Appendix 1

Annual Reports and Accounts 2017-18

Annual Governance Statement

1.0 Introduction and context

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

1.2 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.

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

2.0 Scope of responsibility

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

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

3.0 Governance arrangements and effectiveness

3.1 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.

3.2 The Membership has retained the power to make changes to its core constitution but has delegated the majority of the decision making functions to the CCG's Governing Body. The Governing Body has, in turn, delegated some decision making to the organisation's committees. Further information relating to the delegated responsibility to each of the committees is detailed in the Annual Report and Accounts 2017/18 and Terms of Reference (see pages 43 to 45).

4.0 UK Corporate Governance Code

4.1 NHS Dorset Clinical Commissioning Group is not required to comply with the UK Code of Corporate Governance. 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 Clinical Commissioning Group and best practice.

4.2 From 1 April 2016 and up to the date of signing this statement, the CCG has complied with the provisions set out in the NHS Clinical Commissioning Group's Code of Governance and applied the principles of the Code.

4.3 New governance structures have been introduced which take into account the transformation work streams under the Sustainability and Transformation plans, which will be instrumental in the design, engagement, commissioning and delivery of new services, including services impacting on primary care providers.

4.4 'Declarations of interest' is a standing agenda item at all CCG meetings. All declarations are recorded and, where any conflict of interest is identified, appropriate action is taken. (See page 45)

4.5 Under the comply or explain principle, the CCG does not comply with Statutory Guidance issued regarding conflicts of interest and voting rights in respect of GPs on the Primary Care Commissioning Committee. We believe that having two classes of members, one with and one without voting rights would be detrimental to good governance. We have instead introduced a presumption that GPs will be conflicted from voting or participation in discussion on papers presented to the Committee unless they declare that they are not conflicted.

5.0 Discharge of Statutory Function

5.1 I can confirm that the correct arrangements are in place for the discharge of statutory functions.

5.2 During establishment, the arrangements put in place by the CCG and explained within the UK Corporate Governance Code were developed with extensive expert external legal input to ensure compliance with all the relevant legislation. The legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

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

6.0 Risk Management arrangements and effectiveness

6.1 The CCG has a low appetite for operational risk. It monitors resources and quality closely to ensure operational risks are acceptable to the organisation. The CCG however recognises that to lead the health system, it needs to be bold and courageous, to ensure sustainability for the future. Acknowledgement and acceptance of a higher level of risk may sometimes be necessary to facilitate innovation in the delivery of services.

6.2 Every activity that the CCG undertakes or commissions others to undertake on its behalf, brings with it an element of risk that has the potential to threaten or prevent the organisation achieving its strategic objectives. Unmanaged risk can affect people, assets, the organisation and reputation and ultimately be of detriment to the population the CCG serves.

6.3 The process of appropriately managing identified risk helps the CCG achieve agreed standards, reduce overall costs and maintain and enhance the standard of service provided.

6.4 The CCG is not aiming to create a risk-free environment, but rather one in which risk is considered as a matter of course and appropriately identified, controlled and managed.

6.5 In order to achieve this aim, risk management must be part of the culture of the CCG and a primary concern of all staff and stakeholders.

6.6 The CCG also actively deters risks through the adoption of robust counter-fraud methodology. All clinical and non-clinical staff receives training on the identification of fraud within the CCG. The CCG has a contract with Tiaa (as from 1 July 2016) to provide counter fraud and security management services that have an annual work programme.

6.7 The CCG's Executive Lead for fraud and corruption is the Chief Finance Officer, who is responsible for authorising investigations, including the arrest, interviewing and prosecution of subjects and the recovery or write-off of any sums lost to fraud.

6.8 A Risk Management Framework was approved and endorsed by the shadow Governing Body in December 2012 ready for use in April 2013 to reflect the CCG's risk management requirements. The Framework was subsequently updated and approved by the Directors in May 2015, May 2017 and October 2017 (following changes to the format of the Governing Body Assurance Framework). The next review date is March 2019.

6.9 The Risk Management Framework:

- standardises and clarifies the terminology of risk management;
- sets out the organisation's objective to identify, treat and mitigate risk;
- explains the roles and responsibilities within the CCG relating to risk;
- defines the role and objectives of the CCG's committees and groups;
- clearly explains the tools (Corporate Risk Register and Governing Body Assurance Framework) used by the CCG to document and manage risks to the organisation, detailing the clear, consistent and effective risk scoring systems used;
- details how the organisation has a clear view of the risks affecting each area of its activity, how the risks are being managed and their potential impact on the organisational objectives;
- assures the public, patients and their carers and representatives, staff and partner organisations that the CCG is committed to managing risk appropriately.

6.10 In relation to risk management the Governing Body membership and executive team are responsible for:

- articulating the organisation's strategic objectives;
- identifying risks to the achievement of its strategic objectives;
- protecting the reputation of the CCG; providing leadership, active involvement and support for risk management;
- determining the risk appetite for the CCG;
- ensuring the approach to risk management is consistently applied;
- ensuring that there is a structure in place for the effective management of risk throughout the CCG and that this structure is consistently applied;
- monitoring these processes on an on-going basis via the Governing Body Assurance Framework and Corporate Risk Register;
- reviewing and approving the Risk Management Framework on a biennial basis.

6.11 The CCG ensures that risk management is embedded in all aspects of the work of the organisation. Examples include

6.12 **Equality Impact Assessments:** The CCG is committed to ensuring a reduction in health inequalities and places the needs of Dorset communities at the heart of all commissioning functions. 'Equality analysis' is undertaken when commissioning services, making changes to services, using information within services and within the policies that are used. Additionally, the CCG publishes an annual 'Equality and Diversity report' which acknowledges the organisation's successes in relation to equality and diversity, as well as making recommendations for improvement;

6.13 **Incident Reporting:** Incident and serious incident reporting is openly encouraged from all staff, GP practices and the provider organisations (both NHS and non-NHS) that are commissioned by the CCG. This information is analysed and used to identify any risks which may impact in the business of the CCG.

6.14 **Stakeholder engagement:** The CCG is committed to ensuring that public stakeholders are involved in managing risks which impact on them. Examples include:

- lay representatives regularly attend the Governing Body, Audit and Quality Committee, Quality Group, Dorset Medicines Advisory Group and Medicines Optimisation Group to ensure there is a voice for patients and the public;
- public stakeholders are invited to join the online CCG's Health Involvement Network. Opportunities for involvement are regularly promoted via a newsletter, through social media and other communication networks. Service improvement projects routinely carry out stakeholder analyses to ensure appropriate public stakeholders are invited to be involved and then actively seek their views to inform service development and redesign;
- the CCG has co-designed a new Sustainability Transformation Plan (STP) Public Engagement Group with all STP partner organisations. This group comprises 26 people with lived experience across Dorset's geography, demography and diversity – who meet on a bi-monthly basis and provide advice, comment and challenge on public engagement work across all STP portfolios;
- to support wider public engagement in localities, particularly in relation to GP Transformation plans, the CCG is working with practices across the county to establish an effective network of GP Patient Participation Groups. A dedicated Communications and Engagement Coordinator has been appointed to provide this support;
- a new STP Public Engagement Leads Network has been established. This group meets monthly to provide advice and guidance on public engagement across all STP portfolios, to support the STP Public Engagement Group, to network, avoid duplication and encourage collaborative public engagement;
- the CCG has active communications, media and social media teams, which work collaboratively with all STP partner organisations and communicated regularly to the general public – providing information on service provision,

service change, national and local campaigns and how local people can get involved and have their say. Information is produced in a variety of accessible formats in line with the Accessible Information Standard. Refer to Section 10 for further information.

Capacity to handle risk

6.15 The CCG's Risk Framework provides assurance to the Governing Body of the controls that are in place to mitigate the key risks that could impact on the CCG's delivery of its strategic objectives.

6.16 Key controls where assurance cannot be fully detailed are highlighted in blue on the framework, with an explanation of the work in progress to achieve assurance. Monthly updates are provided to the Executive Team of the progress against achieving full assurance, with formal reports submitted to every Governing Body and Audit and Quality Committee meeting. This pro-active method of managing risk is a preventative approach to limit the risk exposure to the organisation.

6.17 The Corporate Risk Register is a risk management tool which acts as a central repository for all current risks identified by the organisation. All risks are recorded and managed via the Ulysses software 'Safeguard Risk Management System' and are mapped (where applicable) to the strategic objectives of the CCG.

6.18 The CCG is able to assure itself of the validity of the Annual Governance Statement in a number of ways. These are:

- adherence to the Risk Management Framework;
- adherence to the CCG committee structure, Committee Terms of Reference and reporting framework;
- scrutiny of the draft Annual Governance Statement (this document) by members of the Audit and Quality Committee prior to submission and sign off at the special meeting for closure of finances in May 2018.

6.19 Leadership for the risk management process within the CCG is provided via the Governing Body, with responsibility delegated to the Audit and Quality Committee. The organisational structure has been established in order to assist with this process and is described in the following paragraphs.

6.20 All Directors are responsible for compliance with the Risk Management Framework to ensure that remedial actions are identified and taken wherever key risks are identified within their area of responsibility.

6.21 The Director of Quality and Nursing is the designated lead for risk and patient safety within the CCG, and is responsible for ensuring that the Risk Management Framework is implemented and evaluated effectively.

6.22 All Directors, Deputy Directors and Managers have delegated responsibility and authority with regard to the management of risk within their specific areas of work, including compliance with the Risk Management Framework and for

ensuring that remedial action is taken wherever key risks are identified within their area of responsibility, including:

- the reporting of adverse incidents, together with actions to prevent or minimise a reoccurrence;
- identifying and adding risks to the Corporate Risk Register in a timely manner;
- coordinating the application of resources to minimise, manage and control the likelihood and/or impact of the risk;
- undertaking risk assessments and actions implemented;
- ensuring staff undertake mandatory and statutory training.

6.23 The Head of Patient Safety and Risk, supported by the Patient Safety and Risk Manager has delegated responsibility for:

- co-ordinating and managing activities relating to clinical, corporate and financial risks for the CCG;
- monitoring risk management and patient safety within commissioned and corporate services for the CCG;
- maintaining the Corporate Risk Register and Governing Body Assurance Framework through engagement with the Directors and Directorate Risk Leads;
- the management of all Serious Incidents Requiring Investigation and Adverse Incidents.

6.24 The Patient Safety and Risk team within the CCG supports the consistent identification, assessment and management of risk across the organisation and, as a team, are central to the dissemination and application of best practice. Additionally, the team administers the key administration and system processes and acts as a central resource and advisory function in relation to risk and risk management.

6.25 Plans have now been developed to enhance the risk training available to new and existing CCG employee through the enhancement of key training and education programmes to ensure all staff learn through good practice. From April 2018, a bespoke ‘Managers Essentials’ training session will be available for all new and existing managers, covering the key components of risk management.

6.26 The cumulative contribution of the above mechanisms assists in the assurance of commissioning services that ensure patient safety is high profile.

Global Cyber Attack (May 2017)

6.27 From 12 May 2017 until 18 May 2017 Dorset weathered the outbreak of the Wannacry ransomware virus that swept around the globe.

6.28 The virus targeted computers that did not have up to date security patches applied or latest antivirus patterns installed. In Dorset this situation was managed outside of the major incident process; the CCG coordinated efforts across health and social care through the Chief Information Officers and the third party provider for the GP estate.

6.29 The CCG Chief Information Officer coordinated the management of the Dorset response. The impact on Dorset was limited. With regular patching cycles and up to date antivirus patterns and firewall settings, the number of identified infected machines was less than 10, across an estate of circa 30,000 computers.

6.30 Extra precautionary steps were taken for hospital based scanning devices whose inbuilt computers are only accessible by the manufacturer, so steps were put in place to take these scanners offline until their status could be fully confirmed.

6.31 The CCG review following the event highlighted a number of areas to improve in our defences for the future - improved antivirus scanning, shorter hardware refresh cycles in some Trusts, more frequent staff engagement and training on cyber risks.

6.32 As a system, investment is being sought in more advanced monitoring and threat detection software and work together to tighten and enhance network security.

Risk Assessment

6.33 The CCG has continued to develop and embed its approaches to risk management as set out in the Annual Governance Statement (2016/17). The CCG views integrated risk management as a key element in the successful delivery of its business and remains committed to ensuring staff throughout the organisation are equipped to assess, manage, escalate and report risks.

6.34 The CCG has clear governance structures with delegation of responsibility clearly articulated in the terms of reference for committees and groups (as described on pages 43 to 45). All committees review their effectiveness annually and there are clear lines of reporting from all committees and groups to the Governing Body. The Governing Body through reports and updates reviews the quality, performance and financial stewardship of the organisation. Any risks identified relating to these areas have been recorded in the Corporate Risk Register and/or the Governing Body Assurance Framework.

6.35 The CCG operates a 'Declaration of Interest' register and this is checked regularly; potential conflicts of interest are taken into account in all aspects of the CCGs business. Declarations of interest are recorded at every formal committee and group meeting.

6.36 The CCG operates a Governing Body Assurance Framework and Corporate Risk Register that identify the systems of internal control in place to efficiently, effectively and economically manage these risks and provide assurance to the CCG and its organisation's stakeholders that these systems are present.

6.37 All risks identified in the Corporate Risk Register require the formulation of an action plan. A member of the Patient Safety and Risk team meets with risk leads

on a monthly or quarterly basis (dependant on risk level) to record progress against action plans and documents the effect these are having on the residual risk score. All action plans are formally reported via the Corporate Risk Register. The document includes all risks that may impact on the achievement of the CCG's objectives.

6.38 The Governing Body receives regular assurance on the management of internal risks and assurance both directly via regular reports including the full Governing Body Assurance Framework and Corporate Risk Register and via assurance from the Audit and Quality Committee.

6.39 Risks are scored on a likelihood x consequence matrix to score the potential severity of a risk being realised. Risks scored above 15 are categorised as high risk.

6.40 Reports are also received on a monthly basis by Directors summarising the top risks to the organisation (those scoring over 15), new risks, closed risks and any other key risk issues. Directors also review the full Corporate Risk Register at every meeting.

6.41 During 2017/18 the existing process to record operational risks associated with development project continues, with a clear route to escalate any of the risks identified to the Corporate Risk Register.

6.42 Between 1 April 2017 and 31 March 2018, 20 risks were added to the Corporate Risk Register. Of these 20 risks, seven have been closed within the year. 15 risks remain open which were added prior to 31 March 2017.

6.43 Of the remaining 28 open risks, three are assessed as high risk:

- One relates to delayed transfers of care;
- One relates to ambulance response times;
- One relates to the delivery of primary medical services

6.44 The outstanding risks in place on 31 March 2018 are carried over into the new financial year and will continue to be managed within the Risk Management Framework described within this statement.

6.45 The risk profile of the CCG is subject to on-going in-year revision. At the end of the 2017/18 financial year, there were 28 risks on the Corporate Risk Register.

6.46 As Accountable Officer I can confirm that there have been no significant lapses of protective security.

7.0 Other sources of assurance

Internal Control Framework

7.1 A system of internal control is the set of processes and procedures in place in the clinical commissioning group 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.

7.2 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.

7.3 The Corporate Risk Register has controls described for every risk entry. The controls are reviewed on a monthly or quarterly basis (depending on their risk level) along with progress for reducing the risk to ensure they are still effective.

7.4 The framework provides assurance to the Governing Body of the controls that are in place to mitigate the key risks that could impact on the CCG's delivery of its strategic objectives.

Annual Audit of conflicts of interest management

7.5 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.

7.6 In February 2018, the annual internal audit of conflict of interest was undertaken and an overall assurance of 'substantial assurance' was achieved.

7.7 The CCG demonstrated that the updated requirements of NHS England's 'Managing Conflict of Interest – Revised Statutory Guidance for CCGs' have been embedded within its policy and processes.

7.8 The scope of this audit covered the areas set out by NHS England in their published audit template for this nationally mandated review. To meet their requirements, the audit gave assurance over the following five key areas: governance arrangements; declarations of interests and gifts and hospitality; registers of interests, gifts and hospitality and procurement decisions; decision making processes and contract monitoring; and reporting concerns and identifying and managing breaches/ non-compliance.

7.9 Based on the review, the CCG's arrangements for handling conflicts were assessed as being fully compliant, on the basis of robust policy and processes being in place for the five key areas. Identified areas for improvement were relatively minor. For further information, refer to Section 10.

Data Quality

7.10 The data used by the Governing Body and delegated Committees/groups is obtained from various sources the majority of which are national systems and official NHS data sets. The Provider data is quality assured through contract and performance monitoring and against the Secondary Uses Service (SUS).

7.11 The specific governance of data quality and consistency across the STP providers, via the collaborative agreement, is owned by the Operational Finance Reference Group and managed via the Business Intelligence Reference Group (BIRG) and Data Quality Working Group (DQWG) which have relevant membership and representation from all partner organisations.

Information Governance

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

7.13 The CCG places high importance on ensuring there are robust Information Governance (IG) systems and processes in place to manage data security risks and the protection of patient and corporate information.

7.14 Responsibility for IG rests with me, as Accountable Officer; I have delegated authority to the Senior Information Risk Owner (SIRO), the Caldicott Guardian and the Information Governance Group (IGG). A range of measures are used to manage and mitigate information risks, including annual mandatory staff training, physical security, data encryption, access controls and departmental spot checks.

7.15 The CCG's IG status is regularly reviewed by the IGG which is a standing group that reports to the Governing Body via the Audit and Quality Committee. Its purpose is to support and drive the broader IG agenda and provide assurance to the Governing Body that effective IG best practice mechanisms are in place. Risks to information, including data security, confidentiality, integrity and availability, are managed and controlled via this group which meets bi-monthly.

7.16 The SIRO has responsibility for leading and implementing the IG risk assessment and management processes within the CCG in addition to advising the Governing Body on the effectiveness of information risk management throughout the CCG.

7.17 As part of the annual IG Toolkit submission a comprehensive assessment of information security is undertaken. Further assurance is provided from audit and other reviews. The effectiveness of these measures is reported to, and monitored by, the IGG. This includes details of any personal data related serious incidents, the CCG's annual IG toolkit score and reports of other IG incidents and audit reviews. Regular reports are received in relation to policies, the Caldicott risk register, transition and records management.

7.18 There is a staff handbook in place to ensure that staff are aware of their roles and responsibilities under IG and the Data Protection Act.

7.19 The CCG has self-assessed against the IG Toolkit and achieved the target of overall compliance of Level 2 and above, with some criteria achieving Level 3. There has been an audit conducted on the evidence used to support the submission. This has provided substantial assurance to the Governing Body that there is a sound system of control in place.

7.20 There are processes in place for incident reporting and investigation of serious incidents.

7.21 Information risk assessment and management procedures have been established via the IGG, the SIRO and the Risk Management Team. Work continually takes place to ensure that these are embedded throughout the organisation. All incidents which have a data protection element are investigated with lessons learnt shared via the IG Group.

7.22 There have been no serious breaches of the Data Protection Act (Level 2 reportable) in 2017/18 which required reporting to the Information Commissioners Office.

7.23 For further information on responding to Freedom of Information requests please see page 34 of the Annual Report and Accounts.

Business Critical Models

7.24 As Accountable Officer I can confirm that there is an appropriate financial and business framework and environment in place to provide assurance of business critical models, in line with the recommendation from the MacPherson report. These are overseen by the Governing Body and Audit and Quality Committee. External assurance is received via external audit and quarterly assurance meetings with NHS England.

Third party assurances

7.25 Dorset CCG seeks third party assurances when a provider enters a sub-contracting arrangement. The lead provider is then required to report on outcomes of the commissioned service including all aspects of the sub-contracted element of the service. The NHS Standard Contract affords the CCG adequate levers and mechanisms to address any concerns that may arise from any third party arrangements.

8.0 Control issues

8.1 There were no significant control issues identified in 2017/18.

9.0 Review of economy, efficiency & effectiveness of the use of resources

9.1 There are procurement processes to which the CCG adheres. There is a scheme of delegation which ensures that financial controls are in place across the organisation.

9.2 The roles of the accountable and delegated committees and groups are clearly articulated in pages X to X of this statement and the scheme of delegation has been reviewed, and approved, in year.

9.3 In order to ensure that the CCG delivers on its financial duties and meets its control total, and equally to ensure we tackle the sustainable elements of the Sustainability and Transformation Plan (STP), a collaborative agreement was agreed by the four Foundation Trusts within Dorset and the NHS Dorset CCG in December 2016.

9.4 Monthly monitoring of actions, performance and financial metrics have been agreed and are monitored through by Operations and Finance Reference Group (OFRG) and the Senior Leadership Team (SLT). In addition, Dorset has been supported as a first wave 'Integrated Care System' (ICS), one of eight recognised STPs in the country, which recognises the progress Dorset has made and continues to make. Following the move in Dorset towards an Integrated Care System, a Finance Investment Group has now been set up, with an independent lay Chair to ensure strong system wide governance is in place to management investment funding for, and on behalf of, the Dorset system.

9.5 In order to continue to deliver efficiency within the CCG, a sustainability taskforce is in place led by the Accountable Officer to ensure that Quality**,** Innovation**,** Productivity and Prevention (QIPP) continues to be a priority.

9.6 Monthly reporting is in place to Directors, with bi-monthly reporting to the Governing Body on financial performance and delivery against the agreed plan; this will include the actions for QIPP and proposed mitigations for any variance to plan that could lead to non-delivery.

Delegation of functions

9.7 It is implicit through the work of the Governing Body and delegated Committees that members have clear responsibility for ensuring appropriate use of resources. Where there are concerns in relation to budgetary management, these are clearly documented in the Corporate Risk Register including those key financial risks relating to the CCG's commissioned Providers. During the course of 2017/18 there were three risks identified and recorded on the Corporate Risk Register relating to aspects of financial risk.

9.8 Through the committee structure within Dorset CCG, regular reports are received on the performance of contracted Providers. Areas of under and over

performance are addressed through contract meetings and reported though performance and quality papers to CCG groups and committees.

9.9 The Audit and Quality Committee, under the scheme of delegation, monitor the financial stewardship of the organisation via detailed reporting to every meeting and is responsible for scrutinising and signing off the end of year financial accounts. At year end the CCG achieved the control total that had been agreed with NHS England.

9.10 The Governing Body, Audit and Quality Committee, Quality Group and Directors Performance meetings retain oversight of all risks including those deemed to be systematic and are responsible for ensuring that relevant mitigating actions are undertaken. There have been no significant internal control failures identified throughout the financial year 2017/18.

9.11 Internal Audit has found no significant lapses in key controls tested in any of the audits that have been undertaken in this financial year.

9.12 With the exception of the South West 999 service and contract support for some out of area contracts including London, Southampton, Bristol and Portsmouth, Dorset CCG does not contract any commissioning support services from an external Provider.

Counter Fraud Arrangements

9.13 The CCG's Accountable Officer for fraud, bribery and corruption is the Chief Finance Officer, who is responsible for authorising investigations, including the arrest, interviewing and prosecution of subjects and the recovery or write-off of any sums lost to fraud.

9.14 The CCG has a nominated Local Counter Fraud Specialist (LCFS) who is responsible for the investigation of any allegations of fraud, bribery and corruption and for the delivery of a programme of proactive counter fraud work, as detailed in the annual work-plan approved by the Audit and Quality Committee. Where fraud is established or improvements to systems or processes identified, the LCFS will recommend appropriate action to the CCG.

9.15 The LCFS works closely with the Workforce Department when investigating cases involving members of staff and provides evidence to the CCG's investigating officer for disciplinary matters.

9.16 Monitoring of the Group's counter fraud arrangements is undertaken by the Audit and Quality Committee. The LCFS, who is responsible for the investigation of any allegations of fraud, bribery and corruption and for the delivery of a programme of proactive counter fraud work, attends each committee meeting to report progress against the agreed counter fraud work-plan and advise the outcome of any completed investigations or proactive exercises.

9.17 The CCG is required to submit an annual Self Review against NHS Counter Fraud Authority's 'Standards for Commissioners' which provides assurance of compliance to those 'Standards'.

9.18 A Fraud Response Plan is in place which sets out these roles and responsibilities and the steps to be taken by the CCG if fraud is suspected. All staff are required to report any suspicions of fraud, bribery or corruption that they may have either to the LCFS, NHS Counter Fraud Authority or the Chief Finance Officer.

9.19 As part of the Governance arrangements that are in place, external audit undertakes 'a value for money' audit, which assesses the CCGs performance in respect of efficiency, effectiveness and economy. This is undertaken on an annual basis to provide external assurance. In addition, the CCG is required to report to NHS England how it is delivering in respect of use of resources as part of a regular assurance process.

10. Head of Internal Audit Opinion

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

10.2 The purpose of my interim HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Governing Body in the completion of its Annual Governance Statement.

10.3 It is noted that the CCG is currently forecasting to deliver its planned in-year break-even position. My opinion on the organisation's system of internal control has taken this factor into account.

10.4 My opinion is set out as follows:

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

Overall Interim Opinion

10.5 My overall opinion is that **reasonable** assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk;

Basis of interim opinion

10.6 The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit 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.
- Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances.

10.7 During the year, Internal Audit issues the following audit reports:

System	Assurance Assessment
ICT – Change Management	Reasonable
Quality, Innovation, Productivity and Prevention Plan (QIPP)	Limited
Primary Care Commissioning	Reasonable
RightCare	Reasonable
Quality Premium	Substantial
Human Resources Systems	Reasonable
Financial Systems	Substantial
Information Governance – deep dive	Reasonable
Business Continuity	Reasonable
Assurance Framework and Risk Management	Reasonable
Corporate Governance Arrangements – conflicts of interest	Substantial

10.8 There have been no priority 1 audit recommendations during the year.

11 Review of the effectiveness of Governance, Risk Management and Internal Control

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

11.2 Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principles objectives have been reviewed. I have been advised on the implication of the result of this review by:

- the work of the internal auditors;

- Executive Directors, Senior Managers and Clinical Leads within the CCG who have responsibility for the development and maintenance of the internal control framework;
- available performance information;
- comments made by the external auditors in their annual audit letter and other reports.

11.3 The Governing Body Assurance Framework and Corporate Risk Register have been designed to provide me, as Accountable Officer, with sources of assurance which are evidence that the effectiveness of controls that manage risks to the CCG are achieving their principal objectives and are reviewed on an on-going basis as described on pages **X** to **X**.

11.4 The Executive Directors within the CCG who have responsibility for the development and maintenance of the system of internal control provide me, as Accountable Officer, with assurance.

11.5 As Accountable Officer, I have received assurance of the effectiveness of the CCG's internal controls as discharged through the committees described in page **X** to **X**. Plans are in place to address any areas of improvement identified; monitoring arrangements are in place to address these.

11.6 Pages **X** to **X** describe the process that has been applied in maintaining and reviewing the effectiveness of the system of internal control, including the role and outputs of the:
- Governing Body;
- Audit and Quality Committee;
- Clinical Commissioning Committee;
- Remuneration Committee;
- Primary Care Commissioning Committee;

Conclusion

I can confirm that no significant internal control issues have been identified.

Tim Goodson
Accountable Officer
[Date]