ANNUAL GOVERNANCE STATEMENT

INTRODUCTION AND CONTEXT

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).

The Clinical Commissioning Group's (CCG) 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.

SCOPE OF RESPONSIBILITY

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.

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

GOVERNANCE ARRANGEMENTS AND EFFECTIVENESS

The main function of the Governing Body is to ensure that the 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. This is in line with the National Health Service Act 2006 (as amended), at paragraph 14L(2)(b).

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 2016/17 and terms of reference (see pages 52 to 54).

COMPLIANCE WITH THE UK CORPORATE GOVERNANCE CODE

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 Clinical Commissioning Group and best practice.

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.

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.

'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 55)

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.

DISCHARGE OF STATUTORY FUNCTION

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

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.

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

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

RISK MANAGEMENT ARRANGEMENTS AND EFFECTIVENESS

To enable the effective use of Governing Body time the CCG's risk appetite is being further refined to enable the Governing Body to consider an exception based reporting the decisions, thereby permitting the Governing Body to focus on critical issues.

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.

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.

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.

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.

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 been updated and approved by the Directors in May 2015, with a review date of May 2017.

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.

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;

309 - monitoring these processes on an on-going basis via the Governing Body Assurance Framework
310 and Corporate Risk Register;
311 - reviewing and approving the Risk Management Framework on a biennial basis.

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

314 - **Equality Impact Assessments:** The CCG is committed to ensuring a reduction in health
315 inequalities and places the needs of Dorset communities at the heart of all commissioning
316 functions. 'Equality analysis' is undertaken when commissioning services, making changes to
317 services, using information within services and within the policies that are used.
318 Additionally, the CCG publishes an annual 'Equality and Diversity report' which
319 acknowledges the organisation's successes in relation to equality and diversity, as well as
320 making recommendations for improvement;
321 - **Incident Reporting**: Incident and serious incident reporting is openly encouraged from all
322 staff, GP practices and the provider organisations that are commissioned by the CCG. This
323 information is analysed and used to identify any risks which may impact in the business of
324 the CCG.

325 The CCG is committed to ensuring that public stakeholders are involved in managing risks which
326 impact on them. Examples include:

327 - lay representatives regularly attend the Governing Body, the Quality Group, Transformation
328 Quality Assurance Group and Audit and Quality Committee to ensure there is a voice for
329 patients and the public;
330 - information on "the need to change" in Dorset is being widely communicated on an on-
331 going basis to the public and other stakeholders – explaining why the NHS in Dorset needs to
332 change, what is being done and how people can be involved and have their say. This is
333 being communicated in accessible formats at public events, through presentations and Q&A
334 sessions, through newsletters, circulation of an information film etc;
335 - patient and carer representatives are invited to take part in task and finish groups and
336 workshops hosted by the CCG's Clinical Delivery Groups, bringing people into the room so
337 that local care pathways can be designed 'with' them rather than 'for' them;
338 - the CCG has a Patient (Carer) Public Engagement Group comprising about 20 people with
339 lived experience across Dorset's geography, demography and diversity – who meet on a
340 monthly basis and act as a critical friend – providing advice and feedback on proposed
341 service changes/developments.

342 ## CAPACITY TO HANDLE RISK

343 The framework provides assurance to the Governing Body of the controls that are in place to
344 mitigate the key risks that could impact on the CCG's delivery of its strategic objectives. Key controls
345 for which assurance cannot be fully detailed are highlighted in blue on the framework, with an
346 explanation of the work in progress to achieve assurance. Monthly updates are provided to the
347 Executive Team of the progress against achieving full assurance, with formal reports submitted to
348 every Governing Body and Audit and Quality Committee meeting.

349 This pro-active method of managing risk is a preventative approach to limit the risk exposure to the
350 organisation.

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

355 The CCG also actively deters risks through the adoption of robust counter-fraud methodology. All
356 clinical and non-clinical staff receives training on the identification of fraud within the CCG. In
357 addition, the CCG have a contract with Tiaa (as from 1.7.16) and previously with Secure (Fraud and
358 Security Solutions) to provide counter fraud and security management services that have an annual
359 work programme.

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

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

365 • adherence to the Risk Management Framework;
366 • adherence to the CCG committee structure, Committee Terms of Reference and reporting
367 framework;
368 • scrutiny of the draft Annual Governance Statement (this document) by members of the Audit
369 and Quality Committee prior to submission and sign off at the special meeting for closure of
370 finances in May 2017.

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

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

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

380 All Directors, Deputy Directors and Managers have delegated responsibility and authority with
381 regard to the management of risk within their specific areas of work, including compliance with the
382 Risk Management Framework and for ensuring that remedial action is taken wherever key risks are
383 identified within their area of responsibility, including:

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

390

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.

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.

Plans are in place to enhance the risk training available to new and existing CCG employees through the enhancement of key training and education programmes to ensure all staff learn through good practice.

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

RISK ASSESSMENT

The CCG has continued to develop and embed its approaches to risk management as set out in the Annual Governance Statement (2015/16). 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.

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 52 to 54). 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.

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.

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.

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

432 having on the residual risk score. All action plans are formally reported via the Corporate Risk
433 Register. The document includes all risks that may impact on the achievement of the CCG's
434 objectives.

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

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

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

443 During 2016/17 a process has been developed to ensure an operational risk log is maintained for
444 each project. There is a clear route to escalate any of the risks identified on the log to the Corporate
445 Risk Register.

446 Between 1 April 2016 and 31 March 2017, 25 risks were added to the Corporate Risk Register. Of
447 these 25 risks, 10 have been closed within the year. Of the remaining 15 open risks 6 are assessed as
448 high risk:

449 - three relate to primary care capacity;
450 - one relates to delays in initial health assessments for looked after children;
451 - one relates to extension of existing contract for urgent care service;
452 - one relates to funding for digitally transformed Dorset.

453 The outstanding risks in place on 31 March 2017 are carried over into the new financial year and will
454 continue to be managed within the Risk Management Framework described within this statement.

455 The risk profile of the CCG is subject to on-going in-year revision. At the end of the 2016/17 financial
456 year, there were 36 risks on the Corporate Risk Register.

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

459 THE CLINICAL COMMISSIONING GROUP INTERNAL CONTROL FRAMEWORK

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

464 The system of internal control allows risk to be managed to a reasonable level rather than
465 eliminating all risk; it can therefore only provide reasonable and not absolute assurance of
466 effectiveness.

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

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

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.

The annual internal audit of conflicts of interest was carried out January/February 2017 and supported an overall assurance assessment of 'reasonable assurance'. Our level of compliance on the five areas as set by NHS England were as follows:

- governance arrangements – fully compliant;
- declarations of interests and gifts and hospitality – partially compliant; as at 31 March 2017 there are 32 members of staff including temporary and bank staff and those on long-term sick and maternity who have not completed a declaration. 9 paid GPs and 21 practices have not completed a declaration;
- registers of interests, gifts and hospitality and procurement decisions – partially compliant;
- decision making processes and contract monitoring – fully compliant;
- reporting concerns and identifying and managing breaches/non-compliance – fully compliant.

DATA QUALITY

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

INFORMATION GOVERNANCE

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

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. 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.

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.

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

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

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

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

525 There are processes in place for incident reporting and investigation of serious incidents.
526 Information risk assessment and management procedures have been established via the IGG, the
527 SIRO and the Risk Management Team. Work continually takes place to ensure that these are
528 embedded throughout the organisation. All incidents which have a data protection element are
529 investigated with lessons learnt shared via the IG Group.

530 There has been no serious breach of the Data Protection Act (Level 2 reportable) in 2016/17 which
531 required reporting to the Information Commissioners Office.

532 For further information on responding to Freedom of Information requests please see page 37 of the
533 Annual Report and Accounts.

534 BUSINESS CRITICAL MODELS

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

540 THIRD PARTY ASSURANCES

541 Dorset CCG seeks third party assurances when a provider enters a sub-contracting arrangement.
542 The lead provider is then required to report on outcomes of the commissioned service including all
543 aspects of the sub contracted element of the service.

544

CONTROL ISSUES

There were no significant control issues identified in 2016/17.

REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

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.

The roles of the accountable and delegated committees and groups are clearly articulated in pages 52 to 54 of this statement and the scheme of delegation has been reviewed, and approved, in year.

As detailed on page 67, the CCG also actively deters risk through the adoption of robust counter-fraud methodology.

DELEGATION OF FUNCTIONS

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 2016/17 there were three risks identified and recorded on the Corporate Risk Register relating to aspects of financial risk.

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.

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.

The Governing Body, Audit and Quality Committee, Quality Group and Director's 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 2016/17.

Internal Audit has found no significant lapses in financial control or use of resources in any of the audits that have been undertaken in this financial year. With the exception of the South West 999 service, Dorset CCG does not contract any commissioning support services from an external Provider.

COUNTER FRAUD ARRANGEMENTS

The CCG's Accountable Officer 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.

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

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

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

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

596 See page 86 for further information on fraud.

597 HEAD OF INTERNAL AUDIT OPINION

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

602 The purpose of my annual HoIA Opinion is to contribute to the assurances available to the
603 Accountable Officer and the Governing Body which underpin the Governing Body's own assessment
604 of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist
605 the Governing Body in the completion of its Annual Governance Statement (AGS).

606 Based on its draft accounts, the CCG achieved its revenue resource surplus (including the non-
607 recurrent system risk reserve figure of £11.1m) of £28,805k at the year end from a revenue resource
608 limit of £1,161,142k. Our opinion on the organisation's system of internal control has taken this
609 factor into account.

610 My opinion is set out as follows:

611 1. Overall opinion;
612 2. Basis for the opinion; and
613 3. Commentary.
614
615 My overall opinion is that:

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

620

621 The basis for forming my opinion is as follows:

622 • an assessment of the design and operation of the underpinning Assurance Framework and
623 supporting processes; and
624 • an assessment of the range of individual opinions arising from risk-based audit assignments,
625 contained within internal audit risk-based plans that have been reported throughout the year.
626 This assessment has taken account of the relative materiality of these areas and management's
627 progress in respect of addressing control weaknesses.

628 Additional areas of work that may support the opinion will be determined locally but are not
629 required for Department of Health purposes, eg any reliance that is being placed upon Third Party
630 Assurances.

631 During the year, Internal Audit issued the following audit reports:

632 **Table 19: Internal audit reports**

System	Type	Assurance Assessment
Individual Funding Requests	Assurance	Substantial
Safeguarding Adults	Assurance	Reasonable
Cyber Security	Assurance	Reasonable
Procurement	Assurance	Substantial
Governance arrangements over Primary Care	Assurance	Reasonable
Engagement with Public and Patients	Assurance	Reasonable
Clinical Delivery Groups	Assurance	Reasonable
Financial Systems	Compliance	Reasonable
Personal Health Budgets	Assurance	Reasonable
Contract Performance and Quality Monitoring of Providers	Assurance	Substantial
Conflicts of Interest	Assurance	Reasonable
Information Governance Toolkit	Assurance	Substantial
Sustainability and Transformation Plan production processes internally and with partners	Assurance	Substantial
Transformation Plans (Local ICS Vanguards)	Assurance	Substantial
Primary Care Commissioning (draft)	Assurance	Reasonable
Assurance Framework and Risk Management (draft)	Assurance	Reasonable

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

634 REVIEW OF THE EFFECTIVENESS OF GOVERNANCE, RISK MANAGEMENT AND INTERNAL 635 CONTROL

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

641 Our assurance framework provides me with evidence that the effectiveness of controls that manage
642 risks to the clinical commissioning group achieving its principles objectives have been reviewed. I
643 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.

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 60 to 63.

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.

As Accountable Officer, I have received assurance of the effectiveness of the CCG's internal controls as discharged through the committees described in page 52 to 54. Plans are in place to address any areas of improvement identified; monitoring arrangements are in place to address these.

Pages 52 to 54 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;
- Quality Group;
- Information Governance group.
- Transformation Quality Assurance Group

Management has provided representation that the agreed actions which are identified at each of these meetings are being implemented in accordance with the timescales provided to address the findings raised.

Conclusion

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

[Signature to be inserted]

Tim Goodson
Accountable Officer
Xx May 2017