td>
<td>2015/16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS</td>
<td>2,405</td>
<td>362</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-NHS</td>
<td>95</td>
<td>157</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>34</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other financial assets</td>
<td>-</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Total at 31 March</strong></td>
<td><strong>2,534</strong></td>
<td><strong>543</strong></td>
<td></td>
<td><strong>543</strong></td>
</tr>
</tbody>
</table>

17.3 Financial liabilities

<table>
<thead>
<tr>
<th>Payables:</th>
<th>Other 2016/17 £000</th>
<th>Total 2016/17 £000</th>
<th>Other 2015/16 £000</th>
<th>Total 2015/16 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016/17</td>
<td>2015/16</td>
<td>2016/17</td>
<td>2015/16</td>
</tr>
<tr>
<td>NHS</td>
<td>1,706</td>
<td>3,786</td>
<td>1,706</td>
<td>3,786</td>
</tr>
<tr>
<td>Non-NHS</td>
<td>6,708</td>
<td>7,057</td>
<td>6,708</td>
<td>7,057</td>
</tr>
<tr>
<td><strong>Total at 31 March</strong></td>
<td><strong>8,414</strong></td>
<td><strong>10,843</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. Operating segments

The CCG has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the CCG’s Governing Body, considered to be the ‘chief operating decision maker’ of the CCG, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the CCG relates to its role as a commissioner of healthcare for its relevant population. As a result, the CCG considers that it has only one operating segment, being the commissioning of healthcare services.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the statement of comprehensive net expenditure and statement of financial position respectively.

19. Pooled budgets

The CCG entered into a pooled budget arrangement with Darlington Borough Council in respect of the Better Care Fund, with effect from 1 April 2015, through a section 75 agreement. Details can be found on page 14 of the Annual Report.

The CCG contribution to the pooled budget in 2016/17 was £7,056k which was used to commission a range of health and social care services in line with the agreed objectives of the Better Care Fund (2015/16: £8,138k). This contribution to the Better Care Fund is recognised within the financial statements as CCG expenditure.

No other pooled budget arrangements are in place.
20. Related party transactions

During the year the CCG has undertaken transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

<table>
<thead>
<tr>
<th>CCG Governing Body</th>
<th>Job Title</th>
<th>Dates</th>
<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>M Phillips</td>
<td>Accountable Officer</td>
<td>01/04/2016 - 30/04/2016</td>
<td>County Durham &amp; Darlington NHS FT</td>
<td>74,408</td>
<td>-</td>
<td>441</td>
<td>1,972</td>
</tr>
<tr>
<td>L Tempest</td>
<td>Chief Finance Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>North Tees &amp; Hartlepool NHS FT</td>
<td>1,290</td>
<td>-</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>L Tempest</td>
<td>Director of Performance, Planning, and Assurance</td>
<td>01/01/2017 - 31/03/2017</td>
<td>NHS Hartlepool &amp; Stockton on Tees CCG</td>
<td>-</td>
<td>131</td>
<td>123</td>
<td>136</td>
</tr>
<tr>
<td>A Wilson</td>
<td>Chief Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>Academic Health Science Network</td>
<td>12</td>
<td>35</td>
<td>13</td>
<td>-</td>
</tr>
<tr>
<td>A Wilson</td>
<td>Chief Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>NHS Hartlepool &amp; Stockton on Tees CCG</td>
<td>-</td>
<td>131</td>
<td>123</td>
<td>136</td>
</tr>
<tr>
<td>A Wilson</td>
<td>Chief Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>County Durham &amp; Darlington NHS FT (North East Leadership academy element)</td>
<td>74,408</td>
<td>-</td>
<td>441</td>
<td>1,972</td>
</tr>
<tr>
<td>A Wilson</td>
<td>Chief Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>NHS Hartlepool &amp; Stockton on Tees CCG</td>
<td>-</td>
<td>131</td>
<td>123</td>
<td>136</td>
</tr>
<tr>
<td>G Niven</td>
<td>Chief Finance Officer</td>
<td>01/01/2017 - 31/03/2017</td>
<td>NHS Hartlepool &amp; Stockton on Tees CCG</td>
<td>-</td>
<td>131</td>
<td>123</td>
<td>136</td>
</tr>
<tr>
<td>J Piosk</td>
<td>Lay Member Governance</td>
<td>01/01/2017 - 31/03/2017</td>
<td>NHS Hartlepool &amp; Stockton on Tees CCG</td>
<td>-</td>
<td>131</td>
<td>123</td>
<td>136</td>
</tr>
</tbody>
</table>

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

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

- NHS England;
- NHS Litigation Authority; and,
- NHS Foundation Trusts;
- NHS Business Services Authority.

In addition, the CCG 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 Darlington Borough Council.

The increase in related parties disclosed in the table above relate to the Joint Management Structure from the 1st January 2017, where CCG Governing Members are jointly appointed across Darlington CCG and Hartlepool and Stockton-on-Tees CCG.

2015/16 comparative figures:

During 2015/16 the CCG undertook transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

<table>
<thead>
<tr>
<th>CCG Governing Body</th>
<th>Job Title</th>
<th>Related Party</th>
<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>M Phillips</td>
<td>Accountable Officer</td>
<td>01/04/2015 - 31/03/2016</td>
<td>County Durham &amp; Darlington NHS FT</td>
<td>71,138</td>
<td>-</td>
<td>1,755</td>
<td>222</td>
</tr>
<tr>
<td>L Tempest</td>
<td>Chief Finance Officer</td>
<td>01/04/2015 - 31/03/2016</td>
<td>North Tees &amp; Hartlepool NHS FT</td>
<td>1,422</td>
<td>-</td>
<td>5</td>
<td>58</td>
</tr>
<tr>
<td>A Wilson</td>
<td>Acting Accountable Officer</td>
<td>01/04/2015 - 31/03/2016</td>
<td>Academic Health Science Network</td>
<td>24</td>
<td>-</td>
<td>14</td>
<td>-</td>
</tr>
<tr>
<td>A Wilson</td>
<td>Acting Accountable Officer</td>
<td>01/04/2015 - 31/03/2016</td>
<td>NHS Hartlepool &amp; Stockton on Tees CCG</td>
<td>35</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dr R Harker</td>
<td>Quality Lead</td>
<td>01/04/2015 - 31/03/2016</td>
<td>Whinfield Medical Practice</td>
<td>94</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>M Thompson</td>
<td>Lay Member</td>
<td>01/04/2015 - 31/03/2016</td>
<td>MacMillan Cancer Support</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>13</td>
</tr>
<tr>
<td>A Galloway</td>
<td>Secondary Care Clinician</td>
<td>01/04/2015 - 31/03/2016</td>
<td>St Cuthberts Hospice</td>
<td>158</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>A Galloway</td>
<td>Secondary Care Clinician</td>
<td>01/04/2015 - 31/03/2016</td>
<td>NHS North Durham CCG</td>
<td>-</td>
<td>1</td>
<td>501</td>
<td>129</td>
</tr>
<tr>
<td>A Galloway</td>
<td>Secondary Care Clinician</td>
<td>01/04/2015 - 31/03/2016</td>
<td>North of England Commissioning Support</td>
<td>1,813</td>
<td>19</td>
<td>76</td>
<td>46</td>
</tr>
<tr>
<td>Dr J Steel</td>
<td>Locality Lead GP</td>
<td>01/04/2015 - 31/03/2016</td>
<td>Primary Healthcare Darlington</td>
<td>200</td>
<td>-</td>
<td>-</td>
<td>74</td>
</tr>
<tr>
<td>Dr J Steel</td>
<td>Locality Lead GP</td>
<td>01/04/2015 - 31/03/2016</td>
<td>Bayer PLC</td>
<td>-</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>K Azam</td>
<td>Interim Director of Commissioning</td>
<td>01/05/2016 - 31/10/2016</td>
<td>North of England Commissioning Support</td>
<td>1,813</td>
<td>19</td>
<td>76</td>
<td>46</td>
</tr>
<tr>
<td>A Mackay</td>
<td>Lay Member</td>
<td>01/01/2017 - 31/03/2017</td>
<td>NHS Hartlepool &amp; Stockton on Tees CCG</td>
<td>-</td>
<td>131</td>
<td>123</td>
<td>136</td>
</tr>
<tr>
<td>J Piosk</td>
<td>Lay Member Governance</td>
<td>01/01/2017 - 31/03/2017</td>
<td>NHS Hartlepool &amp; Stockton on Tees CCG</td>
<td>-</td>
<td>131</td>
<td>123</td>
<td>136</td>
</tr>
</tbody>
</table>

All of these transactions were undertaken under standard terms and conditions in the normal course of business.
21. Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the CCG.

22. Losses and special payments

There was 1 special payment in 2016/17 for £60k relating to contractual payments in lieu of notice and 2 losses for £12k relating to administrative write-offs (2015/16: none).

23. Financial performance targets

CCGs have a number of financial duties under the NHS Act 2006 (as amended). The CCG’s performance against those duties was as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>164,542</td>
<td>146,376</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>164,542</td>
<td>146,376</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>14,083</td>
<td>-</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>2,295</td>
<td>2,353</td>
</tr>
</tbody>
</table>

The CCG received no capital resource during 2016/17 and incurred no capital expenditure (2015/16: none).

Performance against the revenue expenditure duties is further analysed below:

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Resource</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Administration Resource</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Total</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Revenue resource</td>
<td>162,247</td>
<td>144,008</td>
</tr>
<tr>
<td>Net operating cost for the financial year</td>
<td>158,910</td>
<td>142,255</td>
</tr>
<tr>
<td>Underspend against revenue resource</td>
<td>3,337</td>
<td>1,753</td>
</tr>
</tbody>
</table>

During 2016/17, all CCGs were mandated by NHS England to hold 1% of their total funding allocation uncommitted as a ‘risk reserve’. For Darlington CCG this equated to £1,592k. In March 2017, NHS England confirmed that all CCGs were required to increase their surplus by the value of this risk reserve. This has resulted in the increase in underspend against revenue resource in 2016/17 shown above.
INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS DARLINGTON CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Darlington Clinical Commissioning Group for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. The financial statements 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 the related notes 1 to 23. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (“IFRSs”) as adopted by the European Union, and as interpreted and adapted by the 2016/17 HM Treasury’s Financial Reporting Manual (“the 2016/17 FReM”) as contained in the Department of Health Group Accounting Manual 2016/17 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (“the Accounts Direction”).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior officers on page 108 and related narrative notes on pages 109 to 110;
- the table of pension benefits of senior officers on pages 113 to 114;
- disclosure of payments for loss of office on page 111;
- the analysis of staff numbers on page 116; and
- the table of pay multiples and related narrative notes on pages 111 and 112.

This report is made solely to the members of the Governing Body of NHS Darlington Clinical Commissioning Group in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members 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 members as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities set out on pages 78 and 79, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (“the Code of Audit Practice”).
As explained in the Governance Statement, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG’s resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

**Scope of the audit of the financial statements**

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the CCG’s circumstances and have been consistently applied and adequately disclosed;

- the reasonableness of significant accounting estimates made by the Accountable Officer; and

- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

**Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources**

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 2016, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. 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 2017.
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 form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

**Opinion on regularity**

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

**Opinion on the financial statements**

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Darlington Clinical Commissioning Group as at 31 March 2017 and of its net operating costs for the year then ended; and

- have been properly prepared in accordance with the Health and Social Care Act 2012 and the Accounts Direction issued thereunder.

**Opinion on other matters**

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Annual Report Directions made under the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012); and

- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

**Matters on which we are required to report by exception**

We are required to report to you if:

- in our opinion, the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board; or

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

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
• we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in these respects.

Certificate

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

Nicola Wright
for and on behalf of Ernst & Young LLP
Newcastle upon Tyne
May 2017

The maintenance and integrity of the NHS Darlington Clinical Commissioning Group web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.