# North East Lincolnshire Clinical Commissioning Group

## 2014/15 Annual Report & Accounts

NHS
North East Lincolnshire
Clinical Commissioning Group

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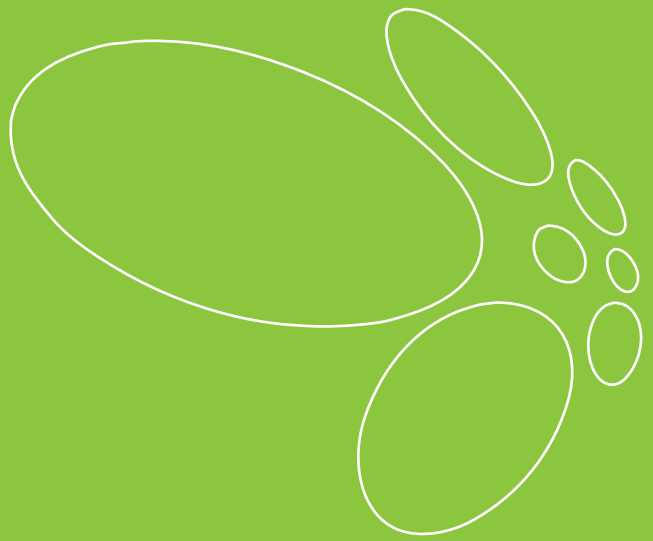
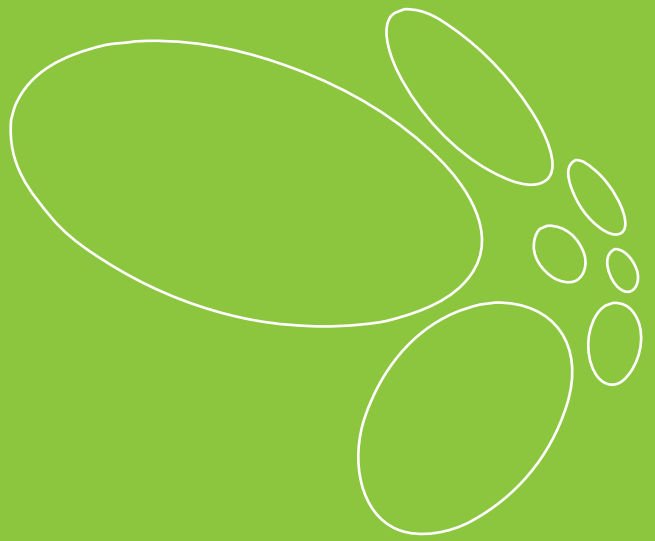


# ANNUAL REPORT 1.0



## Welcome from Chair & Chief Clinical Officer

**Welcome to the second annual report and summary of financial accounts for North East Lincolnshire Clinical Commissioning Group (CCG) which provides an overview of the work of the CCG between 1 April 2014 and 31 March 2015.**

North East Lincolnshire Clinical Commissioning group is a unique organisation in the English health system because it is responsible for commissioning health and adult social care services for over 165,000 people in North East Lincolnshire, and able to drive better and more integrated services. Our CCG therefore works very closely with North East Lincolnshire Council and together we seek to create an approach to commissioning that is engaging, transparent, innovative and effective.

We have been proud to witness the on-going commitment and enthusiasm and energy shown from CCG members, employees, partners and the public to achieving this vision and for delivering and maintaining a high quality service to the public during financially challenging times. Our CCG continues to be clinically led and shaped by the community we serve. The decisions we make about shaping the services for this area are made in collaboration with our community, for example through our network of local people known as Accord. We have found that our decisions and our ideas are richer for it.

The work of our managers, clinicians and community members has already produced some outstanding results and improvements in the delivery of health and adult social care services. Some highlights are shown in **section 1.1 our year in health & adult social care**.

The year has been extremely challenging, not least in respect of the increased pressures of strained healthcare budgets and the need to commission and deliver professional quality services in a cost-efficient way. This year we have delivered savings of £3.2 million for health and £3.6 million for adult social care. The increasing challenge to deliver on-going savings will continue in future years and so we are now actively looking at how we work with our members and partners, to commission future local services to ensure they are sustainable, and retain quality in their clinical and professional design. We will ensure that we are open and transparent in our communication and engagement with the community in these areas.

We certainly have challenges ahead of us that will require all our skill and innovation as well as strong partnerships, but working in this way gives us an excellent chance of delivering the Health and Care services needed for North East Lincolnshire.

We recognise individuals should be at the forefront of their own care services and are committed to actively listening, understanding and responding to any feedback received. We welcome feedback on your experiences of local health & adult social care services as well as your views on how best to shape local health & adult social care to meet local needs. All feedback is seen as an opportunity to review the services we provide and commission to ensure they are fit for purpose and meet the needs of the local population.

**You can find out more about how to share your experiences and ways to get involved with your local CCG by visiting our website Get Involved**

We have achieved a great deal over the last 12 months and there is much on which to reflect. The first part of this annual report provides a summary of our business, performance and work programmes over the past year, as well as commentary on wider events which have shaped our work and priorities as an organisation. The second part is the financial accounts for the year 2014/15.

On behalf of the entire CCG Board we present our annual report to you and place on record

our sincere thanks to our members, managers, staff, community members, and partners for their valued support throughout 2014/15.

**Mark Webb**
**Chair**

**Dr Peter Melton**
**Chief Clinical Officer**
**28th May 2015**

Information contained in this report can also be requested in other languages. If you would like additional copies of this report, please contact us via the details below. An electronic copy of this report is also available online at

**www.northeastlincolnshireccg.nhs.uk/**

## 1.1 Our Year in Health & Social Care

April 2014

**New services for patients living with Parkinson's**

The CCG launched a new Parkinson's education programme to help patients and their family, carers or employers understand and manage symptoms related to the condition. The programme is delivered over six weeks by a range of qualified professionals such as nurse specialists, therapists, and Parkinson's UK information support workers.

Anonymous user

*"The service I have received is excellent. It was a relief to be diagnosed and knowing the range of support available for me prevented it from being a traumatic experience. My boss has been a pillar of support and he was keen to understand my condition and what he could do to support me"*

May 2014

**Planning makes perfect – CCG launches new carers support service**

A new experienced and respected provider is commissioned to deliver Carers' Services in North East Lincolnshire. The charity – North Lincolnshire Carers' Support Centre – has been supporting carers in North Lincolnshire for over 25 years, and now extends its expertise to North East Lincolnshire.

Anonymous user

*"This is a wonderful new service providing specialist advice and information, counselling, befriending, holistic therapies and much more. Both carers and professionals participated in the tendering process so we're confident the new provider will deliver a service genuinely shaped by, and for, carers"*

June 2014

**New opportunities to voice view on care services**

Accord, the CCG's community membership group which gives local people a chance to have their say on the future of health and social care services, re-launched with a new look and feel. 'Suits You' is a new way for people to have their say – 'at a level that suits you, in ways that suit you and about things you are interested in'.

*"Accord is all about getting engaged with what's happening locally; these are our services that affect everyone and Accord gives you the opportunity to ask questions about them and influence things."*

*"Many people may think it's just lip service, but it's not. It's so easy to complain, but if you don't get involved you can't help change things for the better."*

July 2014

**MyLife dementia portal launches**

In partnership with focus the CCG launched MyLife giving people living with dementia, their friends and family, a 'one stop shop' for all support information and signposting. The aim is to provide an online resource to help people stay independent for longer and reduce admissions to hospital and care homes.

mylife
living well with dementia in north east lincolnshire

**www.services4.me.uk/mylife**

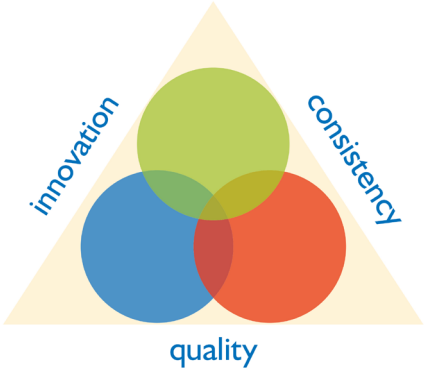
*"We wanted the people of North East Lincolnshire to have a valuable online source of essential advice and resources for people with dementia and their carer's. It is important to work in an integrated way to transform health and social care for people with dementia."*

*"Despite the achievements we have made so far we know that change must go beyond health and social care, and further into our everyday lives."*

Aug 2014

**Community Care across health and social care**

The new Community Care "Triangle" will lead the planning and buying of joined-up health and social care services to meet the needs of adults and carers in North East Lincolnshire.




*"Triangles" represent an integral part of the way our CCG operates; they bring together Clinical Leads (GP), Service Leads and Community Members to drive forward service redesign & improvement. Together these three voices have an equal influence during planning and decision-making."*

Community Member on the Community Care Triangle

*"I want to see, where possible, an improvement in the provision of community care services, as budget restraints make it vital that the community are involved"*

Sept 2014

**1000s benefit from Open Door**

Open Door GP Surgery moved to new premises where it was able to offer not just health care services but social support services, information, advice and guidance such as mindfulness clinics; anger management classes and counselling services to people who have complex needs. The service makes it much easier to empower and support vulnerable people to improve their health and wellbeing and turn their lives around.

Anonymous user

*"I call Open Door my 'safe place' I feel like I can say anything and it is not frowned upon. Things I don't feel I can say in the public domain, I can say there. I have met some wonderful people from all walks of life and what has really stuck out for me is that no-one is treated any differently no matter who they are. Life is looking up."*

Oct 2014

**Top performance for dementia diagnosis**

Dementia diagnosis rates show NEL CCG to be number one in the North Yorkshire and Humber Region and one of the top performing CCGs in England.

*"We have worked very hard to ensure early diagnosis of people with dementia is a key priority because it is still common for a person to live with the condition and never be given a formal diagnosis."*

*"Early diagnosis is hugely important. It opens doors and gives people access to support services and treatments that could relieve their symptoms and give them time to plan their future."*

Nov 2014

**College praises Grimsby GPs**

Raj Medical Centre received the prestigious Quality Practice Award for delivering the very highest quality care to patients, after being thoroughly assessed against a number of criteria.

The award has only been presented to 112 practices across the country in the last five years, none of which had previously been in Grimsby.

*"The Quality Practice Award shows the commitment of the entire team to provide the best possible care for patients at these surgeries. The assessment process was incredibly thorough and we're really pleased to have been recognised by the Royal College of General Practitioners for the work we do."*

Dec 2014

**Grimsby's second assisted living development is unveiled**

Willow House, a £2.5 million development opened, offering local vulnerable adults with learning and physical disabilities in a purpose built development; enabling them to live as independent a life as possible and give them the freedom to manage their own home, budgets and lifestyles.

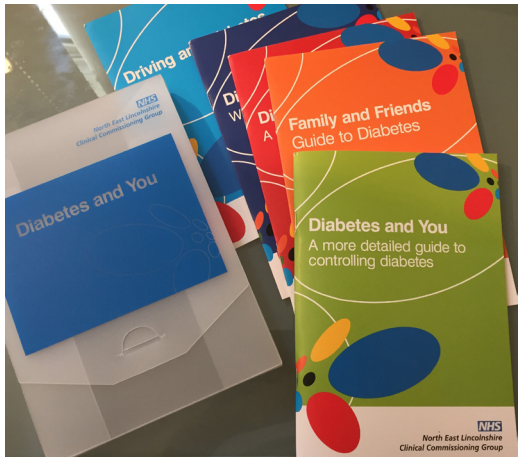
*"There are huge benefits in making this happen. Helping people to become independent enables them to have a real choice about where they live and what sort of support they receive. But most importantly the adults we're supporting here now have the opportunity to live in and contribute to their community."*

*"They can meet neighbours, make friends and take an active part in local life"*

Jan 2015

**New support pack developed with local diabetes patients**

Community members participating in a review of diabetes services worked together to develop a local guide for patients and their families who have been diagnosed with diabetes, advising the CCG on content and style to ensure the publication is 'reader friendly'.




Community member

*"I feel very proud of what we achieved together, working on the information guide. Being involved in something that will make a difference and helping people with diabetes has been very rewarding". "Involving people with personal experience of diabetes enabled us to ensure the contents were relevant to local patient and their families"*

Feb 2015

**Focusing on MS Event**

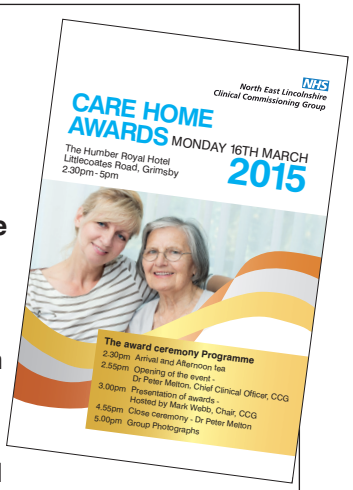
In February 47 patients, family members and carers attended the CCG's Focusing on MS event to have their say on services for people with multiple sclerosis.

Participants shared their experiences of current services and made recommendations to improve access to services, delivery of care and information and support to the symptoms related to MS.

This feedback will inform the continued development of services and involvement of patients and their families moving forward.

Mch 2015

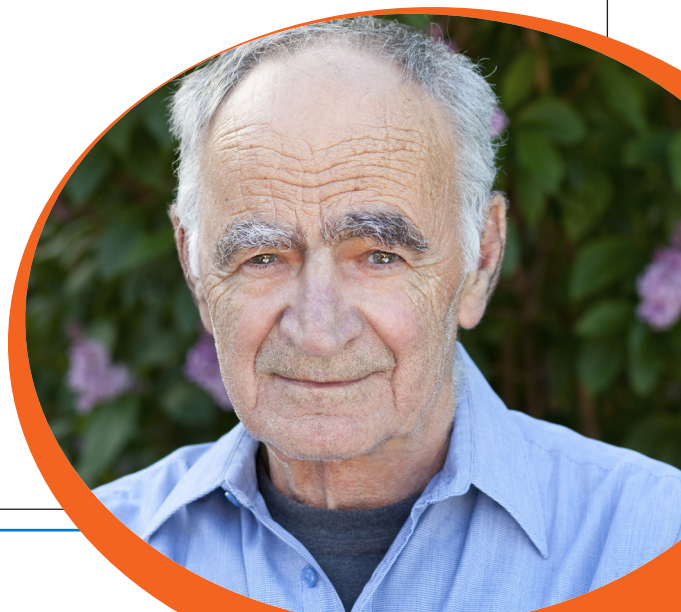
**NEL CCG hosts first local care home awards**




The CCG hosts the first of its kind care home awards in North East Lincolnshire aimed at recognising, encouraging and paying tribute to the people and organisations that make a real difference and change people's lives.

Service Lead for older people

*"We believe this awards ceremony will help show our appreciation of our care home staff, demonstrate how much they are valued in the local area and emphasise what a fantastic job they do."*



## 1.2 Our priorities for 2015/16

Our vision is to deliver joined-up solutions for health and social care. We are doing this by working collaboratively with our partners to improve health, reduce health inequality and ensure the best possible care for adults receiving social care. Underpinning this is our commitment to ensuring that all communities in North East Lincolnshire receive excellent, quality services.

There are a number of challenges the CCG has to overcome. These include:

- An elderly population 3% greater than the national average
- Diabetes expected to rise by 13% by 2030
- A potential financial gap of >£100m across Northern Lincolnshire

To meet these challenges there needs to be a greater emphasis on increasing prevention, self-care and independent living. More care will be delivered away from traditional 'bed based' services with a greater focus on services in the community and home.

Some of the key themes we will be focussing on throughout 2015/16 are:

**Increase prevention and self-care**

We expect people to manage their own physical and mental health and wellbeing where it is safe and appropriate to do so. We want to encourage people to make positive lifestyle choices that keep them healthy and reduce the likelihood of becoming ill.

There's a wide range of support available to help with this such as:

- Providing the right information and advice through national and community organisations
- Encouraging people to take advantage of screening and preventative services
- Developing a model for social prescribing which supports people to look after themselves

**Transform local primary care to manage demands on capacity**

We believe care can be provided closer to people's homes either at home or in a community setting as opposed to a hospital.

To deliver a community based health care services we need to make sure all services work together and are available seven days a week so that a visit to hospital or Emergency Centre is the last resort.

There are a number of ways we can do this, including:

**Outpatient appointments** - Deliver routine appointments that only require an examination or a discussion in a community setting, avoiding hospital visits.

**Rehabilitation and Counselling & support services** – Offer regular appointments closer to the patient's home within a community facility

**Supporting Nursing and Care homes** – Ensuring people in residential care are supported by enhanced care from GPs

**End of life care** - Improve evening and weekend access to local hospices so patients don't have to be admitted to hospital

**Enhance support for the top 2% of health and care users**

Patients with multiple, complex long-term conditions will be managed by dedicated multi-disciplinary teams who co-ordinate their care and care plan providing additional support when needed to avoid unnecessary admissions to hospital.

Our aim is to reduce the number of inappropriate admissions to hospital, help to reduce the length of stay for patients who do need hospital care as well as empower patients to manage their condition.

**Work closely with partners to join services together**

We will be working together with North East Lincolnshire Council and other partner organisation to transform the way health and care is delivered to patients by bringing services closer together.

Our aim is to make health and social care services work together to provide better support at home and earlier treatment in the community prevent people needing urgent care in hospital or early admission into care homes.

**Build better communities to reduce social isolation**

We are developing a number of schemes aimed at getting people involved and taking an active part in their local community. This will help to increase their independence, improve their health and well-being whilst reducing isolation and loneliness.

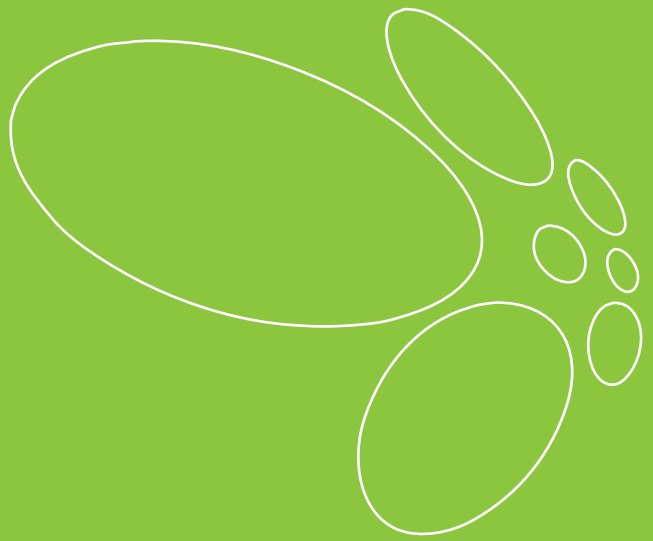
**Develop new models of urgent care**

We will be providing a more integrated approach to the management of urgent care to ensure people are treated within a certain time frame and a setting of care appropriate for their need. We will continue to work to reduce unnecessary A&E attendances and avoidable hospital admissions by fully utilising alternative services in the community.

**Implement seven day services**

Our ambition is to have a comprehensive integrated 7 day working to reduce admissions and support and maintain people's health and wellbeing in their own homes. To achieve this we have set up a pilot working collaboratively with our providers to move towards the development of 7 day working in primary care services, ensuring point of entry services such as the Single Point of Access (SPA) 01472 256256 service is fully integrated into local health services.

# STRATEGIC REPORT 2.0



## 2.1 Statement of Structure & Business

The Health and Social Care Act 2012 established Clinical Commissioning Groups (CCGs) as membership organisations whose members comprise a number of GP practices which hold NHS service contracts. The CCG has been in operation since 1st April 2013 with thirty member practices, and its headquarters is located at Athena Building, Saxon Court, Gilbey Road, Grimsby

Our GP practices serve a registered population for over 165,000 with an allocated budget of £268 million for 2014/15. We commission (or buy) a range of services for the population of North East Lincolnshire, including urgent care (such as A&E services and the GP out of hours service), routine hospital treatment, mental health and learning disability services, community care and adult social care.


The CCGs constitution sets out the membership and governance arrangements of the organisation, and can be found at:

North East Lincolnshire CCG Constitution

The structure and business of the CCG reflects the fact that the organisation is responsible for commissioning:

- a defined range of NHS services for the population that is served by the thirty CCG member practices. The range of NHS services that we commission is set out in the Health and Social Care Act 2012
- Adult Social Care services for the population of North East Lincolnshire. This responsibility is delegated to the CCG through a legal Partnership Agreement with North East Lincolnshire Council.

The allocation for commissioning NHS services is set by NHS England, and comes in two parts.

The first is a 'running cost' allocation, for funding the management and operation of the organisation.

The second 'programme' allocation funds the services that we commission. The income we receive to fund the commissioning of Adult Social Care services is set by North East Lincolnshire Council as part of its annual resource and priorities process. This dual responsibility for commissioning both health and adult social care services in North East Lincolnshire is unique in the English system, and enables the organisation to use the total funds it receives to get improved value for money and integrated service delivery across health and social care.

You can contact North East Lincolnshire CCG in the following ways:

North East Lincolnshire Clinical Commissioning Group
Athena Building,
5 Saxon Court,
Gilbey Road,
Grimsby,
DN31 2UJ

**(switchboard) 0300 3000 400**

nelccg.askus@nhs.net

www.northeastlincolnshireccg.nhs.uk

@NELincsCCG

## 2.2 Our 2014-15 Objectives

The CCG set out an ambitious range of actions for delivery during 2014/15 and fully achieved 94% of these objectives. The remaining 6% are on-going actions which cross over into 2015/16 (and some of them beyond this timeframe).

The Corporate Business Plan is split into 4 Objective themes;

1) Sustainable Services

2) Empowering People

3) Supporting Communities

4) Delivering a fit for purpose organisation.

Within each of the themes are the projects leading to the delivery of the actions and the overall corporate plan has over 60 projects and initiatives.

| Objective | Commentary |
|---|---|
| **Sustainable Services** | By 2019 the CCG aims to deliver cost effective seven day services in North East Lincolnshire of a high standard.<br><br>This will include significant projects around:<br><br>• Enhanced technology<br>• Community Based Care<br>• Mental health services |
| **Empowering People** | By 2019 the CCG aims to deliver information, support and advice which will enable the community to take control of their own health care.<br><br>As part of this priority there are flagship projects underway in<br><br>• End of Life Care<br>• Single Point of Access<br>• Personal Budgets |
| **Supporting Communities** | By 2019 the CCG aims to support older people over 65 and those living with Long Term Conditions (LTCs) to live independently and manage their conditions better. We aim to increase the life expectancy of those in the more deprived areas of North east Lincolnshire.<br><br>As part of this priority there are significant projects underway in areas such as<br><br>• Extra Care Housing<br>• Developing Community Capacity |
| **Delivering a fit for purpose organisation** | CCG aims to continue to deliver an organisation that is fit for purpose within an ever changing environment. To support this aim projects in place include:<br><br>• Effective information systems for individuals and communities<br>• Design, develop and deliver a five year strategic framework for the CCG<br>• Ensure appropriate commissioning arrangements for all contracts<br>• Clinical leadership development and succession |

## 2.3 CCG's vision, mission & values for the future

The CCG Strategic Plan sets out our vision for the future of health and social care in North East Lincolnshire for the next five years, commencing from 2014/15 the plan provides the underpinning context for how we will develop safe, high quality, affordable health and social care services for our local communities for the next five years. We are committed to a person-centred, integrated model of health and social care provision in partnership with North East Lincolnshire Council, as well as a wide range of local providers and we are committed to working in partnership with our local communities to meet their diverse needs.

**Vision:-**

To deliver to the people of North East Lincolnshire the best possible independent healthy living through joined up solutions

**Mission:-**

We will deliver modernised, up to date health and social care provision which will:

- Empower People
- Support Communities
- Deliver Sustainable Services

**Values:-**

Consistency: We will ensure people receive consistent outcomes wherever and whenever they need help

Quality: We will ensure people have access to quality services

Innovation: We will innovate when our best practice is not good enough

The implications resulting from demographic trends, with increasing numbers of older people and younger people with complex needs, is the subject of on-going debate with little certainty nationally on what models of health and social care will meet future needs and be financially sustainable. Our CCG faces the additional challenges of diverse communities within a small geographic area.

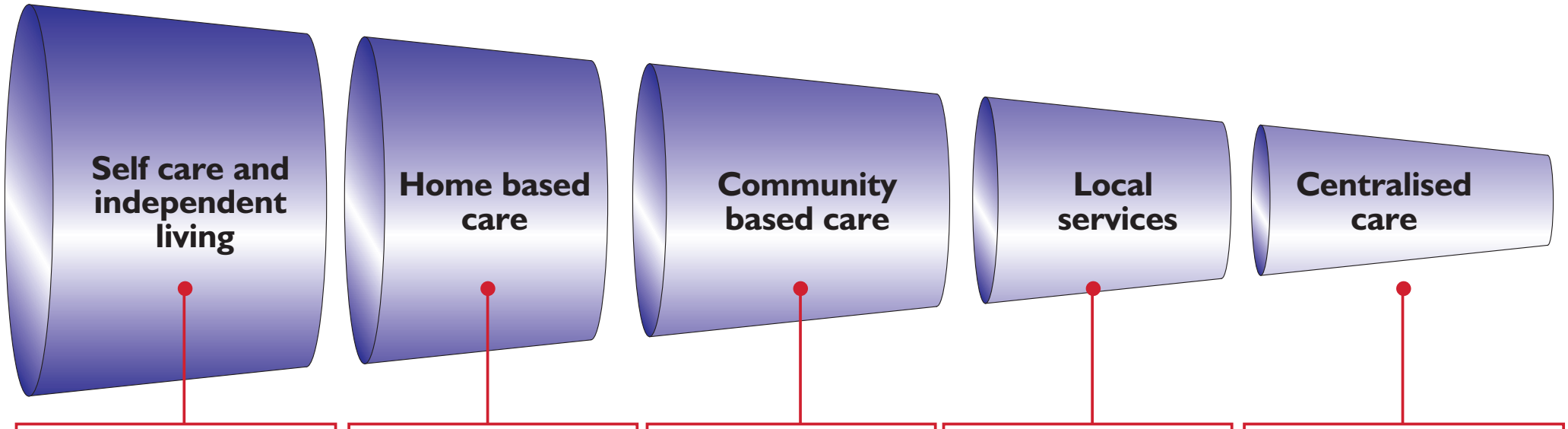
We are determined to deliver the best possible choice, quality and consistency in health and social care whilst driving down costs and offering real value for money. We will continue to lead the way in the development, adoption and diffusion of innovative approaches in the way we work – to enable the people we serve in North East Lincolnshire to have real and increasing choice and control.

## 2.4 Plans for future development

### 2.4.1 Healthy Lives, Healthy Futures

The services we will commission will reflect our concept of the "shift to the left" as set out in figure 1 below which underpins our transformational change programme, Healthy Lives, Healthy Futures which is undertaken in partnership with North Lincolnshire Clinical Commissioning Group.

## The Shared Vision




We expect that people should manage their own health where it is safe and appropriate. This includes making positive lifestyle choices, and taking responsibility for personal wellbeing.

Where intervention is required we aim to deliver care in your own home unless it is better for it to be in a specific care environment.

Most services do not need to be delivered in a hospital setting, so we want to deliver those near your home in your community.

Where services do need to be delivered in a hospital environment, we would expect the majority of these to be in your local hospital.

For some services we know that outcomes are better where they are provided in fewer centres. This could mean more successful treatment or recovery. It may mean you need to travel to another hospital setting, either in North or North East Lincolnshire or to a specialist centre (e.g. Hull or Sheffield).

We will achieve this within the context of increasing pressure on public sector funding to deliver more for less and have set out an ambitious vision for health and social care in 2018/19 which will provide up to date, innovative and effective care for our local communities.

Our plan also takes into consideration the strategic direction outlined by NHS England in its Five Year Forward View, published in October 2014, which emphasises the need to work towards preventing ill health and increasing wellbeing as well as ensuring that mental health services have parity of esteem with physical health services.

Healthy Lives, Healthy Futures (previously the Sustainable Services review) is a review of all services in the Northern Lincolnshire region. The review aims to make sure the services available to people in our area will be safe and of high quality for years to come.

During 2014/15, North East Lincolnshire CCG along with North Lincolnshire CCG led and delivered an engagement and formal consultation programme related to Hyper Acute Stroke Services and Ear, Nose and Throat inpatient services.

The overall response to the consultation was good, engaging with over 1000 primary contacts. It includes those who attended events and meetings including public events, Road show, Stakeholder and Community groups and drop-ins at GP practices:

- Public events (11)
- Road shows (523)
- GP Practice Visits (241)
- Living Well events (93)
- MELA (Multicultural festival) (77)
- Northern Lincolnshire and Goole Hospitals NHS Foundation Trust staff event (29)
- North East Lincolnshire CCG Annual General Meeting (17)
- Stakeholder and Community groups (350)

This resulted in 298 formal consultation responses; comprising 257 questionnaires (26 of which were Easy Read), 29 Comment cards, 6 emails, 5 letters, and 1 Facebook query.

In November 2014, the CCGs took a formal decision to endorse the preferred service options and implement service changes.

Healthy Lives, Healthy Futures continues to be led by North Lincolnshire CCG and North East Lincolnshire CCG working with organisations such as the Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLaG) and other health and social care organisations. The review is linked with similar programmes within the East Riding of Yorkshire and East Lindsey, and is the first in a series of reviews that we expect to be undertaken over the next 5-10 years. All of our reviews will be driven by national best practice recommendations around the services we offer, to ensure that we develop a health and social care system that delivers safe, high quality and affordable services for many years to come.

Please see the link below for further information on this initiative, including examples of public engagement and consultation:

**www.healthylivehealthyfutures.nhs.uk**

### 2.4.2 Adult Social Care – Meeting the needs of the local Population

NEL Clinical Commissioning Group also commissions Adult Social Care Services under a formal section 75 agreement (which is the legal agreement between the Local Authority and the CCG under Section 75 of the NHS Act 2006) and as such, is able to deploy Adult Social Care resources from the local council alongside Health resources to deliver integrated solutions through integrated commissioning. This allows us to have single contracts with local care providers which in turn encourage local providers to deliver integrated and more efficient care pathways.

During 2014/15 the CCG has continued to successfully deliver and implement the Adult Social Care Strategy. We have stabilised and improved the quality within the local residential care market and have introduced some new flexibility to the domiciliary care market to ensure providers are better able to respond to crisis which helps to avoid unnecessary hospital and care home admission. We have continued to shape and re-model the supported living market offering people the opportunity to live independently with support as opposed to within a formal care setting and we are very close to opening our first extra care housing scheme for the frail elderly. The Strategy will be reviewed in-time for 2015/16 to ensure it is fit for purpose in relation to the introduction of new statutory duties associated with the Care Act (2014). The refreshed strategy will set out how the CCG intends to fulfil its delegated responsibilities to ensure that people across the area will continue to receive the care and support necessary to maximise independence, health and wellbeing within the diminishing resources available.

**Adult Social Care Strategy 2015-2018**

### 2.4.3 Primary care co-commissioning

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1 April 2015. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View to deliver a new deal for primary care and another step towards plans set out by NHS England early last year to give patients, communities and clinicians more involvement in deciding local health services.
North East Lincolnshire CCG has assumed responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2015 but these will be discharged under joint decision making processes through a Joint Committee of NHS England and the CCG.

## 2.5 Quality & Performance

### 2.5.1 Our performance

Measuring our performance helps ensure our services are being delivered to a quality standard and that they provide value for money. Our performance is continually assessed by the Department of Health and NHS England in relation to a large number of indicators

North East Lincolnshire CCG monitors the performance of its local healthcare providers to ensure that:

- Local people receive good quality care in areas such as control of infection, the friends and family test, avoiding never events (very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place), governance of quality and safety matters and the response to the Winterbourne review
- Patient rights under the NHS constitution are being promoted. These include: waiting times for A&E, cancer treatment, elective surgery and ambulance calls; mixed-sex accommodation breaches and the mental healthcare programme approach.
- Local people receive good quality care and support for Adult Social Care services to enhance their quality of life by helping them to manage their own support as much as they wish, so that they are in control of what and how support is delivered to match their needs.

Areas of particular scrutiny in 2014-15 for NELCCG were:

- A&E waiting times - North East Lincolnshire CCG's main emergency care provider is Northern Lincolnshire and Goole Foundation Trust (NLaG), which has struggled to achieve the national standard for 95 per cent of patients (NELCCG 93.92%) waiting for no longer than four hours due to the extended period of pressure in the form of admission rates and constant bed capacity pressures which have been a feature across the Yorkshire & Humber hospitals and nationally. There have also been added pressures because of acute and intermediate tier bed closures due to D&V. There are emergent signs of recovery and the CCG have engaged with new operational leaders responsible for Diana Princess of Wales hospital A&E in order to support recovery.
- Elective waiting times – North East Lincolnshire CCG is working with the Trust to ensure that delivery of this key national target is achieved. The NHS operating standard for elective waiting times is that 95 per cent of patients (NELCCG 94.7%*) should have their first outpatient appointment within 18 weeks of clinical referral and 90 per cent of patients (NELCCG 88.5%*), where there has been a clinical decision to admit for treatment, should have their surgery within 18 weeks of the original clinical referral.

*NB Performance is at end of February 2015

Areas of particular success in 2014-15 for North East Lincolnshire CCG were;

- Carers receiving needs assessed or review and a specific carer's service, or advice and information in the year (NELCCG 62.11% against target of 45%*)
- Estimated diagnosis rate for people with dementia (NELCCG 66.56% against target of 53.01%)
- Cancer two-week wait for first outpatient appointment with suspected cancer (NELCCG 98.3% against target of 93%*)
- Cancer two-week wait for first outpatient appointment with breast symptoms (NELCCG 99.4% against target of 93%*)

*NB Performance is at end of February 2015

Our latest performance is available on our **website**

The CCG has a number of financial duties under the National Health Service Act 2006 (as amended)

Please refer to finance performance duties note 42 within the annual accounts

### 2.5.2 Quality premium

The Quality Premium is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

In 2014/15 we received £230k, which related to our performance in 2013/14. The funding received has been spent on the following:-

- Primary Care Access £60k; to support GP recruitment & transformation
- IT mobile working £60k; to support better community working
- Dementia Training £30k
- End of Life education £80k

The quality premium we receive in 2015/16 for performance in 2014/15 will be based on five national measures and one local measure.

Based on our current performance against the Quality Premium measures it is anticipated that North East Lincolnshire CCG will receive £101k on the assumption that the CCG manages within its total resources for 2014-15 and that there are no serious quality failures.

| | Measure | Quality Premium Value | |
|---|---|---|---|
| **National Measures** | Potential years of life lost | 10.0% | £84,339.00 |
| | Delayed transfers of care by NHS (days) | 15.0% | £126,508.50 |
| | Patients discharged at weekends or bank holidays. | 15.0% | £126,508.50 |
| | Mental Health patients in paid employment. | 20.0% | £168,678.00 |
| | Mental Health Quality of life | 10.0% | £84,339.00 |
| | Improving Antibiotic Prescribing | 10.0% | £84,339.00 |
| **Local Priorities** | Proportion of people dying at home | 10.0% | £84,339.00 |
| | Outpatient follow-up attendances | 10.0% | £84,339.00 |
| | **Total before NHS Constitution deductions** | | **£843,390.00** |
| **Constitution Rights and Pledges** | Referral to treatment times | 30.0% | |
| | A&E four hour wait | 30.0% | |
| | Cancer waiting times | 20.0% | |
| | Ambulance Response Times | 20.0% | |
| | Adjustment for failure | | |
| | **QUALITY PREMIUM TOTAL** | | |

## 2.6 Commissioning activity

The CCG, in its strategic role as the commissioner at the centre of the local health and social care economy, has two functions:

To commission and procure a range of health and social care services on behalf of local people;

To empower individuals to procure services directly which meet their particular need.

North East Lincolnshire is unique as it has responsibility for commissioning both health and adult social care services on behalf of its registered population. In other areas adult social care is commissioned by the council. North East Lincolnshire Council has delegated its responsibility to the CCG through a formal partnership agreement so that these two areas of care can be brought together with the aim of improving the services that individuals receive on a day to day basis.

Through this arrangement the CCG has been able to align fee rates and quality requirements for people in long term care irrespective of whether payment is from health or social care funds, brought services that people might need to access in a crisis together and has been able to come up with innovative solutions to help people better manage their health can care needs.

Examples of the services and organisations that the CCG commissions include:

- The majority of hospital services that an individual will access. Its main provider of hospital services is Northern Lincolnshire and Goole Foundation Trust, but it also commissions services from Hull & East Yorkshire Hospitals, Sheffield Teaching Hospitals Foundation Trust and others.
- Community health and social care services, such as community nursing, meals on wheels, and learning disability services, from Care Plus Group
- Adult Mental health services from Navigo. Children's mental health services are commissioned on the CCGs behalf by North East Lincolnshire Council from Lincolnshire Partnership Trust.
- Residential and Nursing home care for those with eligible needs
- Home based / domiciliary care, to help people with eligible needs with the tasks associated with daily living.

In addition to commissioning health and social care services the CCG also commissions a range of support services from external organisations. Please see section **2.7.3 Support Services page 24.**

The CCG does not currently have responsibility for the provision of General Practice, Pharmacy, dentistry & optician services or specialist services. These are commissioned for our registered population by NHS England.

During 2014/15 the CCG has been working to deliver a number of service developments (both new services and service improvements), some of which started in 2014/15 and some of which will commence during 2015/16.

Examples of the service developments and improvements the CCG has undertaken during 2014/15 include:

- Learning disability supported living.
  Purpose built homes within a supported living setting for individuals with complex physical and learning disability. Summer 2014 saw the opening of the second apartment model enabling those with complex physical and learning disability to live as independently as possible in the community.

- A new carer's support service.
  The support available for carers from the service includes specialist advice and information, benefits advice and checks, advocacy support, befriending, support groups, counselling, social activities, holistic therapies and carers training. The service opened on the 1st April 2014.

- An improvement in Dementia diagnosis.
  The CCG has been working with GPs to improve in the rate of dementia diagnosis, which in turn has led to individuals being able to access the additional support they need to live well with dementia and appropriately plan for the future.

- Improvements to Diabetes services.
  These improvements include the production of a patient guide and information pack to help people better understand their conditions; the establishment of a support group in collaboration with Diabetes UK to help people to manage their condition better themselves; and the development of an enhanced insulin service to ensure that all individuals are able to access this service within the community.

- Improvements to Dermatology services.
  A Community Dermatology service providing outpatient appointments, minor surgery and PUVA services based at Cromwell Road primary care centre opened in October 2014. A tele-dermatology service will start in June 2015 which will enable consultant dermatologists to provide primary care with advice and guidance to manage patients in the community where appropriate, and thus avoid the patient having to go to the hospital.

- The creation of Extra Care Housing.
  Purpose built homes within an extra care setting where individuals can receive the care and support they need providing a viable alternative for those who are frail or elderly with a positive alternative to going into residential care. The first of these developments is called
  Strand Court and is on Albion Street in Grimsby, it will be opening in July 2015. Further homes are planned to be built in other areas of the town over the coming years.

- Assisted Living Centre.
  A purpose built centre which will provide advice, information and signposting in relation to all aspects of independent living. The service includes a demonstration facility showcasing the range of Aids for Daily Living (A4DL) available. The Centre is located at Kingsley Grove, Grimsby and will be opening at the end of April 2015.

## 2.7 The resources, principal risks and relationships that may affect the CCG's long-term value

### 2.7.1 Resources

The main categories of resource available to the CCG to assist with the delivery of its objectives comprise of directly employed staff, support service providers, formal partnership arrangements, the capacity it has secured for its clinical leadership and community governance arrangements, money, and collaborative arrangements with other NHS commissioners. The CCG does not have any significant capital assets.

### 2.7.2 Money

The money allocated for commissioning NHS services is set by NHS England, and comes in two parts. The first is a 'running cost' allocation, for funding the management and operation of the organisation. The second 'programme' allocation funds the health services that we commission for the population of North East Lincolnshire from a range of health, private sector and third sector provider organisations.

The income received to fund the commissioning of Adult Social Care services is set by North East Lincolnshire Council as part of its annual resource and priorities process.

### 2.7.3 Support Services

The largest of these arrangements is with Yorkshire and Humber Commissioning Support which provides a wide range of services to North East Lincolnshire CCG and to other NHS commissioning organisations in its area. Further information about these services can be found at **www.nyhcsu.org.uk.**

Other bought-in support services include payroll services from Northumbria Healthcare NHS Foundation Trust, and a number of specific Adult Social Care support services (notably finance) from North East Lincolnshire Council.

### 2.7.4 Formal Partnership Arrangements

The CCG has had two formal partnership arrangements in place

The first is the legal Partnership Agreement between North East Lincolnshire Council and the CCG which sets out the arrangements for delegating commissioning of all Adult Social Care services from the council to the CCG, and the joint working to be pursued to improve the health and wellbeing of the local population. This agreement has been in place since 1st April 2013, and builds on the previous arrangement between North East Lincolnshire Council and the North East Lincolnshire Care Trust Plus.

The second is the partnership agreement between the CCG and 'focus', which is the social enterprise established on 1st September 2013 to provide assessment, post-assessment and case management of adults requiring social work services.

### 2.7.5 Clinical leadership

The CCG has established a number of clinical leadership arrangements to take forward its objectives. This includes having a Chief Clinical Officer (GP) and a Governing Body and Partnership Board where clinicians/professionals are in the majority. The Council of Members has one nominated GP representative from each of the thirty member practices, and is responsible for determining service strategy and the constitutional arrangements of the organisation. There are also a number of clinical lead roles, each of whom work with a community contact and a service lead to form a leadership 'Triangle' for our service themes, and drive our service improvement plans.

### 2.7.6 Community Governance

The CCG has established extensive community involvement in its governance arrangements which are critically supported by the Accord membership scheme. The CCG draws a range of volunteers and roles from the Accord membership to participate in its governance including:

- The lay member on the board who leads Patient Participation and Involvement
- A community contact for each of our service theme Triangles
- Members of corporate groups and committees

The Partnership board also has two elected councillors as members, nominated by North East Lincolnshire Council.

### 2.7.7 Principal risks that may affect the CCG's strategy & development

The CCG adopts an integrated approach to risk management which enables the CCG to consider the potential impact of all types of risks on all processes, activities, stakeholders and commissioned services. The CCG Risk Management Framework aims to provide strategic direction and guidance on embedding the integrated risk management approach in all CCG business.

Further details of the principle risks, can be found in the 'risk assessment' section 6.8, page 74 of the Annual Governance Statement.

## 2.8 Sustainability Report

As a commissioner of healthcare services and as an employer, we recognise the need to minimise our impact on the environment.

A new NHS Sustainable Development Strategy was launched in January 2014; this replaced the NHS Carbon Reduction Strategy of 2009. This new strategy sets out a vision and goals for a sustainable health and care system by reducing carbon emissions, protecting natural resources, preparing communities for extreme weather events and promoting healthy lifestyles and environments.

The NHS is committed to achieve a minimum 10% carbon emissions reduction by 2015 from a 2007 baseline. Since the CCG was formed in April 2013 it has taken account of energy use, waste and transport as detailed below. As the CCG is not listed on the London Stock Exchange it does not have to include carbon footprint data in its Annual Report. In addition the CCG is not a large enough company to qualify to be part of the Carbon Reduction Commitment as electricity consumption for CCG operations falls below the 6000 megawatt-hours per annum threshold.

**Summary of developments in 2014/15**

The CCG's Agile Working project is now fully operational and enables all CCG staff to work in flexible and efficient ways. The CCG has provided staff with mobile technology and this alongside the development of a flexible working policy will reduce travel costs and CO2 emissions as staff do not have to work from designated buildings.

**Greenhouse Gas Emissions:**

The CCG now occupies only one building; this will generate further carbon emission savings, ensuring the CCG will easily surpass the 10% reduction in CO2 building emissions by 2015 against a 2007 target. The CCG has a bike shed and encourages staff to cycle to work. The building is not on any public transport routes so car sharing is promoted wherever possible.

**Waste Minimisation and Management:**

It has been a priority for efforts on CO2 reductions to be aimed at organisational culture changes, as well as behaviour change amongst staff, in an effort to raise the profile of the sustainability agenda. Specific projects aimed at changing staff behaviour include the recycling strategy, where bins are provided so waste paper and dry mixed recycling can be recycled, and the printing strategy, where staff are positively encouraged not to print unless absolutely necessary. The dry mixed recycling process means that many different types of waste can be placed in one container which increases waste recycling rates while reducing costs by not disposing it to landfill. Paper and card are recycled separately and general waste is placed in a separate bin. There are appropriate bins inside and outside the building. The printing strategy is supported by the fact the only two printers in the building print exclusively double sided and in black and white. In addition, we now recycle ink cartridges via a company called Green Lights rather than disposing of them.

The CCG has launched a Waste Campaign to urge patients to take ownership of the quantity of medicine they order. They organised several public events to give people help and information about medicine waste in the NHS, highlighting that pharmacies cannot reuse returned medication and that patients who keep hold of unused medication which may be past its 'use by' date may put their safety at risk.

**Finite Resource Consumption:**

Water consumption is supplied on a metered basis. The estimated water consumption per annum for the last two years was 440 cubic metres. The total cost based on average price per cubic meter of £2.56 is £1,125

**Biodiversity Action Planning and Sustainable Procurement:**

The requirement to report on Biodiversity Action Planning and Sustainable Procurement applies to organisations subject to the Greening Government Commitments. These are the government's commitments for delivering sustainable operations and procurement for the current parliament (to 2014/15). According to guidance from HM Treasury NHS bodies are not subject to the Greening Government Commitments so commentary under this section is not required.

## 2.9 Equality & Diversity Report

Equality, fair treatment and social inclusion lie at the heart of the Government's plans to modernise the health service, as required under the Equality Act 2010. North East Lincolnshire CCG is committed to the following principles:

- to recruit, develop and retain a workforce that is able to deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals;
- to be a fair employer achieving equality of opportunity of outcomes in the workplace;
- to use its influence and resources as an employer to make a difference to the life opportunities and health of its local community.

North East Lincolnshire CCG has an approved Equality Plan which sets out the vision for North East Lincolnshire CCG to take equality and diversity forward. The document sets out how North East Lincolnshire CCG will advance the social and economic wellbeing of the community to ensure equal health and employment outcomes for the whole of the diverse population it serves.

The Public Sector Equality Duty has three key requirements that public bodies must comply with, these are as follows:

**1) Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act**

North East Lincolnshire CCG has undergone an extensive training exercise with its workforce to ensure its employees are fully briefed and aware of its duties, including the behavioural requirements from each staff member. Within the organisation, policies are in place to ensure any staff member experiencing inappropriate conduct has adequate means of redress. Contracting staff undertook additional training with regards to the contracting and contract monitoring of providers and service delivery to ensure their compliance with relevant behaviour and legislation.

**2) Advance equality of opportunity between people who share a protected characteristic and people who do not share it**

As part of tackling health inequalities, North East Lincolnshire CCG has built in mechanisms to its service design process which ensure that disadvantages linked to protected characteristics are highlighted and mitigation measures are put in place. Equality impact assessments are undertaken for each service and our equality impact assessment panel (including community members) reviews and revises those assessments as necessary, ensuring relevant mitigating actions are taken.

**3) Foster good relations between people who share a protected characteristic and people who do not share it**

North East Lincolnshire CCG works proactively with local protected groups to ensure that their interests and their viewpoints are included within thinking and strategy development for the CCG and that staff are kept updated with current issues and emerging trends to tackle health inequalities. The CCG provides leadership to local commissioners and providers to work together to foster good relations between protected groups and the public at large. This collaborative working aims to maximise local impact for the equality agenda and ensure those groups who are most disenfranchised are cared for appropriately.

North East Lincolnshire CCGs Partnership Board receives regular updates on progress related to the organisation's Equality plan and provides active leadership on this agenda.

As an organisation, North East Lincolnshire CCG is committed to equality and valuing diversity within its existing and potential workforce. As such, North East Lincolnshire CCG has a commitment to interviewing job applicants with disabilities where they meet the minimum criteria for the job, making 'reasonable adjustments' to avoid any disabled employee being put at a disadvantage compared to non-disabled people in the workplace and ensuring that staff with disabilities have the opportunity to discuss their development through the CCGs Personal Development and Review process. In addition an equality impact assessment is undertaken on all newly proposed Human Resources policies to determine whether it has a disparate impact on disability.

**Staffing - CCG staff**

The CCG has a staffing establishment of 63.35 whole time equivalents its headquarters functions, and also has formal arrangements in place to buy in a range of support services from a number of different providers at a cost of £2.4m in 2014/15. The sickness rate at the CCG headquarters was regularly below 1% with occasions where a slight increase was seen, the majority of these absences were short term. Turnover rate of employees in 2014/15 was has reduced to 9.76 FTE compared to that of 11.43 FTE of CCG staff (minus the transfer of Focus TUPE) in 2013.

Breakdown of gender (as at 31 March 2015)

| | | |
|---|---|---|
| The number of persons of each sex who sit on the Governing Body | Male 11 | Female 5 |
| The number of persons of each sex who sit on the Council of Members | Male 27 | Female 8 |
| The number of other senior managers of each sex who were a grade VSM (other than persons falling within the above disclosure) | nil | nil |
| The number of persons of each sex who were employees of the CCG | Male 13 | Female 62 |

## 2.10 Legislative Requirements

The CCG is bound by several external legal and regulatory processes. The CCG's statutory duties to commission certain health services are set out in the NHS Act 2006 act and amended by the Health & Social Care Act 2012. The CCG will be held to account if it is failing or has failed to discharge any of its functions or if there is a significant risk of that happening. A summary of the CCG's discharge of its statutory functions is also provided at "Statutory duties" section 6.16 page 84 of the Annual Governance Statement.

The CCG Statutory duties can be summarised as follows:-

**14Z15(2)(a) - Duty to improve the quality of services**

Quality, along with innovation and consistency is one of the core principles of North East Lincolnshire CCG. The CCG has robust processes in place for managing the quality agenda. The day to day management of this rests with the Director of Quality and Nursing.

Key achievements in 2014/15 include the following:-

- An Interim Director of Quality and Nursing came into post - responsible for the strategic leadership and effective Clinical Governance, Quality Assurance, Safeguarding, and MCA
- An experienced GP was appointed as Clinical Lead for Quality, Governance and Caldicott Guardianship and to develop a clinically led local Mortality Committee
- A Lead Nurse for Quality was appointed to develop collaborative working with all our care providers, to influence the quality of care provided. Provide professional expertise to nursing and quality business processes and lead and oversee the Quality Committee ensuring that the CCG has robust governance processes in place that places quality at the heart of the clinical agenda.
- A Clinical Support Manager (fixed term) was allocated to support the work in the Quality Team and develop links with practice GP's and Nurses.
- A Contracting Officer was allocated to ensure there are clear links between the Quality Team and Contracting
- A Patient and Client Experience Manager was allocated to lead, manage and develop an integrated patient and client experience service across North East Lincolnshire's CCG
- Further development of a Quality Framework and inspections to inform commissioning intentions and drive up the quality of care in the local care home sector
- Implementation and full achievement of the dementia screening tool and the Sepsis 6 care bundle
- Developing enhanced working with our Specialist Nurses and Clinical Leads

**Objectives, in relation to quality, for 2015/16 are as follows:**

The Quality Team will further develop areas where a strengthened CCG wide approach to service quality and quality assurance could be undertaken

- Work with CCG service leads on service specifications for quality delivery of care by our providers- develop processes for NICE guidance to be embedded in the service specifications for our providers of care delivery to influence the quality of care delivered NICE (National Institute of Health and Care Excellence - provides national guidance and advice to improve health and social care) Continue to embed and enhance the Quality Framework and inspections
- Further develop Collaborative working and Quality Contract review meetings with our providers of care to monitor and discuss care delivery of key areas of concern with their action plans to improve care delivery. Develop mechanisms for engaging with Allied Healthcare Professionals, linking them in to key work areas of the CCG

Further embed a Duty of Candour

- Develop a culture of candour.by ensuring our providers train and support staff to disclose information about unanticipated events in a patient's care and apologise when appropriate; develop improvements in the levels and accuracy of the reporting of patient safety incidents; spread and apply lessons learned into practice and publicly report these.

Develop a structured framework to support clinicians and lay members undertaking commissioner led visits and the implementation of a programme of clinically led commissioner led visits to our major providers to see at first- hand how patients and families are being afforded high quality care with outcomes discussed and actions monitored, by the Quality Committee.

CCG Quality Leads Peer Support Group to be established to be a focal point for the collaborative continuous professional development of the Senior CCG Quality Team Nursing staff working within East Riding of Yorkshire CCG, North Lincolnshire CCG, North East Lincolnshire CCG and Hull CCG. The Network will have a particular focus on

- Providing a supportive framework for the senior nurses to enable them to discharge both their professional and service delivery duties appropriately and effectively. Provide a forum which will inform and influence a consistent approach to local healthcare commissioning and delivery.

Further develop enhanced working with our Specialist Nurses and Clinical Leads e.g:

- Infection Control Lead Nurse and Team
  To set up process for reporting back on c diff cases and MRSA BSI to GPs
  To set up and deliver Education sessions on sepsis to GPs

- Designated Nurses for Safeguarding
  To roll out Prevent training across the CCG
  Attendance at the Safeguarding Adults Leadership Board as Clinical Advisor
  Development of "Making Safeguarding Personal" Quality information
  Development of support packages for Primary Care for Safeguarding Adult Reviews

- Medicines Management
  To develop further the key achievements from 2014/15 although there will be a greater emphasis on antibiotic prescribing and also the impact of Proton pump inhibitor (PPI) prescribing on C Diff infections

NHS Continuing Healthcare and NHS-funded Nursing Care (CHC)

To reach set of quality targets from the Department of Health which are linked to both performance and achievement of 28 day turnaround from checklist to decision to workforce development.

**14Z15(2)(a)- Duty to reduce inequalities**

The **Equality & Diversity** Report on page 27 of this report provides details of how the CCG have complied with this duty.

**14Z15(2)(a) – Duty to involve and consult with the public**

The CCG's clinical leaders believe the only way we can succeed in delivering high quality services for the community and improving the health of our population is by involving members of the public, partner organisation and of course our member GP practices in the development of services. Therefore it is vital the public and clinical community are not only informed of the process but engaged in it and offered the opportunity to be involved.

The year the CCG launched its Engagement Strategy with the aim to provide the CCG Governing Body, Council of Members, partner organisations and the public with our approach to achieve effective and meaningful stakeholder communication and involvement in our work.

Our long term strategic objectives for communications and engagement are:

- Effectively engage and communicate with Member practices

- Have a community that is well engaged, well informed and interested in local health, wellbeing and social care

- Ensure our partners and other key interested parties are kept informed

- Have supported and valued staff who are well informed and engaged

- Actively engage with local providers and secondary care clinicians

The Accord membership scheme has been developed to support the CCG's engagement with the local community. Over 2,600 members have joined Accord since it was established in 2009. This year saw the re-launch of Accord with new branding, website and the development of 'Suits You' a model of engagement in which members record their areas of interest in health and social care and are given the flexibility to participate at level that suits them such as receiving and reviewing information at home, participating in on-line surveys, attending meetings and focus groups; and collaborative working in decision making as a member of the commissioning team.

We continued to develop our extensive stakeholder list of local community groups, voluntary groups and organisations, including those that represent groups with protected characteristics. This is maintained and utilised to identify those people who may be interested in being involved in particular projects.

Through the Accord and stakeholder databases communications and engagement can be effectively targeted to relevant communities thus increasing the potential for more active engagement.

For more information please refer to our **Engagement Strategy.pdf**

During 2014/15, NELCCG along with North Lincolnshire CCG led and delivered an engagement and formal consultation programme related to Hyper Acute Stroke Services and Ear, Nose and Throat inpatient services, detailed information can be found in section 2.4.1 Healthy Lives, Healthy futures summary at page 17 of this report.

**14Z15(2)(b) – CCG's must contribute to the delivery of the joint health and wellbeing strategy**

The Health and Wellbeing Board has been established to drive health and wellbeing improvement for the population of North East Lincolnshire. It is chaired by the council's cabinet member for health, wellbeing and adult social care; and its membership includes representatives from North East Lincolnshire Council, North East Lincolnshire Clinical Commissioning Group, NHS England, Provider representatives, Healthwatch, the voluntary sector and community representatives.

The Health & Wellbeing Board has actively been engaged with the progress of the Annual Report via the Chairman of the Board and his representation as a Lay Member on the CCG Partnership Board, and Integrated Governance & Audit Committee

The health & wellbeing strategy, agreed by the Health and Wellbeing Board, sets out the local approach to health and wellbeing which is focussing more on prevention and early intervention, and creates a clear expectation that there will be as increasing role for individuals to play in making healthy lifestyle choices (for example to avoid smoking and obesity), managing their own health without dependency on NHS or Adult Social Care services whenever possible and appropriate. There is also an expectation that communities will play a much greater role in supporting the health and wellbeing of their community.

The CCG has set ambitious range of actions to deliver their areas of the strategy, which are reflected in the CCG's corporate business plan.

Examples specific to the Health and Wellbeing strategy include:-

Release & Increase "community capacity" to grow instances of (& support to) self-care skills, tackling isolation & promotion of self-management tools & skills; thus reducing dependency on services & delaying eligibility to formal ASC

Development of Extra Care Housing facilities within NEL to support individuals to maintain their independence and minimise use of statutory services

There are a range of objectives of delivery within the CCG's corporate business plan; at the end of March 2015 we achieved completion rate of 94%. The remaining 6% are on-going which cross over into 2015/16.

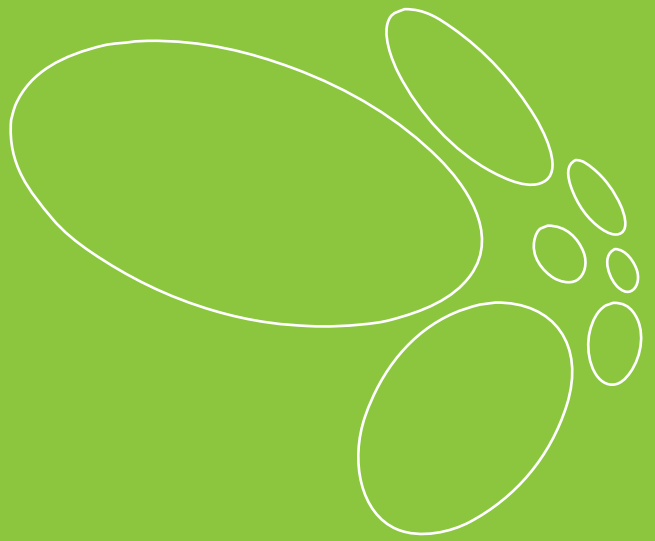
Further details about its work, membership, and the health and well-being strategy that has been agreed by partner agencies for North East Lincolnshire, can be found at **Live Well North East Lincolnshire**.

## 2.11 Accountable Officer Declaration

I, as Accountable Officer, certify that the clinical commissioning group has complied with the statutory duties laid down in the NHS Act 2006 (as amended by the Health & Social Care Act 2012).

**Dr Peter Melton**
**Accountable Officer**
**28th May 2015**

# MEMBERS REPORT 3.0



### 3.1 Disclosure Statement

The Members' Report has been prepared by the Partnership Board and provides an overview of GP practices who are members of the CCG, composition of the Governing Body, Partnership Board and Council of Members, and a biography of members of the Partnership Board and other key points of interest.

Each individual who is a member of the Partnership Board at the time the Members' Report is approved, confirms so far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and, that the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

The table below provides details of the Chair and Accountable Officer during 2014/15 up to the signing of the Annual Report & Accounts.

| Name | Designation |
|---|---|
| Mr Mark Webb | Chair |
| Dr Peter Melton | Chief Clinical Officer |

### 3.2. Members Practices

The table below provides details of the GP Member Practices of the CCG

| Practice | Representative/s | From – To |
|---|---|---|
| Dr E Amin, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW | Dr Amin | April 2013 – present |
| Dr A Hussain, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW | Dr Hussain | April 2013 – present |
| Ashwood Surgery, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW | Dr Reeta Singh | April 2013 – present |
| Dr P Suresh – Babu, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW | Dr P Suresh –Babu | April 2013 – present |
| Beacon Medical, Primary Care Centre, St Hugh's Ave, Cleethorpes, DN35 8EB | Dr Elmer Molave<br>Dr Laura Bernal-Gilliver | April 2013 – January 2015<br>February 2014 – present |
| Birkwood Medical Centre, Westward Ho, Grimsby, DN34 5DX | Dr Karin Severin | April 2013 – present |
| Dr B Biswas & Partner, 142-144 Grimsby Road, Cleethorpes, DN35 7DL | Dr P Ray | April 2013 – present |
| Dr Chalmers** & Dr Meier**, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW | Dr I Chalmers<br>Dr V Meier | April 2013 – present<br>April 2013 – present |
| Chantry Health Group, Cartergate, Grimsby, DN31 1QZ | Dr A M Bamgbala | April 2013 – present |
| Chelmsford Medical Centre, 128 Chelmsford Ave, Grimsby, DN34 5BA | Dr SN Keshri | April 2013 – present |
| Clee Medical Centre, 323 Grimsby Rd, Grimsby, DN35 7XE | Dr Andrew Stead<br>Dr Kazim Sibtain | April 2013 – October 2014<br>October 2014 – present |
| R Kumar, Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH | Dr R Kumar | April 2013 – present |
| Field House Medical Group, Freshney Green Primary Care Centre, Sorrel Rd, Grimsby, DN34 4GB | Dr D Hopper | April 2013 – present |
| Healing Health Centre, Wisteria Drive, Healing, DN41 7PU | Dr KS Koonar | April 2013 – present |
| Dr Jethwa, Weelsby View Health Centre Ladysmith Rd, Grimsby, DN32 9EF | Dr Hasmuck Jethwa | April 2013 – present |

| | | |
|---|---|---|
| Dr S Kumar and Partners, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE | Dr AP Kumar | April 2013 – present |
| Littlefield Surgery, Freshney Green Primary Care Centre, Sorrel Road, Grimsby, DN34 4GB | Dr Nathalie Dukes | April 2013 – present |
| Open Door, 13 Hainton Ave, Grimsby, DN32 9AS | Rob Baty<br>Vicki Bowen | April 2013 – March 2015<br>March 2015 - present |
| Raj Medical Centre, 307 Laceby Road, Grimsby, DN34 5LP | Dr Rakesh Pathak | April 2013 – present |
| Pelham Medical Group, Church View Health Centre, Cartergate, DN31 1QZ | Dr David Elder | April 2013 – present |
| Humberview Surgery, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE | Dr David Elder | April 2013 – present |
| The Roxton Practice, Pilgrim Primary Care Centre, Pelham Road, Immingham, DN40 1JW | Dr Arun Nayyar | April 2013 – present |
| Dr S Sinha & Dr G De, Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH | Dr Anupam Sinha | August 2013 - present |
| Scartho Medical Centre, Springfield Road, Scartho, Grimsby, DN33 3JF | Dr Thomas Maliyil | February 2014 - present |
| Dr Dijoux and Partners, Taylors Avenue Medical Centre, Taylors Avenue, Cleethorpes, DN35 0LJ | Dr Sylvere Dijoux | April 2013 - present |
| Dr Singh & Dr Mathews, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE | Dr Renju Mathews | April 2013 - present |
| Woodford Medical Centre, Freshney Green Medical Centre, Sorrel Road, Grimsby, DN34 4GB | Dr Julian Clark<br>Dr Peter S John | April 2013 – June 2014<br>February 2015 - present |
| Dr O Z Qureshi Surgery (Formally Dr Zaro & Dr Qureshi) Taylors Avenue Medical Centre, Taylors Avenue, Cleethorpes, DN35 0LJ | Dr Omar Qureshi | April 2013 – present |
| Quayside Open Access, 76B Cleethorpes Road, Grimsby, DN31 3EF | Richard Ellis<br>Caroline Day | April 2013 – March 2015<br>March 2015 - present |
| Dr Bedi, New Waltham Surgery, New Waltham, Grimsby, N E Lincolnshire, DN36 4QG | Dr Narinder Bedi | April 2013 – present |

** denotes – both have signed mandate to vote on behalf of their practice – only one vote is counted

### 3.3 Governing Body & Partnership Board Members Profiles

| Name and Biography | Position | Governing Body Sub- Committees | Declarations of Interest |
|---|---|---|---|
|  **Mark Webb ****<br><br>Mark Webb spent a number of years in publishing and now owns a small local newspaper publishing company. He also runs a commercial property and business support company that is a social enterprise dedicated to assisting local business and entrepreneurs. Having spent many years in the commercial sector, Mark also has considerable experience in public/ private sector partnership and working with local communities. A former chair of the local strategic partnership and current chair of the Growth and Development Board, Mark brings this experience to the fore to provide challenge and support in equal measures to all sectors making up the CCG. Above all Mark is passionate about the real involvement of the community in the design and delivery of meaningful health and care to the population of North East Lincolnshire. He joined the Governing Body of the CCG at its commencement. | **Chair**<br><br>(1 April 2013 – present) | Remuneration Committee * (April 2013- present)<br><br>Care Contracting Committee (March 2014 – present) | Managing Director:-<br>E-Factor Ltd<br>Cleethorpes Chronicle<br><br>50% Shareholder in Cleethorpes Chronicle Ltd |
|  **Peter Melton ****<br><br>Dr Peter Melton was born and brought up in North East Lincolnshire. After studying medicine in London he returned to the area to complete his General Practice training. He became a partner in the Roxton Practice in Immingham in 1993 and remains there now. He joined the Governing Body of the CCG at its commencement. | **Chief Clinical Officer**<br><br>(1 April 2013 – present) | Non member of sub commitee | GP Principal – Roxton Practice<br>This practice is a member of 360 care limited & LINCS<br><br>Wife is employed by 360 care Limited<br><br>Director of Doc.Know Ltd<br><br>Wife is Company Secretary of Doc.Know Ltd<br><br>Chair of NHS Commissioning Assembly |

*denotes Chair of that Committee **denotes Governing Body ***denotes Partnership Board member (those who are not members of the Governing Body)

| Name and Biography | Position | Governing Body Sub- Committees | Declarations of Interest |
|---|---|---|---|
|  **Cathy Kennedy ****<br><br>Cathy has over twenty years' experience as an Executive Director in a variety of NHS organisations, including acute provider trusts and commissioning organisations. She has been working in the North East Lincolnshire area since 2000 and joined the Governing Body of the CCG at its commencement. | **Deputy Chief Executive/ Chief Financial Officer**<br><br>(1 April 2013 – present) | Delivery Assurance Committee * (April 2013 – present)<br><br>Central Management Meeting (April 2013 – present)<br><br>Care Contracting Committee (April 2013 – present) | Husband – IP Project Manager with Yorkshire and Humber Commissioning Support<br><br>Healthcare Finance Managers Association (HfMA):<br><br>President of Yorkshire branch<br><br>Chair of National Commissioning Faculty |
|  **Dr Derek Hopper ****<br><br>Dr Derek Hopper has been a GP in Grimsby for thirty eight years. He also has a wide interest in medical politics and is an active member of both the Northern Lincolnshire Local Medical Committee and the National Association of Primary Care. He joined the Governing Body of the CCG at its commencement. | **Vice Chair/ Chair of Council of Members**<br><br>(1 April 2013 – present) | Council of Members * (April 2013 – present)<br><br>Remuneration Committee (April 2013- present) | GP Partner Fieldhouse Medical Group<br><br>Member of Council of National Association of Primary Care (NAPC)<br><br>Son is Dental Surgeon at Freshney Green Primary Care Centre |

*denotes Chair of that Committee **denotes Governing Body ***denotes Partnership Board member (those who are not members of the Governing Body)

| Name and Biography | Position | Governing Body Sub- Committees | Declarations of Interest |
|---|---|---|---|
|  **Helen Kenyon ****<br><br>Helen Kenyon has worked in the NHS for over 20 years, and has worked in North East Lincolnshire since 1999. She is a qualified accountant and has responsibility for both the commissioning and contracting of Adult Social Care on behalf of North East Lincolnshire Council and for the commissioning and contracting of Health services within the CCG. She joined the Governing Body of the CCG at its commencement. | **Deputy Chief Executive**<br><br>(1 April 2013 – present) | Council of Members (March 2014 –present)<br><br>Central Management Meeting * (April 2013– present)<br><br>Care Contracting Committee * (April 2013 – present)<br><br>Delivery Assurance Committee (April 2013 – present) | SJW Solutions in Partnership.<br><br>An independent consultancy company who may in the future look to work directly with the CCG.<br><br>Currently working under contract with LINCs, who the CCG does work with currently |
|  **Philip Bond ****<br><br>Philip worked for thirty years as a lawyer in the Courts Service before ill health caused retirement. Prior to becoming a Lay Member on the CCG Philip had been an elected public Governor at an NHS Hospital Trust for seven years, serving as Lead Governor. He has many years of public sector voluntary service particularly in education. He is currently Chair of Directors of Tollbar Family of Academies, a chain of Academy schools. He joined the Shadow CCG Governing Body in June 2011 and was appointed to the substantive post in April 2013.<br><br>As well as full CCG Board activities, Philip attends monthly Community Forum meetings. He is a member of the CCG Integrated Audit and Governance Committee, the CCG Quality Committee and also the Healthy Lives, Healthy Futures Assurance Group. He has been heavily involved with the re-launch of Accord (the community membership of the CCG), acting as interim Chair of the Accord Steering Group and also instrumental in establishing regular meetings of the Chairs of Patient Participation Groups in North East Lincolnshire. | **Lay Member Community Engagement**<br><br>(1 April 2013 – present) | Integrated Governance & Audit Committee (September 2013- present)<br><br>Quality Committee (31 July 2013 – present) | Member of PPG (Chair) Blundell Park Surgery<br><br>Director of Tollbar Family of Academies (small academy chain) |

*denotes Chair of that Committee **denotes Governing Body ***denotes Partnership Board member (those who are not members of the Governing Body)

| Name and Biography | Position | Governing Body Sub- Committees | Declarations of Interest |
|---|---|---|---|
|  **Dr Arun Nayyar ****<br><br>Dr Arun Nayyar has been a GP partner at Roxton Practice Immingham for 10 years. He is also the CCG Clinical lead for planned care and the GP representative on governing body. He joined the CCG at commencement. | **GP Representative Clinical Lead for Planned Care**<br><br>(1 April 2013 – present) | Council of Members (April 2013 – present) | GP Partner – Roxton Practice<br>X2 GP Partners within my practice have relationship with NELCCG<br><br>Director of Core Care Links Ltd<br>Co-Directors<br>Dr Nathalie Dukes-Wiesenhaan<br>Dr Thomas Maliyil<br>Dr Martin Clausen<br>Dr R Pathak |
|  **Dr Rakesh Pathak ****<br><br>Dr Rakesh Pathak is a full time GP. He was raised in the Grimsby area and is married to another GP. He has an interest in tackling health inequalities. He joined the CCG at commencement. | **GP Representative Clinical Lead for Unplanned Care**<br><br>(1 April 2013 – present) | Council of Members (April 2013 – present) | GP Principal – Raj Medical Centre Laceby Road, Grimsby<br>Wife is also a GP Principal at Raj Medical Centre<br><br>Sister is a GP in London<br><br>Director Core Care Links Ltd<br>Co-Directors<br>Dr Arun Nayyar<br>Dr Nathalie Dukes-Wiesenhaan<br>Dr Thomas Maliyil<br>Dr Martin Clausen<br><br>Director 360 Ltd<br>Other Directors<br>Dr Sean Thrippleton<br>Dr Annapurna Kumar<br><br>Director M & R Medical Ltd<br>Wife is Co-Director of M & R Ltd<br><br>Brother-in-law is Chief Executive of the charity Mission Fish which deals with the charitable aspects of e-bay |

*denotes Chair of that Committee **denotes Governing Body ***denotes Partnership Board member (those who are not members of the Governing Body)

| Name and Biography | Position | Governing Body Sub- Committees | Declarations of Interest |
|---|---|---|---|
|  **Susan Whitehouse ****<br><br>Susan is a member of the Chartered Institute of Internal Auditors and holds a MSC (Distinction) in Internal Audit and Management. She has spent most of her career in auditing in both the public and private sector including a number of years working internationally in a Head of Internal Audit role and as Head of Compliance at the Office of the National Lottery (now the Lotteries Commission). More recently she worked as an independent Lottery and Regulatory consultant both in the UK and overseas. From 2007 she was the Non-Executive Audit Chair for North East Lincolnshire Care Trust Plus before successfully being appointed to the CCG board as a lay member and Chair of the IG&A Committee. Susan brings a substantial amount of business experience and knowledge to the CCG Board gained both in the UK and overseas. | **Lay Member Governance and Audit**<br><br>(1 April 2013 – present) | Integrated Governance & Audit Committee * (April 2013 – present)<br><br>Remuneration Committee (April 2013 - present) | Compliance Manager – 51 community interest companies promoting society lotteries, for raising money for Health related good causes (non- NHS) |
|  **Mr Perviz Iqbal ****<br><br>Mr Perviz Iqbal is consultant in Obstetrics and Gynaecology at Doncaster Royal Infirmary. He joined the Governing Body of the CCG at its commencement. | **Secondary Care Specialist Doctor**<br><br>(1 April 2013 – 31/03/2015) | None member of Sub-Committees | Consultant in Obstetrics & Gynaecology.<br><br>Doncaster & Bassetlaw NHS Trust |
|  **Juliette Cosgrove ****<br><br>Juliette Cosgrove is the Assistant Director for Quality at Calderdale and Huddersfield Foundation Trust where she leads on Quality Governance and Improvement. She joined the Governing Body in April 2013 initially as the nurse on the Governing Body but now is a clinical lay member. | **Clinical Lay Member**<br><br>(1 April 2013 – present) | Quality Committee * (29 September 2014 – present) | Calderdale & Huddersfield NHS Foundation Trust, Assistant Director to the Medical & Nurse Directors<br><br>Husband is a Consultant Neurosurgeon at Lancashire Teaching Hospital NHS Trusts |

*denotes Chair of that Committee **denotes Governing Body ***denotes Partnership Board member (those who are not members of the Governing Body)

| Name and Biography | Position | Governing Body Sub- Committees | Declarations of Interest |
|---|---|---|---|
|  **Joe Warner ****<br><br>Joe Warner qualified as a social worker in 1987 and is registered with the Health and Care Professional Council. Joe is the Managing Director of focus independent Adult Social Work CIC and has worked in senior management positions in several local authorities including joint NHS and council posts and also a London CCG. He was also the managing director of a not for profit company supporting people with a learning disability. He is currently a member of the Adult Faculty Steering Group of the College of Social Work. He joined the Governing Body in September 2013. | **Managing Director Focus Independent Adult Social Care work**<br><br>(1 September 2013 – present) | Council of Members (March 2014 – present) | Director – Praxis Social Care Solutions |
|  **Dr Thomas Maliyil ****<br><br>Dr Thomas Maliyil MBBS, MD, MRCP, MRCGP is a Partner at Scartho Medical Centre and Vice Chair (chair elect) of the Council of Members of NELCCG. He is also a Hull and York Medical School (HYMS) Tutor and a trainer of Foundation Year doctors. His other role is as a Director of Core Care Links LTD, a provider of NHS services. He has trained locally and lived in the area for over fourteen years and is committed to developing and maintaining high quality services for the population of North East Lincolnshire. He joined the CCG in February 2014. He also works as a Specialist Doctor in palliative medicine with St Andrew's Hospice. | **Vice Chair Council of Members/GP representative**<br><br>(1 February 2014 – present) | Council of Members (February 2014 - present) | GP at Scartho Medical Centre<br><br>My wife is practice manager at Blundell Park Surgery & Healing Health Centre<br><br>Trainer - Foundation Year 2 HYMS<br><br>Director of Core Care Links provider of Primary Care Services in NEL<br>Other Directors<br>Dr Arun Nayyar<br>Dr Nathalie Dukes-Wiesenhaan<br>Dr Martin Clausen<br>Dr R Pathak<br><br>Director of Bethesda Ltd – service supply medical cover & healthcare management<br><br>Other Director of Bethesda Ltd (Wife) |

*denotes Chair of that Committee **denotes Governing Body ***denotes Partnership Board member (those who are not members of the Governing Body)

| Name and Biography | Position | Governing Body Sub- Committees | Declarations of Interest |
|---|---|---|---|
|  **Stephen Pintus **** Stephen joined the local authority in January of this year. Prior to this move, Stephen has been working in Derbyshire, jointly with local government and the NHS, leading a reconfiguration of lifestyle services, producing a profile of the health needs of the population and leading a process of renewing the health and wellbeing strategy. Having worked at a senior level in public health for nearly 20 years, Stephen has built up a body of experience of work in a variety of settings: these have included regeneration work with communities, work with the voluntary sector, project management in health inequalities, running partnerships, as well as work in both local government and the NHS commissioning health and wellbeing services. | **Director of Public Health** (1 January 2015 – present) | Delivery Assurance Committee (February 2015 – present) | Director of Public Health North East Lincolnshire Council<br>Chair of Bridge Employment (Sheffield Based) Supported Employment Voluntary Organisation |
|  **Joanne Hewson ***** Joanne has twenty years' experience of working with children and family services and has worked in the private, voluntary and public sectors. In her current role as Deputy Chief Exec she holds responsibility for the DASS and the DCS covering both the adults' and children's agenda. She joined the CCG Partnership Board in September 2013. | **Strategic Director People and Communities** (1 September 2013 – present) | None member of Sub-Committees | NELC Deputy Chief Executive (Communities) |
|  **Councillor Michael Burnett ***** Cllr Mick Burnett has been Deputy Leader of the Council since May 2011 and appointed as non-executive director of the Care Trust Plus in May 2010. He is NELC Portfolio Holder for Tourism, Leisure and Culture. He worked at Courtaulds for 33 years in various roles. As Portfolio holder for Tourism, Leisure & Culture, Mick hopes to make a difference to the health and wellbeing of the residents of North East Lincolnshire. He joined the Partnership Board of the CCG at its commencement. | **NELC representative, portfolio holder for Tourism, Leisure & Culture** (1 April 2013 – present) | Integrated Governance & Audit Committee (April 2013 – present) | Councillor Leader North East Lincolnshire Council<br>Director of Cleethorpes Events<br>Director of Disability Active<br>Director of Lincs Inspire. |

*denotes Chair of that Committee **denotes Governing Body ***denotes Partnership Board member (those who are not members of the Governing Body)

**3.3.1 The following Governing Body & Partnership Board members have resigned from their position during 2014/15**

| Name | Position | Governing Body Sub- Committees | Declarations of Interest |
|---|---|---|---|
| **Geoff Barnes **** | **Acting Director of Public Health**<br>(10 March 2014 – 31 December 2014) | Delivery Assurance Committee<br>(1 January 2014- 31 December 2014) | Nil return |
| **Mandy Coulbeck **** | Locally Practising Nurse<br>(1 April 2013 – 31 January 2015) | Non Member of sub-comittee | No declaration received |
| **Councillor Peter Wheatley ***** | NELC Portfolio Holder for Health, Wellbeing and Adult Social Care<br>(24 May 2013 – 6 February 2015) | Integrated Governance and Audit Committee<br>24 May 2013 – 6 February 2015)<br><br>Remuneration Committee<br>24 May 2013 – 6 February 2015) | North East Lincolnshire Council (Member) |

Details on all committees and sub-committees can be found in the Annual Governance Statement (2014/15)

*denotes Chair of that Committee **denotes Governing Body ***denotes Partnership Board member (those who are not members of the Governing Body)

## 3.4 Pension Liabilities

Further details in relation to the treatment of pension liabilities can be found in note 4 in the Financial Statements and the **"Pension Benefits" Remuneration Report.**

## 3.5 Sickness Absence Data

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

The sickness data provided represents sickness from 1 April 2014 – 31 March 2015

| | |
|---|---|
| Total FTE days lost Apr 14 to March 15 | 243 |
| Total Staff Years | 63 |
| Average working days lost | 4 |
| Cumulative cost of sickness Apr 14 to Mar 15 | £22,188 |

The sickness absence data is included in the employee benefits note 4.3 of the Financial Statements

## 3.6 Cost Allocation & Setting of Charges

We certify that the clinical commissioning group has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

## 3.7 Better Payment Practice Code

The NHS as a whole is signed up to the Confederation of British Industry (CBI) Better Payment Practice Code, which aims to promote good payment practice in the UK. The NHS target is to pay all non-NHS trade creditors within 30 days of receipt of goods or invoice (whichever is the latter) unless other payment terms have been agreed with the supplier.

Details of compliance with the code are given in note 6 of the Financial Statements

## 3.8 Exit Packages & Severance payments

Further details in relation Exit Packages can be found in note 4.4 in the Financial Statements

## 3.9 External audit

Our external auditor is KPMG who is appointed by the Audit Commission. Auditors' remuneration in relation to April 2014 to March 2015 totalled £61,500.00 (excluding VAT). This covered audit services required under the Audit Commission's Code of Audit Practice (giving opinion on the Annual Accounts and work to examine our use of resources and financial aspects of corporate governance).

Our Integrated Governance & Audit Committee receives our external auditor's Annual Audit Letter and other external audit reports.

The external auditor is required to comply with the Audit Commission's standard in respect of independence and objectivity and with International Auditing Standard 260 for UK & Ireland (Standard 260: The auditor's communication with those charged with governance).

Work undertaken by the external auditor during financial year 2014/15 is summarised as follows:

- Audit services: the statutory audit and services carried out in relation to the statutory audit (e.g. reports to NHS England)
- Further assurance services: This refers to services unrelated to the statutory audit where the clinical commissioning group has discretion whether or not to appoint an auditor (e.g. review of achievement of performance indicators)

Any other services provided: Auditors may undertake statutory activities under the Code of Practice that are not related to the audit of the clinical commissioning group's Financial Statements (e.g. value for money work).

## 3.10 Access to Information

During the period 1 April 2014 to 31 March 2015, the CCG processed the following requests for information under the Freedom of Information Act (FOI) 2000

| | 2014/2015 |
|---|---|
| Number of FOI requests processed | 276 |
| Percentage of requests responded to within 20 working days | 100% |
| Average time taken to respond to an FOI request | 13 |

In 6 cases, no information was provided and in 13 cases, only part of the information was provided because an exemption was applied. Exemptions applied included information being accessible by other means, intended for future publication, the cost of providing the information exceeded the limits set by the FOI Act or it was personal information

Our publication scheme contains documents that are routinely published; this is available on our **website**

## 3.11 Principles for remedy

HM Treasury's Managing Public Money contains guidance at Annex 4.14 about the steps public bodies should take where they have caused injustice or hardship by maladministration or service failure.

The Parliamentary and Health Service Ombudsman published revised Principles for Remedy in May 2010, setting out six principles that represent best practice and are applicable to clinical commissioning groups.

The CCG has adopted these six Principles for Remedy which form part of its complaints handling procedure. The six principles are:

- Getting it right,
- Being customer focused,
- Being open and accountable,
- Acting fairly and proportionately,
- Putting things right,
- Seeking continuous improvement.

The CCG has demonstrated its compliance with these principles through the complaints reporting process to the Quality Committee. An annual report on complaints is also received by the CCG's Partnership board and North East Lincolnshire Council Cabinet (consisting of elected members) for scrutiny.

All complaints are assessed in line with the Principles for Remedy, any employee errors or maladministration are dealt with accordingly.

The CCG's Deputy Chief Executive personally signs off all complaint responses and details all remedies or service improvements within the response. Remedies intend to put service users in the position they would have been had the issue leading to the complaint not occurred.

## 3.12 Employee Consultation

In order to recognise the benefits of partnership working, the CCG is an active member of the Joint Trade Union Partnership Forum which is organised by the Workforce Team within Yorkshire and Humber Commissioning Support.

The aim of the Joint Trade Union Partnership Forum is to provide a formal negotiation and consultation process for the CCGs and the Unions to discuss and debate issues in an environment of mutual trust and respect.

The key functions of the forum are as follows:

- Engages employers and trade union representatives in meaningful discussion on the development and implications of future policy.
- Provides a forum for the exchange of comments and feedback on issues that have a direct or indirect effect on the workforce
- Promotes effective and meaningful communication between all parties that can be subsequently disseminated across the membership.

The CCG continues to use the Joint Trade Union Partnership Forum to approve policies as and when they are finalised by the CCG.

All staff has an opportunity to participate in consultation on policy development. New policies which have been agreed in 2014/15 with support of staff consultation:

- Relocation and Expenses Policy
- Temporary Promotion Policy
- Career Break Policy
- Secondment Policy
- Travel Expenses and Subsistence Policy

The CCG has undertaken a number of formal organisational changes between April 2014 and March 2015, all of which have involved employee consultation processes. The Joint Trade Union Partnership Forum was engaged in these CCG organisational changes.

## 3.13 Emergency preparedness

North Yorkshire and Humber NHS England Area Team has responsibility for the emergency preparedness and major incident response plans in place across their area, which includes North East Lincolnshire, and for ensuring that they are compliant with the NHSCB Emergency Preparedness Framework 2013. To support this, the CCG has business continuity plans in place and supports with capacity and control plans for incidents. The Chief Clinical Officer and two Deputy Chief Executives provide out of hours (telephone) cover for emergency issues that require a local CCG commissioning response.

The CCG is assured that the North Yorkshire and Humber Local Area Team regularly reviews and makes improvements to its major incident plan, and engages in the programme established for testing this plan locally.

## 3.14 Health & Safety

North East Lincolnshire Clinical Commissioning Group recognises its responsibilities and duties under the Health & Safety at Work Act (1974) and is committed to ensuring so far as is reasonably practicable, the health, safety and welfare of its employees, visitors and other persons who may be affected by its activities. North East Lincolnshire Clinical Commissioning Group will comply with legislation as a minimum and strive to improve performance on a continual basis by accepting best practice standards and the setting of performance targets in relation to the management of health & safety. North East Lincolnshire Clinical Commissioning Group has commissioned Health & Safety service from North East Lincolnshire Council ensuring that there are robust arrangements in place for the management of health and safety across the organisation.

## 3.15 Additional Disclosures

### 3.15.1 Disabled employees

See section **2.9 Equality & Diversity Report** on page 27 of this report for full details

### 3.15.2 Disclosure of Date Loss Breaches

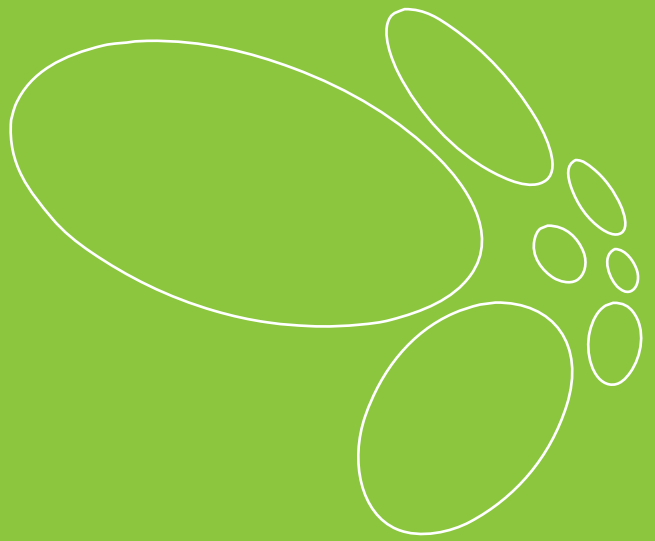
See section 6.15 Data Security on page 83 of this report for full details

### 3.15.3 Counter Fraud

See section 6.5 (2) Counter Fraud on page 72 of this report for full details

**Dr Peter Melton**
**Accountable Officer**
**28th May 2015**

# REMUNERATION REPORT 4.0



## 4.1 Remuneration Committee Members

| | Meeting Dates | | | |
|---|---|---|---|---|
| | 24/04/2014 | 06/11/2014 | 28/01/2015 | 26/03/2015 |
| **Voting Members:** | | | | |
| Mark Webb, CCG Chair - meeting chair | Yes | Yes | Yes | Yes |
| Sue Whitehouse, Lay member for Governance & Audit | Yes | Yes | Apologies | Apologies |
| Cllr Peter Wheatley, Partnership Board NELC nominated representative (Resigned February 15) | Yes | Yes | Yes | n/a |
| Dr Derek Hopper, Chair of Council of Members / Governing Body member | Yes | Yes | Yes | Yes |
| Dr David Elder, Council of Members GP Representative (Started March 2015 | n/a | n/a | n/a | n/a |
| **Other attendees:** | | | | |
| Cathy Kennedy, Chief Financial Officer/ Deputy Chief Executive* | Yes | Yes | Yes | Yes |
| Emma Kirkwood, Human Resources Business Partner, Commissioning Support Unit ** | Apologies | Yes | Yes | Yes |
| Michelle Williamson, Human Resources Officer, Commissioning Support | No | Yes | Yes | Yes |
| Janet Thacker, Head of Workforce, Commissioning Support Unit** | Yes | No | No | No |
| Karen Stamp, PA to Executive Office - Taking notes | Yes | Yes | Yes | Yes |

* attends to present papers from the CCG

** attends to advise the panel on HR implications

Very Senior Manager (VSM) pay was in line with the national guidance entitled “Clinical Commissioning Groups Remuneration Guidance for Chief Officers” (where the senior manager also undertakes the Accountable Officer role & Chief Finance Officer’s guidance).

As part of the VSM framework and contract of employment these senior managers are eligible for access to a non-consolidated bonus based on their annual performance. The decision to make a non-consolidated bonus payment is made by the remuneration committee.

All VSMs are employed on permanent contracts, with notice periods and termination being in line with national guidelines.

## 4.2 Salaries & Allowances

Pension related benefit is the increase in the annual pension entitlement determined in accordance with the HMRC method. This compares the accrued pension and the lump sum at age 60 at the end of the financial year against the same figures at the beginning of the financial year adjusted for inflation. The difference is then multiplied by 20 which represents the average number of years an employee receives their pension (20 years is a figure set out in the CCG Annual Reporting Guidance). These figures do not represent actual cash payments. It should be noted that the GP representative figures are affected by previous employments in non-practitioner roles which can lead to a distortion in the numbers e.g. Dr Maliyil.

| 2014-15<br>Name and Title | (a)<br>Salary<br>(bands of £5,000) | (b)<br>Expense payments (taxable) to nearest £100 | (c)<br>Performance pay and bonuses (bands of £5,000) | (d)<br>Long-term Performance pay and bonuses (bands of £5,000) | (e)<br>All pension related benefits (bands of £2,500) | (f)<br>Total (a-e)<br>(bands of £5,000) |
|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Dr Peter Melton, Chief Clinical Officer | 85-90 | | | | | 85-90 |
| Cathy Kennedy, Deputy Chief Executive / Chief Financial Officer | 100-105 | | | | 0 - 2.5 | 100-105 |
| Helen Kenyon, Deputy Chief Executive | 90-95 | | | | 2.5-5.0 | 95-100 |
| Mark Webb, Chair | 20-25 | | | | | 20-25 |
| Dr Derek Hopper, Vice Chair & Chair of Council of Members | 5-10 | | | | | 5-10 |
| Philip Bond, Lay Member Community Engagement | 5-10 | | | | | 5-10 |
| Dr Arun Nayyar, GP Representative | 5-10 | | | | | 5-10 |
| Dr Rakesh Pathek, GP Representative | 5-10 | | | | | 5-10 |
| Cllr Michael Burnett, Portfolio Holder for Tourism & Culture NELC | 5-10 | | | | | 5-10 |
| Joanne Hewson, NELC Deputy Chief Executive - Communities (started 01/09/13) | 0-5 | | | | | 0-5 |
| Susan Whitehouse, Lay Member Governance & Audit | 10-15 | | | | | 10-15 |
| Cllr Peter Wheatley, Partnership holder for adult social care & wellbeing (left 06/02/15) | 0-5 | | | | | 5-10 |
| Dr Thomas Maliyil, GP Representative (started 01/02/14) | 10-15 | | | | 145-147.5 | 160-165 |
| Mandy Coulbeck, Partnership Board Locally Practicing Nurse (left 31/01/15) | 5-10 | | | | | 5-10 |
| Mr Perviz Iqbal, Secondary Care Doctor | 10-15 | | | | | 10-15 |
| Juliette Cosgrove, Strategic Nurse | 5-10 | | | | | 5-10 |
| Jo Warner, Partnership Board Social Care Representative (started 01/09/13) | 0-5 | | | | | 0-5 |
| Stephen Pintus, director of Public Health (started 01/01/15) | 0-5 | | | | | 0-5 |
| Dr Geoff Barnes, Interim Director Public Health (started 01/01/14 - left 31/12/14) | 0-5 | | | | | 0-5 |

| 2013-14<br>Name and Title | (a)<br>Salary<br>(bands of £5,000) | (b)<br>Expense payments (taxable) to nearest £100 | (c)<br>Performance pay and bonuses (bands of £5,000) | (d)<br>Long-term Performance pay and bonuses (bands of £5,000) | (e)<br>All pension related benefits (bands of £2,500) | (f)<br>Total (a-e)<br>(bands of £5,000) |
|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Dr Peter Melton, Chief Clinical Officer | 85-90 | | | | | 85-90 |
| Cathy Kennedy, Deputy Chief Executive / Chief Financial Officer | 100-105 | | | | (2.5-5.0) | 95-100 |
| Helen Kenyon, Deputy Chief Executive | 90-95 | | | | 35.0-37.5 | 125-130 |
| Mark Webb, Chair | 20-25 | | | | | 20-25 |
| Dr Derek Hopper, Vice Chair & Chair of Council of Members | 5-10 | | | | | 5-10 |
| Philip Bond, Lay Member Community Engagement | 5-10 | | | | | 5-10 |
| Dr Arun Nayyar, GP Representative | 5-10 | | | | 77.5-80.0 | 85-90 |
| Dr Rakesh Pathek, GP Representative | 5-10 | | | | 55.0-57.5 | 75-80 |
| Cllr Michael Burnett, Partnership Board NELC Nominated Representative | 5-10 | | | | | 5-10 |
| Joanne Hewson, Partnership Board NELC Officer Member (started 01/09/13) | 0-5 | | | | | 0-5 |
| Susan Whitehouse, Lay Member Governance & Audit | 5-10 | | | | | 10-15 |
| Cllr Peter Wheatley, Portfolio holder for adult social care & wellbeing (left 06/02/15) | 0-5 | | | | | 5-10 |
| Dr Thomas Maliyil, GP Representative (started 01/02/14) | 0-5 | | | | 20.0-22.5 | 20-25 |
| Mandy Coulbeck, Locally Practicing Nurse (left 31/01/15) | 0-5 | | | | | 0-5 |
| Mr Perviz Iqbal, Secondary Care Doctor | 5-10 | | | | | 5-10 |
| Juliette Cosgrove, Strategic Nurse | 5-10 | | | | | 5-10 |
| Joe Warner, Partnership Board Social Care Representative (started 01/09/13) | 0-5 | | | | | 0-5 |
| Geoff Lake, Partnership Board Social Care Representative (left 31/08/13) | 85-90** | | | | | 85-90 |
| Dr Geoff Barnes, Interim Director Public Health (started 01/01/14 - left 31/12/14) | 0-5 | | | | | 0-5 |
| Jack Blackmore, Partnership Board NELC Officer Member (left 31/08/13) | 10-15 | | | | | 10-15 |
| Dr Sudhakar Allamsetty, GP Representative-Caldecott (left 7/11/13) | 0-5 | | | | | 0-5 |
| Dr Cate Carmichael, Director Public Health (left 31/12/13) | 0-5 | | | | | 0-5 |
| Geoff Lake, Partnership Board Social Care Representative (left 31/08/13) | 85-90** | | | | | 5-10 |
| Cllr Rosalind James, Partnership Board NELC Nominated Representative (left 22/05/13) | 5-10 | | | | | 5-10 |

## 4.3 Pensions Benefits

It is important to note that the pension benefit figures for the GPs relate to their non-practitioner employment only and the pensionable pay figure is grossed up to reflect a whole time equivalent post. The pension data used in these calculations has been provided by the Business Services Authority. Whilst this will include, from 1st April 2014, the work undertaken in their capacity as a senior manager of the CCG it might also include other, non-practitioner work. These pension benefit figures will also include contributions made in previous employments in a non-practitioner role.

Certain Members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for certain Members

| Name and Title | (a) Real increase in pension at age 60 (bands of £2,500) | (b) Real increase in pension lump sum at aged 60 (bands of £2,500) | (c) Total accrued pension at age 60 at 31 march 2015 (bands of £5,000) | (d) Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) | (e) Cash Equivalent Transfer Value at 1 April 2014 | (f) Real increase in cash Equvalent transfer Value | (g) Cash Equivalent Transfer Value at 31 March 2015 | (h) Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Cathy Kennedy, Deputy Chief Executive / Chief Financial Officer | 0.0-2.5 | (2.5-5.0) | 35-40 | 110-115 | 628 | 30 | 675 | |
| Helen Kenyon, Deputy Chief Executive | 0.0-2.5 | (2.5-5.0) | 25-30 | 85-90 | 408 | 22 | 441 | |
| Dr Arun Nayyar, GP Representative | (0.0-2.5) | (0.0-2.5) | 10-15 | 30-35 | 165 | 4 | 173 | |
| Dr Rakesh Pathak, GP Representative | (0.0-2.5) | (0.0-2.5) | 5-10 | 25-30 | 113 | 3 | 119 | |
| Dr Thomas Maliyil, GP Representative | 5.0-7.5 | (0.0-2.5) | 5-10 | 25-30 | 53 | 102 | 156 | |

## 4.4 Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). 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.

### 4.4.1 Real increase in CETV

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 state and end of the period

## 4.5 Pay multiples

| Year | 2014/15 (£1000) | 2013/14 (£1000) |
|---|---|---|
| Band of highest paid directors' total remuneration (£'000) | 120-125 | 120-125 |
| Median total | 26,677 | 24,949 |
| Ratio | 4.6 | 5.0 |

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 director, on a full time equivalent basis (FTE) in North East Lincolnshire Clinical Commissioning Group in the financial year 2014-15 was £120,000 - £125,000. The mid-point of the banded remuneration of the highest paid director would usually be the same as the band reflected in the directors' remuneration table. However as the highest remuneration for this ratio has been based on an annualised FTE basis these are different. This was 4.6 times the median remuneration of the workforce, which was £26,677.

In 2014-15, no employees received remuneration in excess of the highest-paid director as per the remuneration table. Remuneration ranged from £6,256 to £103,125.

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

## 4.6 Off payroll engagements

Off payroll engagements are any and all engagements for the services of an individual where payment is not made through payroll, and therefore after the deduction of income tax and national insurance. This therefore includes all payments to GP practices as well as payments to individuals who claim to be self-employed, and are therefore paid through accounts payable.

Off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months are as follows:

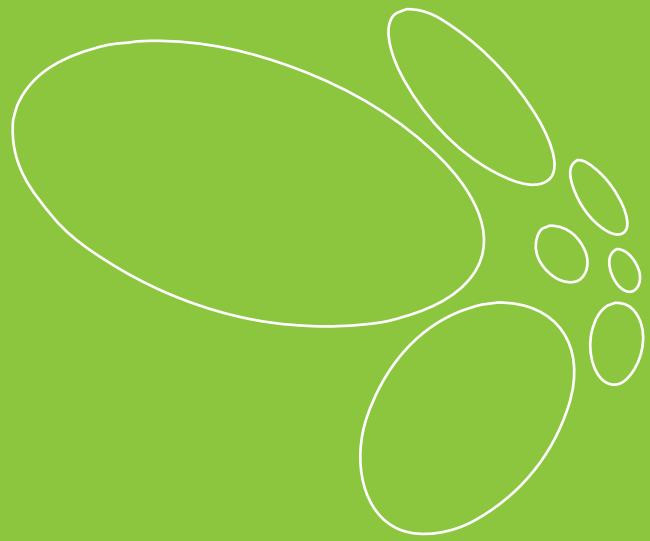
**Dr Peter Melton**
**Accountable Officer**
**28th May 2015**

| | Number |
|---|---|
| Number of existing engagements as of 31 March 2015 | 36 |
| Of which, the number that have existed: | |
| • For less than 1 year at the time of reporting | 25 |
| • For between 1 and 2 years at the time of reporting | 11 |
| • For between 2 and 3 years at the time of reporting | 0 |
| • For between 3 and 4 years at the time of reporting | 0 |
| • For 4 or more years at the time of reporting | 0 |

| | Number |
|---|---|
| Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015 | 25 |
| Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations | 0 |
| Number for whom assurance has been requested | 23 |
| Of which: | |
| assurance has been received | 14 |
| assurance has not been received | 9 |
| engagements terminated as a result of assurance not being received<br>*If no assurance is recieved from individuals they may face the risk of their contract being terminated.* | 0 |

| | Number |
|---|---|
| Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year | 5 |
| Number of individuals that have been deemed " Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements) | 21 |

# STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES 5.0



## 5. Statement of Accountable Officer's Responsibilities

Under the National Health Service Act 2006 (as amended) NHS England has directed North East Lincolnshire 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 resource outturn, application of resources, 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 Government Financial Reporting Manual 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 Government Financial Reporting Manual have been followed, and disclose and explain any material departures inthe financial statements; and
- Prepare the financial statements on a going concern basis.

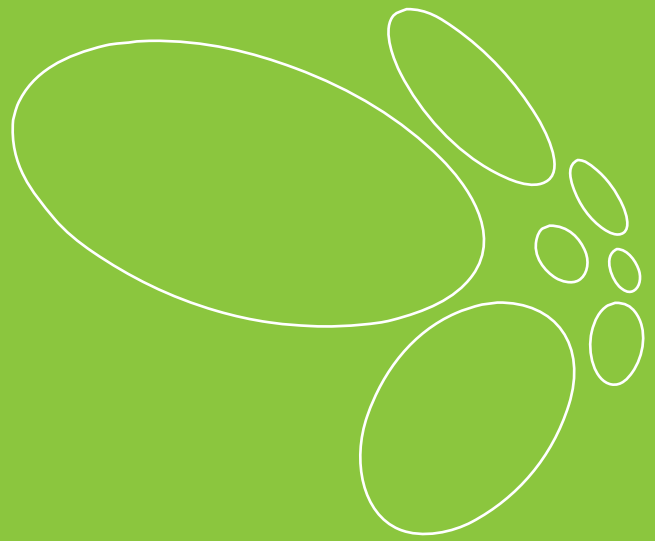
NHS England has designated the Chief Clinical Officer as Accounting Officer of North East Lincolnshire Clinical Commissioning Group. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding North East Lincolnshire Clinical Commissioning Group's assets, are set out in Managing Public Money published by the HM Treasury.

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.

**Dr Peter Melton**
**Accountable Officer**
**28th May 2015**

*Delivering joined up solutions*

# ANNUAL GOVERNANCE STATEMENT 6.0



# 6. Governance Statement by the Chief Clinical Officer as the Accountable Officer of North East Lincolnshire Clinical Commissioning Group

## 6.1 Introduction & Context

The Clinical Commissioning Group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2014, the Clinical Commissioning Group was licensed without conditions

## 6.2 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 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.

## 6.3 Compliance with the Corporate Governance Code

This Governance Statement is intended to demonstrate the CCGs compliance with the principles set out in The UK Corporate Governance Code, issued by the Financial Reporting Council.

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance with relevant principles of the Code is considered to be good practice.

In line with best practice the CCG has completed a self-assessment of the code and identified that we are compliant with 50 (out of a total of 53) provisions that are relevant to the CCG.

## 6.4 The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

*The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.*

### *6.4.1 Constitution*

We have a constitution which has been agreed by our Member Practices and which sets out the arrangements we have made to meet our responsibilities for commissioning care for the people for whom we are responsible. It describes the governing principles, rules and procedures that ensure probity and accountability in the day to day running of the CCG

to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to our goals.

Good governance is a fundamental aspect of the CCG's vision and values (as defined within our constitution and in accordance with section 14L (2) (b) of the 2006 Act, section 4.4 of our Constitution reflects that the Group will at all times observe 'such generally accepted principles of good governance as are relevant to it' in the way it conducts its business. These include:

a) the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business;

b) *The Good Governance Standard for Public Services*;

c) the standards of behaviour published by the *Committee on Standards in Public Life (1995)* known as the 'Nolan Principles

d) the seven key principles of the *NHS Constitution*;

e) The Equality Act 2010.

Our constitution is a living document; a review of the constitution has recently been carried out by the Chief Finance Officer and was submitted to the Council of Members for approval on 8 January 2015. The changes made were around joint commissioning arrangements and have been based on national guidance. The changes have been approved by NHS England and the CCG Governing Body and will take effect from 1st April 2015

### *6.4.2 Governing Body and the Committee Governance Structure*

Our governance meeting structure is headed by the Governing Body. The Governing Body has responsibility to undertake the roles and responsibilities as delegated through the Constitution signed by the 30 Member Practices which constitute the CCG. The constitution has delegated significant responsibility to the Partnership Board which is formally a committee of the Governing Body. The Partnership Board enables the local authority to be engaged in the governance of the organisation throughout the year which is essential to enable the continuation of integrated health and social care commissioning by the CCG.

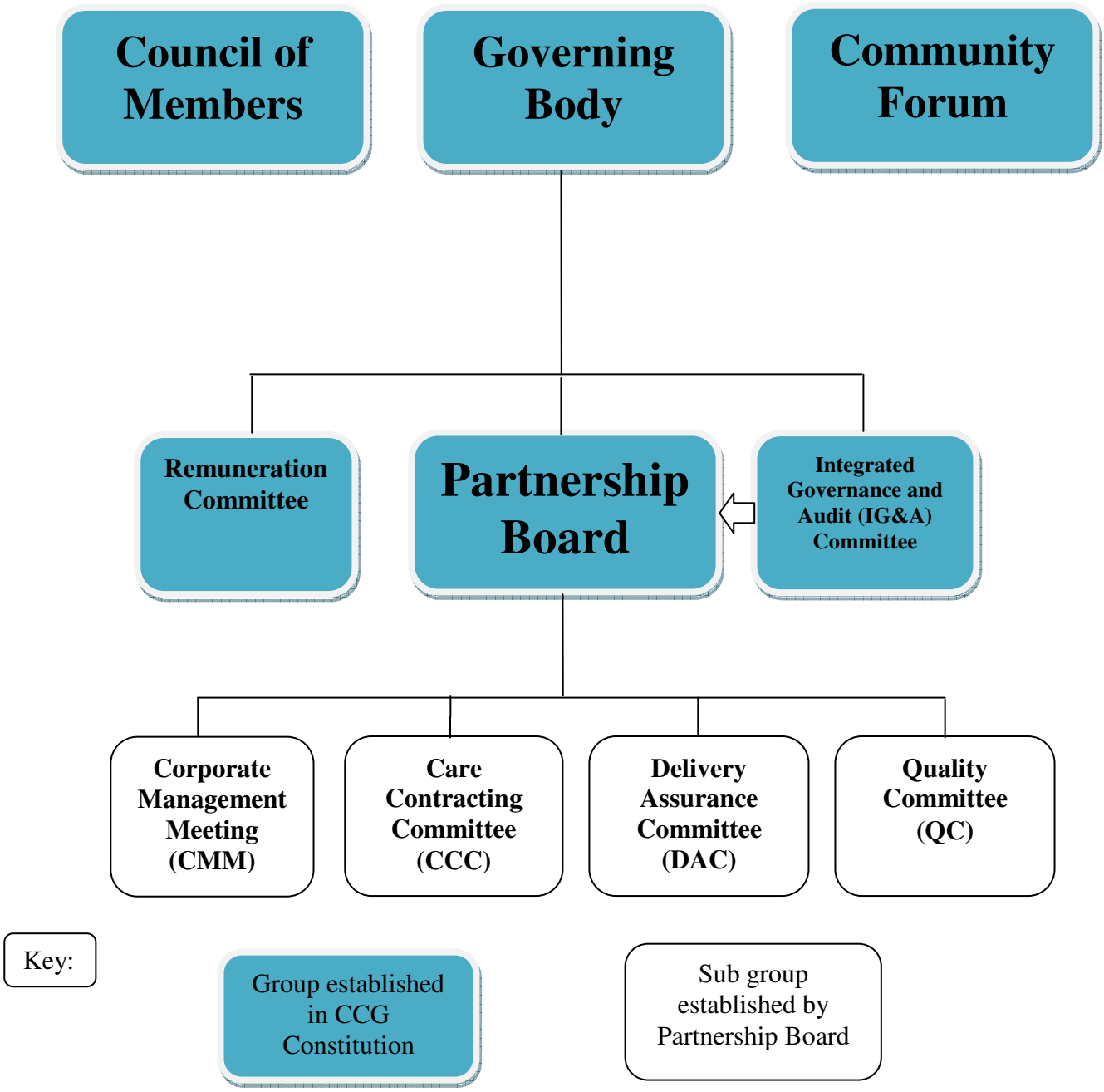
This engagement is a requirement of the legal partnership agreement between North East Lincolnshire Council and North East Lincolnshire Clinical Commissioning Group.

Member Practices are actively engaged within the CCGs service planning and redesign process. This is achieved via the Council of Members and the service triangles. Each service triangle is led by a clinical lead, a service lead and a community lead and they cover seven themes. This ensures engagement of Member Practices in the work of their Governing Body.

The CCG as part of its governance arrangements is required to "make arrangements for the public to be engaged. North East Lincolnshire CCG has strengthened this commitment through the development of the Community Forum. Community Contacts, who are drawn from the CCG's Accord membership scheme, have the opportunity to contribute to the CCG's governance arrangements through positions on Service Triangles, committees and working groups, where they sit as equal partners with health professionals to influence service improvements.

*The committee structure that has been established to support the Governing Body in fulfilling its functions is detailed in figure 1 on the next page*

*Figure 1: North East Lincolnshire CCG committee structure.*




Corporate activity is captured via the corporate business plan and the performance report (which is received by the Partnership Board and the Delivery Assurance Committee on a bi-monthly basis).

The performance dashboard represents an overview of performance and risk for health and social care services across North East Lincolnshire. The dashboard consists of seven performance and six risk domains that incorporate all areas that the CCG's strives to improve on. A judgement has been made of the status for each domain based on the performance measures and risks underpinning them.

These judgements try to balance the current position with the expected outcome at the end of the year and weightings with respect to priority. The Delivery Assurance Committee (DAC) is asked to make a decision on the final status of the dashboard before reporting to the Partnership Board.

The table below details the role and performance / highlights of the CCG's Council of Members, Governing Body, and its Committees. Attendance records are maintained for each to ensure quoracy and clinical representation.

| **Meeting** | **Role and Performance Highlights** |
|---|---|
| Governing Body | The Governing Body has responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically.<br><br>The Governing Body met twice during 2014/15. Attendance records demonstrate that both the meetings were quorate.<br><br>For Governing Body performance highlights, see the Partnership Board section below. |
| Partnership Board | The Partnership Board is responsible for those matters delegated to it within the constitution, its principle functions are:<br><br>➢ effective discharge of the CCGs' statutory duties for the commissioning of health and health care services<br><br>➢ effective discharge of the CCG's responsibilities for Adult Social Care as defined in the legal Partnership Agreement with North East Lincolnshire Council<br><br>The Partnership Board met seven times throughout 2014/15 which included an extraordinary meeting to discuss and approve the public consultation options for Hyper-Acute stroke services, ENT inpatient surgery and children's surgery. Attendance records demonstrate that every meeting was quorate.<br><br>Performance/highlights:<br><br>In addition to its core business (E.g. Reviewing the CCG Assurance Report, monitoring the functions of its committees), the Partnership Board has effectively overseen the following key areas of work (*Please note: This list is not exhaustive*):<br><br>➢ The Engagement Strategy -The aim of this strategy is to provide the CCG Governing Body, Council of Members, partner organisations and the public with not only a vision of how the communications and engagement should be shaped but a route map of how the engaging and informing will be achieved<br>➢ Proposals for the re-launch of the ACCORD Membership Scheme<br>➢ Quality of services, including standardised Hospital Mortality Index (SHMI) performance and CQC reports<br>➢ The Healthy Lives, Healthy Futures programme |

| | |
|---|---|
| Community Forum | The Community Forum provides assurance to the CCG Partnership Board that there are robust structures, processes and accountabilities in place for engagement with local people around the commissioning decisions of the organisation.<br><br>The Community Forum met every month throughout 2014/15. Attendance records demonstrate that each meeting was quorate. In December 2014 the Forum held a planning workshop to review progress and refresh strategic aims which are:<br><br>➢ To work effectively as part of the CCG governance arrangements, supporting delivery of its business and priorities<br>➢ To actively support the implementation of the CCG's strategic aims for public engagement (Engagement Strategy)<br>➢ To work pro-actively with the Voluntary, Community and Social Enterprise (VCSE) sector and wider community to cascade and receive information<br>➢ To continue to develop the skills and knowledge of members to ensure quality and resilience<br><br>Collectively the Forum highlights for 2014/15 include:<br><br>➢ Influenced the development of engagement materials for the Healthy Lives Healthy Futures consultation specifically the East Read summary<br>➢ Provided input on design and content of the Patient Prospectus<br>➢ Considered and commented on key strategic plans and policies including the Adult Society Care Strategy, Engagement Strategy, Business Plan Priorities and Care Act implementation<br>➢ Gathered community views to feed into the Healthy Lives, Healthy Futures programme<br><br>Individually through participation in service triangles, committees and working groups members highlights include:<br><br>➢ Planning and development of the Assisted Living Centre and Extra Care Housing initiative<br>➢ Procurement of Domiciliary Care service providers<br>➢ Planning and development of the Paediatric Assessment Centre at DPOW, the Community Nursing project and Unplanned Teen pregnancy review<br>➢ Participation in multi-agency initiatives such as the Health and Wellbeing Board joint operational group, the Single Point of Access Steering Group and Alliance Board, the Preventative Board and Releasing Community Capacity board<br>➢ Participation in cross-area planning such as the Area Prescribing Committee and Healthy Lives, Healthy Futures Transport group<br>➢ Involvement in quality inspections at Care Homes<br>➢ Creation of a Community Forum Blog to raise awareness of Forum activities and achievements<br>➢ Presented at Accord Ambassador Training sessions<br>➢ Active participation in community awareness raising events such as for dementia, learning disabilities and medicines management<br><br>➢ Review CCG and partner publications and make recommendations to |

| | |
|---|---|
| | improve readability and understanding<br>➢ Consultation with stakeholders to inform service planning for emergency care pathways<br>➢ Mentoring of new Forum members<br>Review, revision and monitoring of CCG equality impact assessments |
| Council of Members | The Council of Members is the arena in which all member practices have the opportunity to come together to:<br><br>➢ consider and advise on the service commissioning agenda for Health & Social Care<br>➢ ensure that the continued development of the CCG is aligned to the principles and aspirations of the constituent practices<br>➢ shape the organisation's strategic direction and key objectives<br>➢ approve service strategies and significant service change proposals<br><br>The Council of Members met every month, except for January 2014 and August 2014, throughout 2014/15. The December 2014 meeting was not quorate and therefore all decisions were deferred until the January 2015 meeting.<br><br>Performance/highlights include:<br><br>➢ Continual good representation by GP practices which enhances engagement between the CCG and member practices<br>➢ Review and update of amendment to the CCG's constitution<br>➢ Input into the evaluation of the following service (re)design proposals (Please note: This list is not exhaustive):<br>• Community dermatology services<br>• Ophthalmology services<br>• GP Front Ending<br><br>In May 2014 an extraordinary meeting was held where members voted in agreement to go out to consultation on the proposals for Hyper-Acute stroke and ENT services |
| Integrated Governance & Audit Committee (IG&A) | The IG&A Committee is responsible for the CCG's governance, risk management and internal control arrangements.<br><br>The IG&A Committee met four times throughout 2014/15. Attendance records demonstrate that each meeting was quorate.<br><br>Performance/highlights include *(Please note: This list is not exhaustive)*:<br><br>➢ Completion of the IG&A Committee Annual Report (Including completion of the Audit Committee Handbook self-assessment checklist, and mapping the Committee against the outcome based effectiveness measures)<br>➢ Review of the Committees Terms of Reference<br>➢ Approval of a significant number of policies and standing operating procedures to ensure a safe procedural basis for all CCG activities<br>➢ Development of the CCG Risk Register and understanding throughout the CCG as the integral part risk management plays in all staffs day to day roles. |

| | |
|---|---|
| Remuneration Committee | The Remuneration Committee, on behalf of the Governing Body, makes recommendations on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the CCG, and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme. They also agree the remuneration and terms of service of the Partnership Board Lay Members.<br><br>The Remuneration Committee met four times throughout 2014/15. Attendance records demonstrate that each meeting was quorate.<br><br>Performance/highlights:<br><br>Review of remuneration and terms of service/reference for the following:<br><br>➢ Clinical Leads<br>➢ Very Senior Managers<br>➢ Governing Body & Partnership Board Members<br>➢ Triangle Clinical Leads<br>➢ Out of Pocket Expenses for Community volunteers for Community Forum & Accord Steering Group |

**Record of Attendance**

| **Meeting – Governing Body & Partnership Board** | **Meeting dates** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 08/05/2014 | 26/06/2014 | 10/07/2014 | 11/09/2014 | G.Body 11/09/2014 | 13/11/2014 | 15/01/2015 | 12/03/2015 | G.Body 12/03/2015 |
| Voting Members: | | | | | | | | | |
| Mark Webb - NEL CCG Chair | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes |
| Geoff Barnes - Acting Director of Public Health (left post 31/12/14) | No | Yes | Yes | Yes | Yes | No | NA | NA | NA |
| Philip Bond - Lay Member Public Involvement | No | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Dr Derek Hopper - Vice Chair/Chair of Council of Members | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Mr Perviz Iqbal - Secondary Care Doctor | Yes | No | Yes | Yes | No | Yes | No | No | No |
| Cathy Kennedy - Chief Financial Officer/Deputy Chief Executive | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes |
| Helen Kenyon - Deputy Chief Executive | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Dr Thomas Maliyil - GP Representative/Vice Chair Council of Members | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Dr Peter Melton - Chief Clinical Officer | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Dr Arun Nayyar - GP Representative | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |

| **Meeting – Governing Body & Partnership Board** | **Meeting dates** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 08/05/2014 | 26/06/2014 | 10/07/2014 | 11/09/2014 | G.Body 11/09/2014 | 13/11/2014 | 15/01/2015 | 12/03/2015 | G.Body 12/03/2015 |
| Cllr Peter Wheatley - Portfolio Holder for Health, Wellbeing & Adult Social care NELC (left post 06/02/15) | Yes | No | Yes | No | NA | Yes | Yes | NA | NA |
| Juliette Cosgrove - Strategic Nurse | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes |
| Mandy Coulbeck - Locally Practising Nurse (left post 31/01/15) | Yes | Yes | No | Yes | Yes | Yes | No | NA | NA |
| Joanne Hewson - Strategic Director People and Communities – NELC | No | Yes | No | Yes | N/A | No | No | Yes | NA |
| Dr Rakesh Pathak - GP Representative | Yes | Yes | No | Yes | Yes | Yes | Yes | No | No |
| Joe Warner Managing Director – Focus independent adult social care work | Yes | Yes | No | Yes | Yes | Yes | Yes | No | No |
| Sue Whitehouse - Lay Member Governance and Audit | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes |
| Cllr Mick Burnett - Portfolio Holder for Tourism and Culture – NELC | Yes | Yes | No | Yes | NA | Yes | Yes | No | NA |
| Stephen Pintus – Joint Director of Public Health (commenced in post 01/01/15) | NA | NA | NA | NA | NA | NA | Yes | Yes | No |

| **Community Forum** | **Meeting dates** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 08/04/14 | 13/05/14 | 10/06/14 | 08/07/14 | 12/08/14 | 09/09/14 | 14/10/14 | 11/11/14 | 09/12/14 | 13/01/15 | 10/02/15 | 10/03/15 |
| Voting Members: | | | | | | | | | | | | |
| Anne Hames | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Geoff Allen | No | No | No | Yes | Yes | No | No | No | Yes | Yes | No | Yes |
| April Baker | Yes | No | Yes | Yes | Yes | Yes | No | No | Yes | Yes | Yes | Yes |
| Albert Bennett | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Philip Bond - Lay Member Public Involvement | Yes | No | No | Yes | Yes | Yes | Yes | No | Yes | No | Yes | Yes |
| Diane Edmonds | Yes | No | Yes | Yes | No | No | Yes | Yes | Yes | Yes | Yes | Yes |
| Christine Forman | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes |
| Bernard Henry | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| David McGuire | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Roy Rufus Isaacs | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Pam Taylor | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes |
| Wendy Wood | Yes | Yes | Yes | No | No | Yes | No | Yes | Yes | Yes | Yes | Yes |
| Margaret Henry | No | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Terrence Simco | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No |
| Sally Czabanuik - | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Cathy Kennedy- Chief Financial Officer/Deputy Chief Executive | No | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | No | Yes |

| **Council of Members** | **Meeting dates** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 03/04/14 | 01/05/14 | 22/05/14 | 05/06/14 | 03/07/14 | 03/09/14 | 02/10/14 | 06/11/14 | 04/12/14 | 08/01/14 | 05/02/15 | 05/03/15 |
| Voting Members: | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr Amin | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr Hussain | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr R Singh | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr P Suresh – Babu | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr Elmer Molave (left post Jan 2015) | No | No | No | Yes | No | Yes | No | Yes | No | N/A | N/A | N/A |
| Dr Laura Bernal-Gilliver (commenced in post Feb 2014) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | Yes | Yes | Yes |
| Dr Karin Severin | Yes | Yes | Yes | Yes | No | Yes | No | Yes | Yes | Yes | No | Yes |
| Dr P Ray | No | Yes | Yes | Yes | No | Yes | No | No | No | No | No | Yes |
| Dr I Chalmers | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr V Meier | | | | | | | | | | | | |
| Dr A M Bamgbala | No | No | No | Yes | Yes | Yes | No | Yes | No | No | No | Yes |
| Dr S N Keshri | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr Andrew Stread (left post Oct 2014) | Yes | No | No | Yes | No | Yes | N/A | N/A | N/A | N/A | N/A | N/A |
| Dr Kazim Sibtain (commenced in post Oct 2014) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | Yes | No | No | No | No |
| Dr R Kumar | No | Yes | No | No | No | No | No | No | No | No | No | No |
| Dr D Hopper | No | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | No |
| Dr KS Koonar | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr H Jethewa | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr A P Kumar | No | No | No | Yes | No | No | No | No | No | No | No | No |
| Dr Nathalie Dukes | Yes | Yes | No | Yes | Yes | Yes | No | No | No | Yes | Yes | Yes |
| Rob Baty (left post March 2015) | No | No | No | No | No | No | No | No | No | No | No | No |

| **Council of Members** | **Meeting dates** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 03/04/14 | 01/05/14 | 22/05/14 | 05/06/14 | 03/07/14 | 03/09/14 | 02/10/14 | 06/11/14 | 04/12/14 | 08/01/14 | 05/02/15 | 05/03/15 |
| Voting Members: | | | | | | | | | | | | |
| Vicki Bowen (commenced in post March 2015) | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr Rakesh Pathak | Yes | Yes | Yes | Yes | No | No | Yes | Yes | Yes | No | No | Yes |
| Dr David Elder | Yes | No | No | Yes | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes |
| Dr Arun Nayyar | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | Yes | Yes |
| Dr Anupam Sinha | Yes | No | Yes | Yes | Yes | Yes | No | No | Yes | No | Yes | No |
| Dr Thomas Maliyil | No | Yes | Yes | Yes | Yes | No | Yes | Yes | No | Yes | Yes | Yes |
| Dr Sylvere Dijoux | Yes | Yes | Yes | Yes | No | No | Yes | Yes | Yes | No | No | No |
| Dr Renju Mathews | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr Julian Clarke (left post June 2014) | Yes | No | No | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Dr Peter S John (commenced in post Feb 2015) | No | No | No | No | No | No | No | No | No | No | No | No |
| Dr Omar Qureshi | No | No | No | Yes | No | No | Yes | Yes | No | Yes | No | No |
| Mandy Coulbeck (left post Jan 2015) | Yes | Yes | No | Yes | No | Yes | No | Yes | No | No | N/A | N/A |
| Caroline Day (commenced post March 2015) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | No |
| Dr Narinder Bedi | No | No | No | No | No | No | No | No | No | No | No | No |
| Helen Kenyon (Health Vote) | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | No | No |
| Joe Warner (Adult Social Care Vote) | No | Yes | Yes | Yes | Yes | Yes | Yes | Yes | No | No | No | Yes |

| **Council of Members** | **Meeting dates** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 03/04/14 | 01/05/14 | 22/05/14 | 05/06/14 | 03/07/14 | 03/09/14 | 02/10/14 | 06/11/14 | 04/12/14 | 08/01/14 | 05/02/15 | 05/03/15 |
| **Alternative Attendees** | | | | | | | | | | | | |
| Dr Wilson (Dr K Severin deputy) | No | No | No | No | Yes | No | No | No | No | No | No | No |
| Sue Collis (Dr Bamgbala deputy) | No | Yes | No | No | Yes | No | Yes | Yes | No | No | Yes | Yes |
| Lindsey Collett (Dr Stead/Dr Sibtain Deputy) | No | Yes | No | No | No | No | No | No | Yes | No | No | No |
| John Noton (Dr Hopper deputy) | Yes | No | No | No | No | No | Yes | No | No | No | Yes | Yes |
| Mercedes Mello-Jenkins (Dr Dukes deputy) | No | No | Yes | No | No | No | No | Yes | Yes | No | No | No |
| Vicky Lane (Dr Sinha deputy) | No | No | Yes | No | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes |
| Steve Lewis (Dr Maliyil deputy) | Yes | No | No | No | No | No | No | No | No | No | No | No |
| Lindsey Collett (Dr Stead/Dr Sibtain Deputy) | No | Yes | No | No | No | No | No | No | Yes | No | No | No |
| John Noton (Dr Hopper deputy) | Yes | No | No | No | No | No | Yes | No | No | No | Yes | Yes |
| Debbie Landymore (Dr Dijoux deputy) | No | No | No | No | No | Yes | No | Yes | No | Yes | No | No |

| **Meeting – Integrated Governance & Audit Committee** | **Meeting dates** | | | |
|---|---|---|---|---|
| | 02/06/2014 | 02/09/2014 | 02/12/2014 | 31/03/2015 |
| Voting Members: | | | | |
| Mrs Sue Whitehouse – Chair & Governing Body lay member | Yes | Yes | Yes | Yes |
| Councillor Mick Burnett – Partnership Board lay member | Yes | Yes | Yes | No |
| Councillor Peter Wheatley – Partnership Board lay member (resigned February 2015) | Yes | Yes | Yes | N/A |
| Mr Philip Bond – Governing Body lay member | Yes | Yes | Yes | No |
| Dr Karin Severin – GP Member | Yes | Yes | Yes | Yes |
| | | | | |

| **Meeting – Remuneration Committee**<br>**Please refer to section 4.1 for details of attendance #remunerationcommittee** |
|---|

## 6.5 The Clinical Commissioning Group Risk Management Framework

As outlined in its Risk Management Strategy, North East Lincolnshire CCG has adopted a risk management process where logical steps are taken to manage risk effectively. Following on from setting priorities, potential risks or opportunities are then identified and evaluated before a course of action is determined to address the identified risks. As few risks remain static and new issues are likely to emerge, it is essential that all risks captured are routinely monitored. Finally, reporting of risk issues and in particular reporting and reflecting on any adverse events that do occur is essential to ensure that the CCG continuously improves its risk management activities.

New risks identified for inclusion on the risk register and assurance framework are assessed for likelihood and consequence using a 5 x 5 risk matrix in accordance with the risk management strategy. Each risk is assessed against the risk matrix to provide the original risk rating that is the risk rating before any controls are in place and the current risk rating, which is the risk rating taking the current controls in to consideration. A target risk rating is also given to each risk, which is the level of risk which the CCG will find acceptable (risk appetite). If the assessment of the risk is higher than the risk appetite, further action would be taken to reduce the likelihood and/or impact of the risk occurring. If this is not possible, contingency plans would be put in place to bring the risk exposure level (residual risk) back within the accepted range.

Risks scored at 15 or above are notified to the Partnership Board through the Assurance Framework and / or corporate risk register or via exception reporting.

Risk Management is embedded within the activities of North East Lincolnshire CCG through

- Review of the risk register and assurance framework at the monthly Service Leads meeting and at the Integrated Governance & Audit Committee on a quarterly basis, which ensures that the process is kept live and relevant.

- One to one sessions between the Corporate Assurance Officer and staff who have been assigned the management of a risk
- Awareness sessions via the CCG timeouts, newsletters

- Staff are openly encouraged to report any concerns through the incident reporting process and each incident is reviewed and investigated as applicable.

- All policies, procedures, projects, functions and services within the CCG undergo an Equality Impact Assessment. The CCG has developed and implemented a tool and guidance for use by staff to help identify the likely impact. Specific training has also been provided to our CCG members and staff.

- Public Stakeholders are involved in managing risks through lay membership of the CCG's Committee's (as per table above). These measures are in place to ensure that CCG decision making processes are transparent, to ensure that community engagement continues to be embedded in this process and, ultimately, to provide further assure the organisation.

The risk management strategy is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Governance and internal control of the CCG is an on-going process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of North East Lincolnshire Clinical Commissioning Group

- Evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically.

In addition to the risk management process described above, the following robust assessment processes are in place as part of the key decision making processes within the CCG.

1) Conflict of Interests

The CCG has in place clear principles and procedures for minimising, managing and registering potential conflicts of interests which could be deemed to affect the decisions made by those involved in the business of the CCG. These decisions could include awarding contracts, procurement, policy development or employment. Declarations of interests are submitted by each member of the Governing Body, Partnership Board and their Committees.

2) Counter fraud

The Integrated Governance and Audit Committee has assured itself that the organisation has adequate arrangements in place for countering fraud and regularly reviews the outcomes of counter fraud work. There is an approved risk based counter-fraud plan in place which is monitored at each IG&A committee meeting.

3) Others

- Human Resources (HR) policies (see section 2.9 & 3.12 for further details)
- Service Proposal Management Tool (see section 6.9 for further details)
- Data Security Risks (see section 6.15 for further details)
- Performance dashboard (see section 2.5 for further details)
- Emergency Preparedness (see section 3.13 for further details)

The key elements of the Risk Management Strategy are:

- To support the Partnership Board in carrying out its duties effectively, the Delivery Assurance Committee provide assurance (and the Integrated Governance and Audit Committee independent assurance) via regular risk reports, that corresponding robust and adequately progressed risk treatment plans exist and that risks are regularly reviewed and updated.

- The Chief Clinical Officer has overall accountability for ensuring there is a sound system in place for the management of risk and is responsible for ensuring systems and processes are implemented to comply with the strategy.

Each risk is assigned to a senior manager to manage on a day to day basis with a named Director to provide oversight and support as required. Senior managers are contacted on a monthly basis to review and update their risks as appropriate. Those risks which are rated 15 and above are reviewed monthly and those 12 and below are reviewed quarterly. Risks which are deemed to have reached their target risk rating and are no longer a threat to the CCG are taken to the Integrated Governance and Audit Committee for approval to close.

Regular risk reports provide assurance to the Integrated Governance and Audit Committee and Delivery Assurance Committee that risks are regularly reviewed and updated.

## 6.6 The Clinical Commissioning Group Internal Control Framework

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.

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.

The system of internal control within the CCG is based on an on-going process designed to identify and prioritise the risks, It is frequently the case that whilst the impact of the risk may remain the same as the original raw assessment, successful mitigating actions/internal controls will reduce the likelihood of the risk occurring. The system has been in place in the CCG for the year ending 31 March 2015 and up to the date of approval of the Annual Report and Accounts.

## 6.7 Information Governance

The CCG has not had any data disclosure incidents or data security incidents for the 2014-15 year.

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.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertakes annual information governance training. There are processes in place for incident reporting and investigation of serious incidents. We are developing training programme for information asset owners and administers, together with records management training. These will be established to fully embed for 2015/16.

## 6.8 Risk Assessment in Relation to Governance, Risk Management & Internal Control

In assessing risk, the North East Lincolnshire CCG reviews the potential hazards, which are situations with the potential to cause harm against the risk (the probability) of the hazard occurring using the principles of the international standard ISO 31000 for its risk management process which the CCG has adopted as best practice.

The CCG Assurance Framework provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives The Assurance Framework and risk register are mapped to the six domains in the NHS England Assurance Framework 2014/15:

Domain 1 - Patients are receiving clinically commissioned, high quality services
Domain 2 - Patients and the public are actively engaged and involved.
Domain 3 - CCG plans are delivering better outcomes for patients
Domain 4 - The CCG has robust governance arrangements
Domain 5 - The CCG is working in partnership with others.
Domain 6 - The CCG has strong and robust leadership

The Assurance Framework has been reviewed bimonthly by the Partnership Board and quarterly by the Integrated Governance & Audit Committee. The Assurance Framework provides an effective focus on new and emerging strategic and reputational risks rather than operational issues, and highlights any gaps in control and assurances. It provides the Partnership Board with confidence that systems and processes are in place and that it operates in a way that is safe and effective.

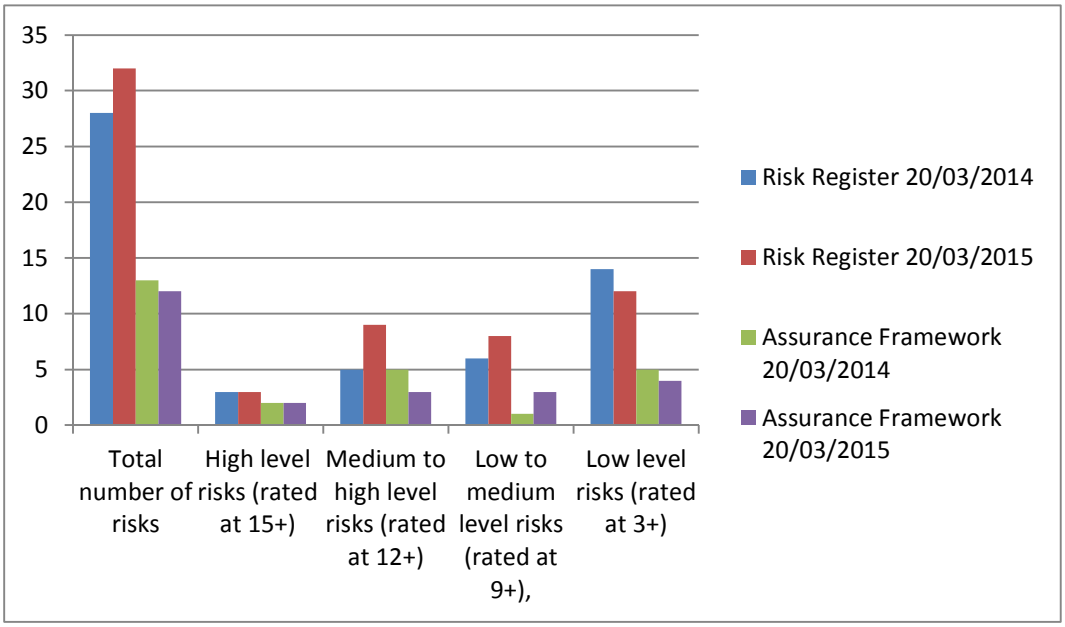
The CCG will continue to develop its assurance framework in 2015/16 in line with the latest guidance for CCG Assurance Framework 2015/16. NHS England have recently revised their approach as much has changed since the original authorisation process and now that CCGs have been in existence for two years, the new domains will draw on their record of performance and improvements for patients.

The assurance framework records the strategic risks to the CCG, maps out the key controls to mitigate the risks and provides a mechanism to inform the Partnership Board of the assurances received about the effectiveness of these controls. Any gaps in control or assurance are also recorded and actions developed to reduce the gaps. The strategic risks to compliance with the CCG licence are captured in the Assurance Framework. All risks within the Board Assurance Framework have been mapped to the Top 10 themes as identified in the MIAA Insight – CCG Assurance Framework Benchmarking.

Outcome of mapping
The CCG cover 7 risks of the 'top 10' risk themes.
The CCG have 2 risks with a high risk score (15 – 25).

During the period 20 March 2014 to 20 March 2015, the risk register had 6 risks which were closed and 10 new risks were identified. The assurance framework had 1 new risk and two risks closed in the same period. The total number of risks on the risk register as at 20 March 2015 is 32 (oppose to 28 in March 2014). The total number of risks on the assurance framework is currently 12 (oppose to 13 as at 20 March 2014)

The chart below compares the risk register and assurance framework at 20 March 2014 and 20 March 2015.




The North East Lincolnshire CCG principal risks (that is a risk rating of 15 and above) identified in the assurance framework and risk register as at 20 March 2015 are:

| Risk Description | Actions taken to mitigate the risks | Current Residual Risk rating |
|---|---|---|
| Assurance Framework | | |
| Healthy Lives, Healthy Futures will not deliver the quality and financial sustainability outcomes in the requisite timeframe | The HLHF Programme Board reviews progress monthly towards financial and clinical sustainability goals for Northern Lincolnshire and reviews the programme risk log on a monthly basis.<br>The Accountable Officers Group of the Programme Board meets weekly (virtually) to review the financial sustainability position. | 16 |
| Financial challenges | Integrated Governance & Audit Committee (IG&A) review of key risks and actions<br>Medium Term Financial Plan reports to IG&A and Partnership Board | 16 |

| Risk Register | | |
|---|---|---|
| Failure to achieve Accident and Emergency 4 hour targets | Commissioning weekly monitoring of performance.<br><br>The System Resilience Group, with Commissioner & Provider membership, has a primary purpose in the monitoring and resilience of the A&E 4 hour performance.<br><br>Action Plans focussing on all issues with potential impact on 4 hour A&E wait performance. | 20 |
| On-going failure to meet Clinical Handover time targets for East Midlands Ambulance Service patient delivery at Diana Princess of Wales Hospital A&E | Performance is monitored by the Urgent Care Board. | 16 |
| 18 Week RTT (Referral to Treatment) Performance | Commissioning action plan is in place which is reported through Delivery Assurance Committee for progress.<br><br>Updates fed into internal Groups for information/further discussion and action: Service Leads, Council Of Members, System Resilience Group.<br><br>Clinically led collaborative meeting with Providers to discuss service delivery concerns/ improvements.<br><br>Financial penalties imposed on Providers for non-achievement of Key Performance Indicators. | 16 |

The CCG's policy for managing its principal risks is outlined in the Risk Management Strategy.

## 6.9 Review of Economy, Efficiency and Effectiveness of the use of Resources

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically in accordance with the NHS principles of good governance.

Our constitution delegate's responsibility to ensure appropriate arrangements are in place for the CCG to fulfil this duty to the Integrated Governance & Audit (IG&A) Committee and requires that this Committee undertakes functions as set out in its Terms of Reference as agreed by the Governing Body. The partnership board also receives a finance report from the Deputy Chief Finance Officer at every meeting, where open challenge takes place.

The Chief Finance Officer is a member of the Governing Body and is responsible for providing financial advice to the Group and for supervising financial control and accounting systems. The role of Chief Finance Officer includes:

- Being the Governing Body's professional expert on finance and ensuring, through robust systems and processes, the regularity and propriety of expenditure is fully discharged;
- Making appropriate arrangements to support, monitor on the CCG's finances;
- Overseeing robust audit and governance arrangements leading to propriety in the use of the CCG's resources;
- Being able to advise the Governing Body on the effective, efficient and economic use of the CCG's allocation to remain within that allocation and deliver required financial targets and duties; and
- Producing the financial statements for audit and publication in accordance with the statutory requirements to demonstrate effective stewardship of public money and accountability to NHS England;
- Being the Governing Body lead officer for Business Information Intelligence.

Internal Audit is responsible for assessing the effectiveness of the system of internal control within the CCG, details of which are summarised in the Head of Internal Audit Opinion Statement which is presented to the Governing Body and Integrated Governance & Audit Committee annually.

The CCG has in place a number of processes, procedures and governance arrangements to ensure that the services it commissions are delivering best value and outcomes and that any associated risks are adequately managed. The Service Proposal Management Tool is a process to support the CCG's procurement and business planning process. This online tool allows any individual, practice or group providing services to the CCG to submit an idea for service provision or reorganisation which improves quality or efficiency or contributes to the transformation of health or social care in our area. It ensures that all business cases are assessed by each service triangle, an endorsement panel and approved by the CCG Care Contracting Committee.

All cases submitted for approval via the Service Proposal Management Tool are assessed against the same criteria so that they are able to deliver an equal or improved quality of service for less expenditure than is currently committed, or to increase the safety and quality of the service currently in place for the population of North East Lincolnshire. The aim of the Tool is to increase efficiency and value the CCG gets for its investment into services with providers.

For established contracts, the contracts team and contract leads monitor progress on a monthly basis. The Contracts team for Adult Social care visit residential home providers to ensure they meet the quality standards that the CCG has set out and contract leads will hold to account other providers at regular meetings to ensure the services performance and quality have been met as per the contract. These meetings will inform the key performance indicators (KPI's) and Commissioning for Quality and Innovation Indicator (CQUINS) measurement, providers can be financially penalised for failing to meet these measurements, e.g. A&E 4 hour waiting times.

CCG performance, across its whole commissioning agenda, is monitored internally by the Delivery Assurance Committee and Quality Committee where any contract issues will be discussed and identified for further investigation or action. The CCG has effective commissioning and contract monitoring processing in place to ensure that funding is used effectively and efficiently.

In addition to monitoring performance and outcomes, the Service Proposal Management Tool also considers any possible equality & diversity implications of the proposed service, further reducing potential risk to the organisation.

## 6.10 Review of the Effectiveness of Governance, Risk Management and Internal Control

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

## 6.11 Capacity to Handle Risk

The CCG's Partnership Board is accountable for the performance management of the Risk Management Framework and systems of clinical, financial and organisational control and oversees the overall system of risk management and assurance to satisfy itself that the CCG is fulfilling its organisational responsibilities and public accountability. The Partnership Board uses the risk management process and more specifically the Assurance Framework as a means to assist achievement of its goals and provides a clear commitment and direction for risk management within the CCG.

The constitution and the Partnership Board have delegated responsibility for some aspects of risk management to the Integrated Governance and Audit Committee

The Integrated Governance and Audit Committee are responsible for:-

- Reviewing the establishment and maintenance of an effective system of governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical including information and financial risk) to support the achievement of the organisation's objectives.
- Agreeing and monitoring the Internal Audit work plan and seeking assurance to ensure development of the Annual Governance Statement.

There are other committees / meetings at which risk may also be considered and these include:-

- Delivery Assurance Committee – responsible for overseeing the continuous development of the organisations internal performance and delivery assurance framework, encompassing balanced scorecard and exception reporting. The committee provides delivery assurance to the CCG Partnership Board that there are robust structures, processes and accountabilities in place for managing performance and delivery throughout the organisation.

- Quality Committee – responsible for overseeing and providing assurance on the clinical governance arrangements in commissioned services and ensuring that arrangements are in place to deliver governance and statutory requirements as identified by the Governing Body as being within the remit of the Committee.

- Service Leads Meeting – operational forum to raise awareness of and discuss matters relating to each service area. The meeting takes place every month and is attended by all Service Leads. Risk is a standing item at this meeting.

The Chief Finance Officer has delegated responsibilities for the development and implementation of financial risk management and financial governance including those relating to key financial controls.

The Deputy Chief Finance Officer has delegated responsibility for driving the development of the Risk Management Framework and Integrated Governance Framework. The Deputy Chief Finance Officer is the responsible officer for implementing the system of internal control, including the risk management process for the assurance framework and risk register for the CCG.

The Director of Quality has delegated responsibility for assuring that the CCG has effective clinical governance arrangements in place and has effective multidisciplinary engagement arrangements in place. Most notably in relation to service planning and redesign for management the development and implementation of clinical risk management, clinical governance and patient safety.

An interactive Effectiveness and Risk workshop was held during December 2014 for all members of the Partnership Board, facilitated by East Coast Audit Consortium (Internal Audit). The objective of the session was to review the CCG's risk management process to ensure it is relevant to the organisation and able to assist in the management and decision making of the CCG.

Two sessions were held in January and February 2015 with each manager/assignee being allocated half an hour to allow discussion of their risks, both operational risks on the risk register and strategic risks on the Assurance Framework. All risks on the risk register and assurance framework were reviewed on these two dates and the sessions also provided an opportunity for risk owners and assignees to raise any queries they had about the process. The feedback from the sessions was very positive, all risks were reviewed, including refresh of risk descriptions, internal controls and risk ratings. The risk register and assurance framework templates were revised. Directors will start to receive their risks biannually for information and risks will only be deleted with their approval.

Areas for development during 2015/16

- Integrated Governance and Audit Committee workshop outcome - A proposal for further sessions on risk appetite and target setting following the 'deep-dive' comments into element 5 on risk and agility.

- Identify a mechanism for monitoring static risks, for example if the risk rating of a risk has not changed for the last four quarters, what actions should be taken.

## 6.12 Review of Effectiveness

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 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 management letter and other reports.

*The Board Assurance Framework* itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Integrated Governance & Audit Committee, the Service Leads Meeting and the Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

*The Board Assurance Framework* itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- External Audit providing progress reports to the Integrated Governance and Audit Committee, the Annual Management Letter and their annual value for money conclusion.

- Internal Audit reviews of systems of internal control and progress reports to the Integrated Governance & Audit Committee.
- Assurance reports on risk and governance received from the Integrated Governance & Audit Committee.

- Performance management systems.

- Internal Committee structure with delegated responsibility for risk identification, evaluation, control, review and assurance.

- Review of the Assurance Framework. Action plans to address any identified weaknesses, and ensure continuous improvement of the system, are in place via action plan embedded within the Assurance Framework and the Risk Register.

- Quarterly Risk Reports capturing key risks across the spectrum of corporate governance.

- Self-assessment undertaken by the Integrated Governance & Audit Committee to ensure adherence to the principles contained within the NHS Audit Committee Handbook.

- The CCG Strategy which captures clear clinical priorities, QIPP (Quality, Innovation, Productivity & Prevention) priorities and key risks.

A Partnership Board workshop to assess board effectiveness & risk took place on 11 December 2014 to develop the Board Effectiveness and Risk. Internal Audit undertook an interactive session to assess the review the governance arrangements via the use of the Governance Maturity Matrix developed by the Corporate Governance Institute.

Following the workshop Internal Audit prepared a development plan which focuses on three areas of development and sets out the agreed next steps. The Integrated Governance & Audit Committee will have responsibility for ensuring that the recommendations to strengthen the governance framework are implemented. In summary, the suggested next steps were for the CCG to review:-

1 The frequency and content of any future evaluative sessions (e.g. to deep-dive each element over a planned review timetable, using the matrix tool as a prompt for debate)

2 The format of the adopted maturity matrix to build in NHSE elements (following pilot feedback) without losing required detail within the current tool; and

3 The proposal for further sessions on risk appetite and target setting following the 'deep-dive' comments into element 5 on risk and agility.

The integrated governance & audit annual report, was presented to the Governing Body on 12 March 2015, detailing the outcomes of the review of the effectiveness of the committee. The report assured the members of the effective governance arrangements of the organisation, and specifically that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principals of good governance.

The Governance Manager and Corporate Assurance Officer have worked closely with the support team from the North Yorkshire and Humber Commissioning Support to maintain continuous improvement in the management of risk throughout the year.

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion an on the adequacy and effectiveness of the Clinical Commissioning Group's systems of risk management, governance and internal control. The

## For 2014/15 the Head of Internal Audit concluded that:-

***Significant Assurance*** *can be given that 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 weaknesses in the design or inconsistent application of controls put the achievement of particular objectives at risk: particularly in relation to the management of Adult Social Care debtors.*

During the year the internal audit issued the following audit report with a conclusion of limited assurance

- **Adult Social Care Financials**

*There are weaknesses in the design and / or operation of controls which could have a significant impact on the achievement of the key system, function or process objectives but should not have a significant impact on the achievement of organisational objectives.*

*Key Improvement Areas: Although it was confirmed that in-year adult social care debtor and creditor transactions have been properly raised, recorded and supported by evidence (via Focus), the debtor application was not fully used for recovery and this weakness, taken in the context of the escalating level of debt, contributed towards the limited assurance opinion.*

During the year there have been no audit reports with a conclusion of no assurance

## 6.13 Data Quality

Data is collated and managed by Yorkshire & Humber Commissioning Support on behalf of the CCG. Data presented to the Partnership Board and sub committees is sourced from national systems and local data sources. Where possible, data is triangulated to alternate sources to ensure accuracy. Yorkshire & Humber Commissioning Support has in place internal procedures and controls in order to ensure data presented is of the best quality possible. Any data issues noted in source data is reviewed and identified with the source provider. Should data issues arise resulting from internal Yorkshire & Humber Commissioning Support processes, a root cause analysis is undertaken, and corrective actions put in place and on-going learning identified.

## 6.14 Business Critical Models

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.

All business critical models have been identified and 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.

The Clinical Commissioning Group contracts specifically with Yorkshire and Humber Commissioning Support for a range of commissioning support functions. Future commissioning support arrangements are subject to the NHS England lead provider framework. Yorkshire and Humber Commissioning Support was not approved on to the framework and so the CCG is an active member of the Yorkshire and Humber Commissioning Support Transition Group which is determining the commissioning support arrangements for 2016/17 and beyond.

## 6.15 Data Security

The CCG works in partnership with the Yorkshire & Humber Commissioning Support Unit to oversee management of personal and sensitive data; this is managed as part of the Information Governance Toolkit. The Corporate Governance Manager is the designated Information Asset Manager within the CCG and oversees this process and manages the Information Asset register

We have submitted a satisfactory level of compliance with the information governance toolkit assessment

There have been no data security breaches during the period covered by this report.

## 6.16 Discharge of the CCG's Statutory Functions

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 the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, which is the independent review undertaken by Mr Geoffrey Harris on behalf of the Department of Health of the arrangements made by Strategic Health Authorities for the approval of registered medical practitioners and approved clinicians under the Mental Health Act 1983, 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 legislation 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 Senior Officer. The organisation has confirmed as part of its authorisation assessment that its structure and support arrangements provide the necessary capability and capacity to undertake all of the CCGs statutory duties.

The CCG has established and maintained a range of information governance, human resources and other corporate policies in place to support the delivery of its statutory functions and underpin the requirements of the CCG Constitution. A programme is in place to review these policies and adapt them, as necessary, this piece of work will continue throughout 2015/16.

Compliance with statutory functions is delivered through the CCG's management structure and monitored through its committee structure and work programmes.

## 6.17 Conclusion

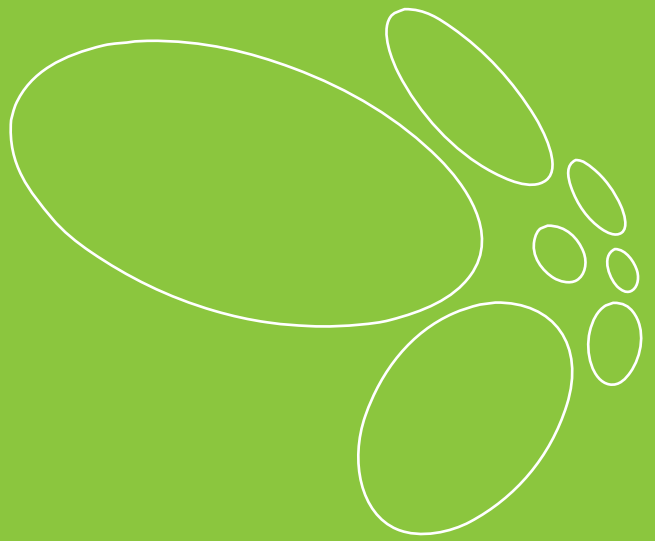
No significant internal control issues have been identified, however the Head of Internal Audit has identified, as part of their planned audit work for 2014/15, one area for improvement. Please refer to section Review of Effectiveness page 82 of this report for details

Dr Peter Melton

Accountable Officer

28 May 2015

# ANNUAL ACCOUNTS 7.0



# 7.1 FOREWORD TO THE ACCOUNTS

## NHS NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2015 have been prepared by NHS North East Lincolnshire Clinical Commissioning Group under section 232 (schedule 15,3 (1) of the National Health Service Act 2006 in the form which the Secretary of State has, within the approval of the Treasury directed

Dr Peter Melton
Accountable Officer

28 May 2015

# 7.2 INDEPENDENT AUDITORS REPORT

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS NORTH EAST LINCOLNSHIRE CCG

We have audited the financial statements of NHS North East Lincolnshire Clinical Commissioning Group for the year ended 31 March 2015 on pages 91 to 130, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes. These financial statements have been prepared under applicable law and the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Members of North East Lincolnshire CCG, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Members of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the CCG, 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, on page 55, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view. 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.

**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 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.

**Opinion on regularity**

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

**Opinion on financial statements**

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2015 and of its net operating expenditure for the year then ended; and

- have been properly prepared in accordance with the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

**Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies**

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the information given in the Strategic Report and Members' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with NHS England's Guidance;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of, the audit.

**Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources**

**Respective responsibilities of the CCG and auditor**

The CCG is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the CCG has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies 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 2015.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

**Conclusion**

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all material respects, NHS North East Lincolnshire CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

**Certificate**

We certify that we have completed the audit of the accounts of NHS North East Lincolnshire CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

John Graham Prentice
For, and on behalf of, KPMG LLP Statutory Auditor

Chartered Accountants
1 The Embankment
Leeds
LS1 4DW

28 May 2015

## Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2015

| | Note | 2014-15 £000 | 2013-14 £000 |
|---|---|---|---|
| **Total Income and Expenditure** | | | |
| Employee benefits | 5 | **3,174** | 4,716 |
| Operating Expenses | 5 | **267,533** | 257,670 |
| Other operating revenue | 2 | **(56,933)** | (55,817) |
| **Net operating expenditure before interest** | | **213,774** | **206,569** |
| Investment Revenue | 8 | **0** | 0 |
| Other (gains)/losses | 9 | **0** | 0 |
| Finance costs | 10 | **0** | 0 |
| **Net operating expenditure for the financial year** | | **213,774** | **206,569** |
| Net (gain)/loss on transfers by absorption | 11 | **0** | 0 |
| **Total Net Expenditure for the year** | | **213,774** | **206,569** |
| Of which: | | | |
| **Administration Income and Expenditure** | | | |
| Employee benefits | 5 | **2,637** | 2,556 |
| Operating Expenses | 5 | **2,899** | 2,984 |
| Other operating revenue | 2 | **(1,942)** | (1,642) |
| **Net administration costs before interest** | | **3,594** | **3,898** |
| **Programme Income and Expenditure** | | | |
| Employee benefits | 5 | **537** | 2,160 |
| Operating Expenses | 5 | **264,634** | 254,686 |
| Other operating revenue | 2 | **(54,991)** | (54,175) |
| **Net programme expenditure before interest** | | **210,180** | **202,671** |

| **Other Comprehensive Net Expenditure** | | 2014-15 £000 | 2013-14 £000 |
|---|---|---|---|
| Impairments and reversals | 22 | **0** | 0 |
| Net (gain)/loss on revaluation of property, plant & equipment | | **0** | 0 |
| Net (gain)/loss on revaluation of intangibles | | **0** | 0 |
| Net (gain)/loss on revaluation of financial assets | | **0** | 0 |
| Movements in other reserves | | **0** | 0 |
| Net (gain)/loss on available for sale financial assets | | **0** | 0 |
| Net (gain)/loss on assets held for sale | | **0** | 0 |
| Net actuarial (gain)/loss on pension schemes | | **2,281** | (4,176) |
| Share of (profit)/loss of associates and joint ventures | | **0** | 0 |
| Reclassification Adjustments | | **0** | 0 |
| On disposal of available for sale financial assets | | **0** | 0 |
| **Total comprehensive net expenditure for the year** | | **216,055** | **202,393** |

The notes on pages 95 to 130 form part of this statement

## Statement of Financial Position as at 31 March 2015

| | Note | 31 March 2015 £000 | 31 March 2014 £000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 13 | **0** | 0 |
| Intangible assets | 14 | **0** | 0 |
| Investment property | 15 | **0** | 0 |
| Trade and other receivables | 17 | **0** | 0 |
| Other financial assets | 18 | **0** | 0 |
| **Total non-current assets** | | **0** | 0 |
| **Current assets:** | | | |
| Inventories | 16 | **0** | 0 |
| Trade and other receivables | 17 | **6,968** | 4,913 |
| Other financial assets | 18 | **0** | 0 |
| Other current assets | 19 | **0** | 0 |
| Cash and cash equivalents | 20 | **46** | 67 |
| **Total current assets** | | **7,014** | 4,980 |
| Non-current assets held for sale | 21 | **0** | 0 |
| **Total current assets** | | **7,014** | 4,980 |
| **Total assets** | | **7,014** | 4,980 |
| **Current liabilities** | | | |
| Trade and other payables | 23 | **(16,711)** | (14,165) |
| Other financial liabilities | 24 | **0** | 0 |
| Other liabilities | 25 | **0** | 0 |
| Borrowings | 26 | **0** | 0 |
| Provisions | 30 | **(408)** | (336) |
| **Total current liabilities** | | **(17,119)** | (14,501) |
| **Total Assets less Current Liabilities** | | **(10,105)** | (9,521) |
| **Non-current liabilities** | | | |
| Trade and other payables | 23 | **(5,479)** | (3,083) |
| Other financial liabilities | 24 | **0** | 0 |
| Other liabilities | 25 | **0** | 0 |
| Borrowings | 26 | **0** | 0 |
| Provisions | 30 | **(8)** | 0 |
| **Total non-current liabilities** | | **(5,487)** | (3,083) |
| **Assets less Liabilities** | | **(15,592)** | (12,604) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | **(7,540)** | (6,833) |
| Revaluation reserve | | **0** | 0 |
| Other reserves | | **(8,052)** | (5,771) |
| Charitable Reserves | | **0** | 0 |
| **Total taxpayers' equity:** | | **(15,592)** | (12,604) |

The notes on pages 95 to 130 form part of this statement

The financial statements on pages 91 to 94 were approved by the Integrated Governance & Audit Committee on 21 May 2015 and signed on its behalf by:

Dr Peter Melton
Accountable Officer
28 May 2015

## Statement of Changes In Taxpayers Equity for the Year Ended 31 March 2015

| | General fund £000 | Revaluation reserve £000 | Other reserves £000 | Total reserves £000 |
|---|---|---|---|---|
| **Changes in Taxpayers' Equity for 2014-15** | | | | |
| **Balance at 1 April 2014** | (6,833) | 0 | (5,771) | **(12,604)** |
| Transfer between reserves in respect of assets transferred from closed NHS bodies | 0 | 0 | 0 | **0** |
| **Adjusted Balance at 1 April 2014** | **(6,833)** | **0** | **(5,771)** | **(12,604)** |
| **Changes in Taxpayers' Equity for 2014-15** | | | | |
| Net operating expenditure for the financial year | (213,774) | | | (213,774) |
| Net gain/(loss) on revaluation of property, plant and equipment | | 0 | | 0 |
| Net gain/(loss) on revaluation of intangible assets | | 0 | | 0 |
| Net gain/(loss) on revaluation of financial assets | | 0 | | 0 |
| **Total revaluations against revaluation reserve** | **0** | **0** | **0** | **0** |
| Net gain/(loss) on available for sale financial assets | 0 | 0 | 0 | 0 |
| Net gain/(loss) on revaluation of assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 | 0 |
| Net actuarial gain/(loss) on pensions | 0 | 0 | (2,281) | (2,281) |
| Movements in other reserves | 0 | 0 | 0 | 0 |
| Transfers between reserves | 0 | 0 | 0 | 0 |
| Release of reserves to the Statement of Comprehensive Net Expenditure | 0 | 0 | 0 | 0 |
| Reclassification adjustment on disposal of available for sale financial assets | 0 | 0 | 0 | 0 |
| Transfers by absorption to (from) other bodies | 0 | 0 | 0 | 0 |
| Reserves eliminated on dissolution | 0 | 0 | 0 | 0 |
| **Net Recognised Expenditure for the Financial Year** | **(213,774)** | **0** | **(2,281)** | **(216,055)** |
| Net funding | 213,067 | 0 | 0 | 213,067 |
| **Balance at 31 March 2015** | **(7,540)** | **0** | **(8,052)** | **(15,592)** |

| | General fund £000 | Revaluation reserve £000 | Other reserves * £000 | Total reserves * £000 |
|---|---|---|---|---|
| **Changes in Taxpayers' Equity for 2013-14** | | | | |
| **Balance at 1 April 2013** | **0** | **0** | **(9,947)** | **(9,947)** |
| Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition | 0 | 0 | 0 | **0** |
| **Adjusted Balance at 1 April 2013** | **0** | **0** | **(9,947)** | **(9,947)** |
| **Changes in Taxpayers' Equity for 2013-14** | | | | |
| Net operating costs for the financial year | (206,569) | 0 | 0 | (206,569) |
| Net gain/(loss) on revaluation of property, plant and equipment | 0 | 0 | 0 | 0 |
| Net gain/(loss) on revaluation of intangible assets | 0 | 0 | 0 | 0 |
| Net gain/(loss) on revaluation of financial assets | 0 | 0 | 0 | 0 |
| **Total revaluations against revaluation reserve** | **0** | **0** | **0** | **0** |
| Net gain (loss) on available for sale financial assets | 0 | 0 | 0 | 0 |
| Net gain (loss) on revaluation of assets held for sale | 0 | 0 | 0 | 0 |
| Impairments and reversals | 0 | 0 | 0 | 0 |
| Net actuarial gain (loss) on pensions | 0 | 0 | 4,176 | 4,176 |
| Movements in other reserves | 0 | 0 | 0 | 0 |
| Transfers between reserves | 0 | 0 | 0 | 0 |
| Release of reserves to the Statement of Comprehensive Net Expenditure | 0 | 0 | 0 | 0 |
| Reclassification adjustment on disposal of available for sale financial assets | 0 | 0 | 0 | 0 |
| Transfers by absorption to (from) other bodies | 0 | 0 | 0 | 0 |
| Reserves eliminated on dissolution | 0 | 0 | 0 | 0 |
| **Net Recognised Expenditure for the Financial Year** | **(206,569)** | **0** | **4,176** | **(202,393)** |
| Net funding | 199,736 | 0 | 0 | 199,736 |
| **Balance at 31 March 2014** | **(6,833)** | **0** | **(5,771)** | **(12,604)** |

*** Figures restated**

## Statement of Cash Flows for the Year Ended 31 March 2015

| | Note | 2014-15 £000 | 2013-14 £000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year (see note 46) | | **(213,205)** | (206,186) |
| Depreciation and amortisation | 5 | **0** | 0 |
| Impairments and reversals | 5 | **0** | 0 |
| Movement due to transfer by Modified Absorption | | **0** | 0 |
| Other gains (losses) on foreign exchange | | **0** | 0 |
| Donated assets received credited to revenue but non-cash | | **0** | 0 |
| Government granted assets received credited to revenue but non-cash | | **0** | 0 |
| Interest paid | | **0** | 0 |
| Release of PFI deferred credit | | **0** | 0 |
| Other Gains & Losses | | **0** | 0 |
| Finance Costs | | **0** | 0 |
| Unwinding of Discounts | | **0** | 0 |
| Increase/(decrease) in inventories | | **0** | 0 |
| Increase/(decrease) in trade & other receivables | 17 | **(2,509)** | 705 |
| Increase/(decrease) in other current assets | | **0** | 0 |
| Increase/(decrease) in trade & other payables | 23 | **2,546** | 9,336 |
| Increase/(decrease) in other current liabilities | | **0** | 0 |
| Provisions utilised | 30 | **(297)** | (650) |
| Increase/(decrease) in provisions | 30 | **377** | 336 |
| **Net Cash Inflow (Outflow) from Operating Activities** | | **(213,088)** | (196,459) |
| **Cash Flows from Investing Activities** | | | |
| Interest received | | **0** | 0 |
| (Payments) for property, plant and equipment | | **0** | 0 |
| (Payments) for intangible assets | | **0** | 0 |
| (Payments) for investments with the Department of Health | | **0** | 0 |
| (Payments) for other financial assets | | **0** | 0 |
| (Payments) for financial assets (LIFT) | | **0** | 0 |
| Proceeds from disposal of assets held for sale: property, plant and equipment | | **0** | 0 |
| Proceeds from disposal of assets held for sale: intangible assets | | **0** | 0 |
| Proceeds from disposal of investments with the Department of Health | | **0** | 0 |
| Proceeds from disposal of other financial assets | | **0** | 0 |
| Proceeds from disposal of financial assets (LIFT) | | **0** | 0 |
| Loans made in respect of LIFT | | **0** | 0 |
| Loans repaid in respect of LIFT | | **0** | 0 |
| Rental revenue | | **0** | 0 |
| **Net Cash Inflow (Outflow) from Investing Activities** | | **0** | 0 |
| **Net Cash Inflow (Outflow) before Financing** | | **(213,088)** | (196,459) |
| **Cash Flows from Financing Activities** | | | |
| Grant in Aid Funding Received | | **213,067** | 199,736 |
| Other loans received | | **0** | 0 |
| Net modified absorption accounting transfer through reserves | | **0** | (3,210) |
| Other loans repaid | | **0** | 0 |
| Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT | | **0** | 0 |
| Capital grants and other capital receipts | | **0** | 0 |
| Capital receipts surrendered | | **0** | 0 |
| **Net Cash Inflow (Outflow) from Financing Activities** | | **213,067** | 196,526 |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 20 | **(21)** | 67 |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | | **67** | 0 |
| Effect of exchange rate changes on balance of cash and cash equivalents held in foreign currencies | | **0** | 0 |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | | **46** | 67 |

## Notes to the financial statements

### 1 Accounting Policies

NHS England has directed that the financial statements of CCGs shall meet the accounting requirements of the Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2014-15 issued by the Department of Health. The accounting policies contained in the Manual for Accounts 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 Manual for Accounts 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 & Discontinued Operations

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

### 1.4 Movement of Assets within the Department of Health Group

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

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

### 1.5 Charitable Funds

From 2014-15, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

### 1.6 Pooled Budgets

Where the 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.

### 1.7 Critical Accounting Judgements & 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.

#### 1.7.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- Secondary Care Activity; Counting and coding of secondary care is not finalised until after the completion of the audited annual accounts process in June. Assumptions have been made around the liabilities of this for the CCG with a range of secondary care providers based on a number of factors including historical activity performance and known changes in activity, as well as non PBR tariffed contract arrangements. The actual cost of activity will be different to the carrying amounts held in the Statement of Financial Performance and any variance will need to be managed in the Statement of Comprehensive Net Expenditure in the subsequent year. There is unlikely to be a significant change to the carrying value of assets and liabilities once activity is validated based on previous years out-turn verses actual.

- Accruals; There are a number of estimated figures within the accounts. The main areas where estimates are included are:

  • Prescribing - The full year figure is estimated on the spend for the first 10 months of the year,
  • Purchase of Healthcare - The full year figure is estimated on the month 11 actual information as agreed between the provider and commissioner.
  • Continuing Care - This is based upon the client data base of occupancy at the financial year end.

### 1.7.2 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:

- Bad Debt Provision
- Continuing Care Provision
- Local Government Pension Scheme as advised by the actuaries Hymans Robertson LLP

### 1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

### 1.9 Employee Benefits

### 1.9.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

### 1.9.2 Retirement Benefit Costs

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

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the CCG's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

### 1.10 Other Expenses

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

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

### 1.11 Property, Plant & Equipment

#### 1.11.1 Recognition

Property, plant and equipment is capitalised if:

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

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

#### 1.11.2 Valuation

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

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

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

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

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

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

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

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

### 1.11.3 Subsequent Expenditure

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

## 1.12 Intangible Assets

### 1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the CCG's business or which arise from contractual or other legal rights. They are recognised only:

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

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

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

### 1.12.2 Measurement

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

## 1.13 Depreciation, Amortisation & Impairments

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

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

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

### 1.13 Depreciation, Amortisation & Impairments

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

### 1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

### 1.15 Government Grants

The value of assets received by means of a government grant is credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

### 1.16 Non-current Assets Held For Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.
The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

### 1.17 Leases

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

#### 1.17.1 The CCG as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the CCG's surplus/deficit.

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

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

### 1.17.2 The CCG as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the CCG's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the CCG's net investment outstanding in respect of the leases.
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

### 1.18 Private Finance Initiative Transactions

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The CCG therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

### 1.18.1 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

### 1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the CCG's approach for each relevant class of asset in accordance with the principles of IAS 16.

### 1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.
An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure. The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

### 1.18.4 Lifecycle Replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the CCG's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

### 1.18.4 Lifecycle Replacement (Continued)

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

### 1.18.5 Assets Contributed by the CCG to the Operator For Use in the Scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the CCG's Statement of Financial Position.

### 1.18.6 Other Assets Contributed by the CCG to the Operator

Assets contributed (e.g. cash payments, surplus property) by the CCG to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the CCG, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

### 1.19 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

### 1.20 Cash & Cash Equivalents

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

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the CCG's cash management.

### 1.21 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 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

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.

### 1.22 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.

### 1.23 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.

### 1.24 Continuing healthcare risk pooling

In 2014-15 a risk pool scheme has been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme CCG contribute annually to a pooled fund, which is used to settle the claims.

### 1.25 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the CCG makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

### 1.26 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the 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.

### 1.27 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.

### 1.27.1 Financial Assets at Fair Value through Profit and Loss

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

### 1.27.2 Held to Maturity Assets

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

### 1.27.3 Available For Sale Financial Assets

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

### 1.27.4 Loans & Receivables

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

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

The 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.

### 1.28 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.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

### 1.28.1 Financial Guarantee Contract Liabilities

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

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

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

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

### 1.28.3 Other Financial Liabilities

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

### 1.29 Value Added Tax

Most of the activities of the 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.

### 1.30 Foreign Currencies

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

### 1.31 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the CCG has no beneficial interest in them.

### 1.32 Losses & Special Payments

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

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

### 1.33 Subsidiaries

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

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

### 1.34 Associates

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

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

### 1.35 Joint Ventures

Material entities over which the CCG has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

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

### 1.36 Joint Operations

Joint operations are activities undertaken by the CCG in conjunction with one or more other parties but which are not performed through a separate entity. The CCG records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

### 1.37 Research & Development

Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

### 1.38 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2014-15, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.

## 2 Other Operating Revenue

| | 2014-15 Admin £000 | 2014-15 Programme £000 | 2014-15 Total £000 | 2013-14 Total £000 |
|---|---|---|---|---|
| Recoveries in respect of employee benefits | **22** | **0** | **22** | 0 |
| Patient transport services | **0** | **0** | **0** | 0 |
| Prescription fees and charges | **0** | **0** | **0** | 0 |
| Dental fees and charges | **0** | **0** | **0** | 0 |
| Education, training and research | **0** | **56** | **56** | 108 |
| Charitable and other contributions to revenue expenditure: NHS | **0** | **0** | **0** | 0 |
| Charitable and other contributions to revenue expenditure: non-NHS | **0** | **0** | **0** | 0 |
| Receipt of donations for capital acquisitions: NHS Charity | **0** | **0** | **0** | 0 |
| Receipt of Government grants for capital acquisitions | **0** | **0** | **0** | 0 |
| Non-patient care services to other bodies * | **503** | **95** | **598** | 0 |
| Income generation | **0** | **0** | **0** | 0 |
| Rental revenue from finance leases | **0** | **0** | **0** | 0 |
| Rental revenue from operating leases | **0** | **0** | **0** | 0 |
| Other revenue ** | **1,417** | **54,840** | **56,257** | 55,709 |
| **Total other operating revenue** | **1,942** | **54,991** | **56,933** | **55,817** |

** This relates to funding for Healthy Lives Health Futures and Care Act.*

*** This includes £47.9m in relation to the adult social care partnership agreement and £7m in relation to adult social care private client revenue.*

## 3 Revenue

| | 2014-15 Admin £000 | 2014-15 Programme £000 | 2014-15 Total £000 | 2013-14 Total £000 |
|---|---|---|---|---|
| From rendering of services | 1,942 | 54,991 | 56,933 | 55,817 |
| From sale of goods | 0 | 0 | 0 | 0 |
| **Total** | **1,942** | **54,991** | **56,933** | **55,817** |

## 4. Employee benefits and staff numbers

### 4.1.1 Employee benefits

| 2014-15 | Admin | | | Programme | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 | Total £000 |
| Employee Benefits | | | | | | | | | |
| Salaries and wages | 2,093 | 64 | **2,157** | 310 | 187 | **497** | 2,403 | 251 | **2,654** |
| Social security costs | 175 | 5 | **180** | 24 | 0 | **24** | 199 | 5 | **204** |
| Employer Contributions to NHS Pension scheme | 294 | 6 | **300** | 16 | 0 | **16** | 310 | 6 | **316** |
| Other pension costs | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| Other post-employment benefits | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| Other employment benefits | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| Termination benefits | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| **Gross employee benefits expenditure** | **2,562** | **75** | **2,637** | **350** | **187** | **537** | **2,912** | **262** | **3,174** |
| Less recoveries in respect of employee benefits (note 4.1.2) | (22) | 0 | **(22)** | 0 | 0 | **0** | (22) | 0 | **(22)** |
| **Total - Net admin employee benefits including capitalised costs** | **2,540** | **75** | **2,615** | **350** | **187** | **537** | **2,890** | **262** | **3,152** |
| Less: Employee costs capitalised | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| **Net employee benefits excluding capitalised costs** | **2,540** | **75** | **2,615** | **350** | **187** | **537** | **2,890** | **262** | **3,152** |

| 2013-14 | Admin | | | Programme | | | Total | | |
|---|---|---|---|---|---|---|---|---|---|
| | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 | Total £000 |
| Employee Benefits | | | | | | | | | |
| Salaries and wages | 2,052 | 65 | **2,117** | 1,359 | 541 | **1,900** | 3,411 | 606 | **4,017** |
| Social security costs | 174 | 0 | **174** | 97 | 0 | **97** | 271 | 0 | **271** |
| Employer Contributions to NHS Pension scheme | 266 | 0 | **266** | 153 | 0 | **153** | 419 | 0 | **419** |
| Other pension costs | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| Other post-employment benefits | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| Other employment benefits | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| Termination benefits | 0 | 0 | **0** | 9 | 0 | **9** | 9 | 0 | **9** |
| **Gross employee benefits expenditure** | **2,492** | **65** | **2,557** | **1,618** | **541** | **2,159** | **4,110** | **606** | **4,716** |
| Less recoveries in respect of employee benefits (note 4.1.2) | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| **Total - Net admin employee benefits including capitalised costs** | **2,492** | **65** | **2,557** | **1,618** | **541** | **2,159** | **4,110** | **606** | **4,716** |
| Less: Employee costs capitalised | 0 | 0 | **0** | 0 | 0 | **0** | 0 | 0 | **0** |
| **Net employee benefits excluding capitalised costs** | **2,492** | **65** | **2,557** | **1,618** | **541** | **2,159** | **4,110** | **606** | **4,716** |

**4.1.2 Recoveries in respect of employee benefits**

| | 2014-15 | | | 2013-14 | | |
|---|---|---|---|---|---|---|
| | **Permanent Employees £000** | **Other £000** | **Total £000** | **Permanent Employees £000** | **Other £000** | **Total £000** |
| **Employee Benefits - Revenue** | | | | | | |
| Salaries and wages | **(19)** | **0** | **(19)** | 0 | 0 | 0 |
| Social security costs | **(1)** | **0** | **(1)** | 0 | 0 | 0 |
| Employer contributions to the NHS Pension Scheme | **(2)** | **0** | **(2)** | 0 | 0 | 0 |
| Other pension costs | **0** | **0** | **0** | 0 | 0 | 0 |
| Other post-employment benefits | **0** | **0** | **0** | 0 | 0 | 0 |
| Other employment benefits | **0** | **0** | **0** | 0 | 0 | 0 |
| Termination benefits | **0** | **0** | **0** | 0 | 0 | 0 |
| **Total recoveries in respect of employee benefits** | **(22)** | **0** | **(22)** | **0** | **0** | **0** |

*This relates to a recharge for 2 staff seconded to Focus Independent Adult Social Work CIC.*

**4.2 Average number of people employed**

| | 2014-15 | | | 2013-14 | | |
|---|---|---|---|---|---|---|
| | **Permanently employed Number** | **Other Number** | **Total Number** | Permanently employed Number | Other Number | Total Number |
| **Total** | **65** | **3** | **68** | 106 | 9 | 115 |
| Of the above: | | | | | | |
| **Number of whole time equivalent people engaged on capital projects** | **0** | **0** | **0** | 0 | 0 | 0 |

*The reduction in staff numbers between financial years relates to the transfer of 110 whole time equivalent staff to Focus Independent Adult Social Work CIC from the CCG on 1st September 2013.*

**4.3 Staff sickness absence and ill health retirements**

| | **2014-15 Number** | 2013-14 Number |
|---|---|---|
| Total Days Lost | **129** | 509 |
| Total Staff Years | **63** | 133 |
| **Average working Days Lost** | **2** | 4 |

The CCG had no retirements on early ill health grounds or additional pension liabilites accrued in 2014/15 (2013/14: NIL )

### 4.4 Exit packages agreed in the financial year

There were no exit packages agreed in 2014/15. In 2013/14 there was 1 exit package agreed for £9,336.

### 4.5 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 NHS 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 NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

#### 4.5.1 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the Scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

#### 4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

### 4.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

- The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;
- With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as "pension commutation";
- Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).
- Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.
- 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 the employer.
- Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

### 4.5.4 Local Government Pension Scheme

The CCG has admitted body status within the Local Government Pension Scheme in respect of former council employees and new employees performing social care functions. The scheme provides members with defined benefits related to pay and service. The cost of the employer's contributions is equal to the contributions paid to the funded pension scheme for these employees.

The contributions rate is determined by the Funds Actuary based on triennial actuarial valuations: the last formal valuation was carried out at 31st March 2013. The CCGs accounts include an employer's contribution 34.8% of gross salary with effect from 1st April 14. In 2013/14 the employer's contribution was 20.6% of gross salary.

The Local Government Scheme is accounted for as a defined benefits scheme :

- The liabilities of The East Riding of Yorkshire pension scheme attributable to the CCG are included in the balance sheet on an actuarial basis using the projected unit method i.e. an assessment of the future payments that will be made in relation to retirement benefits earned to date by employees, based on assumptions about mortality rates, employee turnover rates, etc. and projections of projected earnings for current employees.
- Liabilities are discounted to their value at current prices, using a discount rate based on the Corporate bond yield curve which is constructed based on the constituents of the iBoxx £ Corporates AA index and using the UBS delta curve fitting methodology.
- the principle assumptions used by the independent qualified actuaries in updating the latest valuations of the Fund for IAS 19 purposes were:

### 4.5.4 Local Government Pension Scheme (Continued)

| | **31 March 2015** | 31 March 2014 |
|---|---|---|
| | **% p.a.** | % p.a. |
| Pension Increase rate | **2.4%** | 2.8% |
| Salary Increase rate | **3.8%** | 4.1% |
| Discount Rate | **3.2%** | 4.3% |

| | **31st March 2015** | | 31st March 2014 | |
|---|---|---|---|---|
| **Mortality Assumptions** | **Males Years** | **Females Years** | Males Years | Females Years |
| Current Pensioners | **21.9** | **24.1** | 21.9 | 24.1 |
| Future Pensioners** | **24.2** | **26.7** | 24.2 | 26.7 |

** Figure assume members aged 45 as at the last formal valuation date

| **Sensitivity Analysis** | **31st March 2015** | | 31st March 2014 | |
|---|---|---|---|---|
| Change in assumptions at year ended 31 March 2015 | **Approximate % increase to Employer liability** | **Approximate monetary amount £'000** | Approximate % increase to Employer liability | Approximate monetary amount £'000 |
| 0.5% decrease in Real Discount Rate | **11%** | **3,733** | 10% | 3,012 |
| 1 year increase in member life expectancy | **3%** | **1,028** | 3% | 885 |
| 0.5% increase in the Salary Increase Rate | **0%** | **103** | 0% | 75 |
| 0.5% increase in the Pension Increase | **11%** | **3,634** | 10% | 2,962 |

The change in the net pensions liability is analysed into seven components:

- Current service cost; the increase in present liabilities expected to arise from employee service in the current period (allocated to the revenue accounts of services for which the employees worked in the Income and Expenditure Account).
- Past service cost; the increase in liabilities arising from current year decisions whose effect relates to years of service earned in earlier years.
- Interest cost; the expected increase in the present value of liabilities during the year as they move one year closer to being paid.
- Expected return on assets; is based on the long term future expected investment return for each asset class at the beginning of the period.
- Gains/losses on settlements and curtailments; the cost of the early payment of pension benefits if any employee has been made redundant in the previous financial year.
- Actuarial gains and losses; changes in actuarial deficits or surpluses that arise because events have not coincided with the actuarial assumptions made for the last valuation (experience gains and losses) or the actuarial assumptions have changed.
- Contributions paid to the East Riding Pension fund; cash paid as employer's contributions to the pension fund.

It is estimated that the Employers Contributions payable for the year to 31 March 2016 will be approximately £47,000.

**Employer membership statistics**

| | **31 Dec 2014** | 31 Dec 2013 |
|---|---|---|
| | **Number** | Number |
| Actives | **4** | 4 |
| Deferred pensioners | **305** | 285 |
| Pensioners | **146** | 141 |
| Total | **455** | 430 |

The above is the latest information available at the time of the tri-annual valuation.

| 5. **Operating expenses** | **2014-15 Admin £000** | **2014-15 Programme £000** | **2014-15 Total £000** | 2013-14 Total £000 |
|---|---|---|---|---|
| **Gross employee benefits** | | | | |
| Employee benefits excluding governing body members | **2,298** | **537** | **2,835** | 4,399 |
| Executive governing body members | **339** | **0** | **339** | 317 |
| **Total gross employee benefits** | **2,637** | **537** | **3,174** | 4,716 |
| **Other costs** | | | | |
| Services from other CCGs and NHS England | **1,186** | **1,052** | **2,238** | 2,830 |
| Services from foundation trusts | **0** | **102,996** | **102,996** | 99,816 |
| Services from other NHS trusts | **0** | **14,989** | **14,989** | 16,710 |
| Services from other NHS bodies | **0** | **0** | **0** | 0 |
| Purchase of healthcare from non-NHS bodies | **0** | **61,978** | **61,978** | 55,603 |
| Social Care from Independent Providers | **0** | **53,270** | **53,270** | 52,507 |
| Chair and Non Executive Members | **129** | **0** | **129** | 150 |
| Supplies and services – clinical | **0** | **0** | **0** | 0 |
| Supplies and services – general | **73** | **847** | **920** | 1,698 |
| Consultancy services | **655** | **411** | **1,066** | 491 |
| Establishment | **271** | **392** | **663** | 548 |
| Transport | **9** | **0** | **9** | 9 |
| Premises | **165** | **248** | **413** | 300 |
| Impairments and reversals of receivables | **0** | **630** | **630** | 147 |
| Inventories written down | **0** | **0** | **0** | 0 |
| Depreciation | **0** | **0** | **0** | 0 |
| Amortisation | **0** | **0** | **0** | 0 |
| Impairments and reversals of property, plant and equipment | **0** | **0** | **0** | 0 |
| Impairments and reversals of intangible assets | **0** | **0** | **0** | 0 |
| Impairments and reversals of financial assets | **0** | **0** | **0** | 0 |
| · Assets carried at amortised cost | **0** | **0** | **0** | 0 |
| · Assets carried at cost | **0** | **0** | **0** | 0 |
| · Available for sale financial assets | **0** | **0** | **0** | 0 |
| Impairments and reversals of non-current assets held for sale | **0** | **0** | **0** | 0 |
| Impairments and reversals of investment properties | **0** | **0** | **0** | 0 |
| Audit fees | **74** | **0** | **74** | **73** |
| Other non statutory audit expenditure | | | | |
| · Internal audit services | **75** | **0** | **75** | 64 |
| · Other services | **0** | **0** | **0** | 0 |
| General dental services and personal dental services | **0** | **0** | **0** | 0 |
| Prescribing costs | **0** | **26,223** | **26,223** | 25,775 |
| Pharmaceutical services | **0** | **0** | **0** | 0 |
| General ophthalmic services | **0** | **0** | **0** | 0 |
| GPMS/APMS and PCTMS ***** | **0** | **476** | **476** | 0 |
| Other professional fees excl. audit | **228** | **143** | **371** | 487 |
| Grants to other public bodies | **0** | **119** | **119** | 0 |
| Clinical negligence | **0** | **0** | **0** | 0 |
| Research and development (excluding staff costs) | **0** | **0** | **0** | 0 |
| Education and training | **26** | **51** | **77** | 149 |
| Change in discount rate | **0** | **0** | **0** | 0 |
| Provisions ****** | **8** | **369** | **377** | 0 |
| CHC Risk Pool contributions | **0** | **308** | **308** | 0 |
| Interest (Local Government Pension Scheme) | **0** | **1,255** | **1,255** | 1,570 |
| Expected Return on Assets (Local Governement Pension Scheme) | **0** | **(1,123)** | **(1,123)** | (1,257) |
| Other expenditure | **0** | **0** | **0** | 0 |
| **Total other costs** | **2,899** | **264,634** | **267,533** | 257,670 |
| **Total operating expenses** | **5,536** | **265,171** | **270,707** | 262,386 |

* GPMS/APMS ; This relates to Enhanced Services - (minor surgery costs). The costs have been analysed separately in 2014/15 . In 2013/14 these costs were included in Purchase of Healthcare from Non-NHS Bodies (£582k)

** Provisions ; The costs have been analysed separately in 2014/15. In 2013/14 provisons arising during the year (£336k) were included in Purchase of Healthcare from Non-NHS bodies. For further analysis see note 30.

## 6. Better Payment Practice Code

### 6.1 Measure of compliance

| | 2014-15 Number | 2014-15 £000 | 2013-14 Number | 2013-14 £000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade invoices paid in the Year | **35,660** | **116,357** | 34,023 | 113,792 |
| Total Non-NHS Trade Invoices paid within target | **33,545** | **113,274** | 29,454 | 108,030 |
| **Percentage of Non-NHS Trade invoices paid within target** | **94.07%** | **97.35%** | 86.57% | 94.94% |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | **1,968** | **121,043** | 1,255 | 117,371 |
| Total NHS Trade Invoices Paid within target | **1,955** | **121,005** | 1,226 | 117,352 |
| **Percentage of NHS Trade Invoices paid within target** | **99.34%** | **99.97%** | 97.69% | 99.98% |

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

### 6.2 The Late Payment of Commercial Debts (Interest) Act 1998

| | 2014-15 £000 | 2013-14 £000 |
|---|---|---|
| Amounts included in finance costs from claims made under this legislation | - | - |
| Compensation paid to cover debt recovery costs under this legislation | - | - |
| **Total** | **-** | **-** |

## 7. Income Generation Activities

The CCG does not undertake any income generation activities.

## 8. Investment Revenue

The CCG had no investment revenue as at 31 March 2015 (31 March 2014: £NIL).

## 9. Other Gains & Losses

The CCG had no other gains and losses as at 31 March 2015 (31 March 2014: £NIL).

## 10. Finance Costs

The CCG had no finance costs as at 31 March 2015 (31 March 2014: £NIL).

## 11. Net Gain (Loss) on Transfer by Absorption

The CCG has no recognised gain or loss on transfer by absorption in the Statement of Comprehensive Net Expenditure.

## 12. Operating Leases

### 12.1 As lessee

The CCG makes payments to NHS Property Services Ltd under an operating lease arrangement to occupy Athena building (main headquarters) and other buildings. There are no contingent rental obligations and the lease arrangement for the CCG HQ will continue into 2015-16. There are no purchase options or escalation clauses. The leases restrict that the properties can be used as office accomodation only.

While our arrangements with NHS Property Services Ltd 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.

#### 12.1.1 Payments recognised as an Expense

| | Land £000 | Buildings £000 | Other £000 | **2014-15 Total £000** | 2013-14 Total £000 |
|---|---|---|---|---|---|
| **Payments recognised as an expense** | | | | | |
| Minimum lease payments | 0 | 97 | 9 | **106** | 186 |
| Contingent rents | 0 | 0 | 0 | **0** | 0 |
| Sub-lease payments | 0 | 0 | 0 | **0** | 0 |
| **Total** | **0** | **97** | **9** | **106** | **186** |

#### 12.1.2 Future minimum lease payments

| | Land £000 | Buildings £000 | Other £000 | **2014-15 Total £000** | 2013-14 Total £000 |
|---|---|---|---|---|---|
| **Payable:** | | | | | |
| No later than one year | 0 | 0 | 6 | **6** | 9 |
| Between one and five years | 0 | 0 | 1 | **1** | 6 |
| After five years | 0 | 0 | 0 | **0** | 0 |
| **Total** | **0** | **0** | **7** | **7** | **15** |

### 12.2 As lessor

The CCG is not a lessor.

#### 12.2.1 Rental revenue

The CCG had no rental revenue as at 31 March 2015 (31 March 2014: £NIL).

## 13. Property, Plant & Equipment

The CCG had no property, plant & equipment as at 31 March 2015 (31 March 2014: £NIL).

## 14. Intangible Assets

The CCG had no intangible Assets as at 31 March 2015 (31 March 2014: £NIL).

## 15. Investment Property

The CCG had no investment property as at 31 March 2015 (31 March 2014: £NIL).

## 16. Inventories

The CCG had no inventories as at 31 March 2015 (31 March 2014: £NIL).

## 17 Trade & Other Receivables

| | **Current 2014-15 £000** | **Non-current 2014-15 £000** | Current 2013-14 £000 | Non-current 2013-14 £000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 188 | 0 | 241 | 0 |
| NHS receivables: Capital | 0 | 0 | 0 | 0 |
| NHS prepayments and accrued income | 798 | 0 | 123 | 0 |
| Non-NHS receivables: Revenue | 3,056 | 0 | 2,604 | 0 |
| Non-NHS receivables: Capital | 0 | 0 | 0 | 0 |
| Non-NHS prepayments and accrued income | 3,751 | 0 | 2,222 | 0 |
| Provision for the impairment of receivables | (3,126) | 0 | (2,672) | 0 |
| VAT | 7 | 0 | 82 | 0 |
| Private finance initiative and other public private partnership arrangement prepayments and accrued income | 0 | 0 | 0 | 0 |
| Interest receivables | 0 | 0 | 0 | 0 |
| Finance lease receivables | 0 | 0 | 0 | 0 |
| Operating lease receivables | 0 | 0 | 0 | 0 |
| Other receivables | 2,294 | 0 | 2,313 | 0 |
| **Total Trade & other receivables** | **6,968** | **0** | 4,913 | **0** |
| **Total current and non current** | **6,968** | | 4,913 | |
| Included in the CCG NHS Receivables are pre-paid pensions contributions | 0 | | 0 | |

The great majority of trade is with NHS England and North East Lincolnshire Council. As NHS England and North East Lincolnshire Council are funded by Government, no credit scoring of them is considered

Other receivables include £2,294k in relation to the adult social care partnership agreement.

### 17.1 Receivables past their due date but not impaired

| | **2014-15 £000** | 2013-14 £000 |
|---|---|---|
| By up to three months | (178) | (276) |
| By three to six months | (354) | (230) |
| By more than six months | 0 | (14) |
| **Total** | **(532)** | **(520)** |

### 17.2 Provision for impairment of receivables

| | **2014-15 £000** | 2013-14 £000 |
|---|---|---|
| **Balance at 1 April 2014** | (2,672) | (2,593) |
| Amounts written off during the year | 176 | 68 |
| Amounts recovered during the year | 364 | 736 |
| (Increase) decrease in receivables impaired | (994) | (883) |
| Transfer (to) from other public sector body | 0 | 0 |
| **Balance at 31 March 2015** | **(3,126)** | (2,672) |

The provision relates to two main areas:

- House Sale income which is collected from clients for residential and nursing care.
- Debtors ledger income

| | **2014-15 %** | 2013-14 % |
|---|---|---|
| Receivables are provided against at the following rates: | | |
| NHS debt | 0% | 0% |
| 7 to 9 months | 25% | 25% |
| 10 to12 months | 50% | 50% |
| 1 to 2 years | 75% | 75% |
| over 2 years | 100% | 100% |

## 18. Other financial assets

The CCG had no other financial assets as at 31 March 2015 (31 March 2014: £NIL).

## 19. Other current assets

The CCG had no other current assets as at 31 March 2015 (31 March 2014: £NIL).

## 20. Cash and cash equivalents

| | **2014-15 £000** | 2013-14 £000 |
|---|---|---|
| Balance at 1 April 2014 | 67 | 0 |
| Net change in year | (21) | 67 |
| **Balance at 31 March 2015** | **46** | **67** |
| Made up of: | | |
| Cash with the Government Banking Service | 46 | 67 |
| Cash with Commercial banks | 0 | 0 |
| Cash in hand | 0 | 0 |
| Current investments | 0 | 0 |
| **Cash and cash equivalents as in statement of financial position** | **46** | **67** |
| Bank overdraft: Government Banking Service | 0 | 0 |
| Bank overdraft: Commercial banks | 0 | 0 |
| **Total bank overdrafts** | **0** | **0** |
| **Balance at 31 March 2015** | **46** | **67** |
| Patients' money held by the clinical commissioning group, not included above | 0 | 0 |

## 21. Non-current Assets Held for Sale

The CCG had no non-current assets held for sale as at 31 March 2015 (31 March 2014: £NIL).

## 22. Analysis of Impairments & Reversals

The CCG had no impairments or reversals recognised in expenditure during 2014-15 (2013-14: £NIL).

## 23. Trade and other payables

| | **Current 2014-15 £000** | **Non-current 2014-15 £000** | Current 2013-14 £000 | Non-current 2013-14 £000 |
|---|---|---|---|---|
| Interest payable | 0 | 0 | 0 | 0 |
| NHS payables: revenue | 309 | 0 | 2,382 | 0 |
| NHS payables: capital | 0 | 0 | 0 | 0 |
| NHS accruals and deferred income | 2,293 | 0 | 867 | 0 |
| Non-NHS payables: revenue | 1,809 | 0 | 1,077 | 0 |
| Non-NHS payables: capital | 0 | 0 | 0 | 0 |
| Non-NHS accruals and deferred income | 12,146 | 0 | 9,614 | 0 |
| Social security costs | 31 | 0 | 28 | 0 |
| VAT | 0 | 0 | 0 | 0 |
| Tax | 32 | 0 | 32 | 0 |
| Payments received on account | 0 | 0 | 0 | 0 |
| Other payables | 91 | 5,479 | 165 | 3,083 |
| **Total Trade & Other Payables** | **16,711** | **5,479** | **14,165** | **3,083** |
| Total current and non-current | **22,190** | | **17,248** | |

Other payables include £47k outstanding pension contributions at 31 March 2015 (31 March 2014: £42k).

Other non-current trade payables relate to the Local Government Pension Scheme.

### 24. Other Financial Liabilities

The CCG had no other financial liabilities as at 31 March 2015 (31 March 2014: £NIL).

### 25. Other Liabilities

The CCG had no other liabilities as at 31 March 2015 (31 March 2014: £NIL).

### 26. Borrowings

The CCG had no borrowings as at 31 March 2015 (31 March 2014: £NIL).

### 27. Private Finance Initiative, LIFT & Other Service Concession

The CCG had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2015 (31 March 2014: None).

### 28. Finance Lease Obligations

The CCG had no finance lease obligations as at 31 March 2015 (31 March 2014: None).

### 29. Finance Lease Receivables

The CCG had no finance lease receivables as at 31 March 2015 (31 March 2014: None).

### 30. Provisions

| | **Current 2014-15 £000** | Current 2013-14 £000 | **Non-current 2014-15 £000** | Non-current 2013-14 £000 |
|---|---|---|---|---|
| Pensions relating to former directors | 0 | 0 | 0 | 0 |
| Pensions relating to other staff | 0 | 0 | 0 | 0 |
| Restructuring | 0 | 0 | 0 | 0 |
| Redundancy | 0 | 0 | 0 | 0 |
| Agenda for change | 0 | 0 | 0 | 0 |
| Equal pay | 0 | 0 | 0 | 0 |
| Legal claims | 0 | 0 | 8 | 0 |
| Continuing care | 139 | 336 | 0 | 0 |
| Other | 269 | 0 | 0 | 0 |
| **Total** | **408** | **336** | **8** | **0** |

| | | |
|---|---|---|
| **Total current and non-current** | **416** | **336** |

## 30. Provisions (continued)

| | Pensions Relating to Former Directors | Pensions Relating to Other Staff | Restructuring | Redundancy | Agenda for Change | Equal Pay | Legal Claims | Continuing Care | Other | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Balance at 1 April 2014** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **336** | **0** | **336** |
| Arising during the year | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 101 | 269 | **377** |
| Utilised during the year | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (297) | 0 | **(297)** |
| Reversed unused | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Unwinding of discount | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Change in discount rate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| Transfer (to) from other public sector body | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Balance at 31 March 2015** | **0** | **0** | **0** | **0** | **0** | **0** | **8** | **139** | **269** | **416** |
| **Expected timing of cash flows:** | | | | | | | | | | |
| Within one year | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 139 | 269 | **408** |
| Between one and five years | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 0 | 0 | **8** |
| After five years | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | **0** |
| **Balance at 31 March 2015** | **0** | **0** | **0** | **0** | **0** | **0** | **8** | **139** | **269** | **416** |

Other provisions relate to three adult social care provisions created within 2014/15.

- Section 117 reimbursement of client contributions
- sustainability funding to support planned closure of Learning Disability Provider
- Estate dilapidation costs

It is anticipated these provisions will be utilised in full during 2015/16

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2015 is £1,524k (31 March 2014 £2,450k).

## 31. Contingencies

The CCG had no borrowings as at 31 March 2015 (31 March 2014: £NIL).

## 32. Commitments

### 32.1 Capital commitments

The CCG had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2015 (31 March 2014: £NIL).

### 32.2 Other financial commitments

The CCG had no non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2015 (31 March 2014: £NIL).

## 33. Financial instruments

### 33.1 Financial risk management

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

Because the 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 standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG and internal auditors.

#### 33.1.1 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 and therefore has low exposure to currency rate fluctuations.

#### 33.1.2 Interest rate risk

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

#### 33.1.3 Credit risk

Because the majority of the CCG and revenue comes 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.

#### 33.1.4 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.

## 33. Financial instruments cont'd

### 33.2 Financial assets

| | At 'fair value through profit and loss' 2014-15 £000 | Loans and Receivables 2014-15 £000 | Available for Sale 2014-15 £000 | Total 2014-15 £000 |
|---|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 | **0** |
| Receivables: | | | | |
| · NHS | 0 | 188 | 0 | **188** |
| · Non-NHS | 0 | 3,056 | 0 | **3,056** |
| Cash at bank and in hand | 0 | 46 | 0 | **46** |
| Other financial assets | 0 | 2,294 | 0 | **2,294** |
| **Total at 31 March 2015** | **0** | **5,584** | **0** | **5,584** |

| | 2013-14 £000 | 2013-14 £000 | 2013-14 £000 | 2013-14 £000 |
|---|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 | 0 |
| Receivables: | | | | |
| · NHS | 0 | 241 | 0 | 241 |
| · Non-NHS | 0 | 2,604 | 0 | 2,604 |
| Cash at bank and in hand | 0 | 67 | 0 | 67 |
| Other financial assets | 0 | 2,313 | 0 | 2,313 |
| **Total at 31 March 2014** | **0** | **5,225** | **0** | **5,225** |

### 33.3 Financial liabilities

| | At 'fair value through profit and loss' 2014-15 £000 | Other 2014-15 £000 | Total 2014-15 £000 |
|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 |
| Payables: | | | |
| · NHS | 0 | 2,602 | 2,602 |
| · Non-NHS | 0 | 19,525 | 19,525 |
| Private finance initiative, LIFT and finance lease obligations | 0 | 0 | 0 |
| Other borrowings | 0 | 0 | 0 |
| Other financial liabilities | 0 | 0 | 0 |
| **Total at 31 March 2015** | **0** | **22,127** | **22,127** |

| | 2013-14 £000 | 2013-14 £000 | 2013-14 £000 |
|---|---|---|---|
| Embedded derivatives | 0 | 0 | 0 |
| Payables: | | | |
| · NHS | 0 | 3,249 | 3,249 |
| · Non-NHS | 0 | 10,691 | 10,691 |
| Private finance initiative, LIFT and finance lease obligations | 0 | 0 | 0 |
| Other borrowings | 0 | 0 | 0 |
| Other financial liabilities | 0 | 0 | 0 |
| **Total at 31 March 2014** | **0** | **13,940** | **13,940** |

## 34. Operating Segments

In additon to the core role of the CCG, being commissioning of health services for the North East Lincolnshire area, the CCG also operates a pooled budget arrangement with North East Lincolnshire Council for the commissioning of Adult Social Care for the area. See note 35 for further information.

| **2014/15** | **Gross expenditure** | **Income** | **Net expenditure** | **Total assets** | **Total liabilities** | **Net assets** |
|---|---|---|---|---|---|---|
| | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** |
| Health | 215,635 | (1,861) | **213,774** | 2,296 | (12,038) | **(9,742)** |
| Adult Social Care | 55,072 | (55,072) | **0** | 4,718 | (10,568) | **(5,850)** |
| **Total** | **270,707** | **(56,933)** | **213,774** | **7,014** | **(22,606)** | **(15,592)** |

| **2013/14** | **Gross expenditure** | **Income** | **Net expenditure** | **Total assets** | **Total liabilities** | **Net assets** |
|---|---|---|---|---|---|---|
| | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** |
| Health | **208,489** | **(1,920)** | **206,569** | **706** | **(9,677)** | **(8,971)** |
| Adult Social Care | **52,327** | **(52,327)** | **0** | **4,274** | **(7,907)** | **(3,633)** |
| Discontinued operations | **1,570** | **(1,570)** | **0** | **0** | **0** | **0** |
| Total | **262,386** | **(55,817)** | **206,569** | **4,980** | **(17,584)** | **(12,604)** |

## 35. Pooled Budgets

The CCG entered into a pooled budget with North East Lincolnshire Council. The pool is hosted by NHS North East Lincolnshire CCG.

Under the arrangement funds are pooled under Section 75 of the National Health Service Act 2006 for the provision of Adult Social Care within North East Lincolnshire

The table below provides a summary of the income and expenditure handled by the pooled budget in the financial year

| | **2014-15 £000** | 2013-14 £000 |
|---|---|---|
| Section 75 Partnership Agreement | **47,869** | 45,861 |
| Other Contributions | **7,203** | 8,036 |
| Adult social care expenditure | **(55,072)** | (53,897) |
| Total | **0** | 0 |

The Better Care Fund, which creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, comes into effect from the 1st April 2015. The Better Care Fund will build on the Partnership Agreement arrangements we already have in place in North East Lincolnshire.

The main change for 2015/16 is that £3.6m funding, previously received directly by North East Lincolnshire Council and then transferred in full to NEL CCG (as part of the Partnership Agreement) will come direct to the CCG. This will not therefore change the CCGs overall funding.

## 36. NHS LIFT Investments

The CCG had no NHS LIFT investments as at 31 March 2015 (31 March 2014: £NIL).

## 37. Intra-government and other balances

| | Current Receivables 2014-15 £000 | Non-current Receivables 2014-15 £000 | Current Payables 2014-15 £000 | Non-current Payables 2014-15 £000 |
|---|---|---|---|---|
| **Balances with:** | | | | |
| · Other Central Government bodies | 57 | 0 | 1,420 | 0 |
| · Local Authorities | 2,374 | 0 | 142 | 0 |
| · NHS bodies outside the Departmental Group | 183 | 0 | 226 | 0 |
| · NHS Trusts and Foundation Trusts | 803 | 0 | 2,376 | 0 |
| · Public corporations and trading funds | 0 | 0 | 0 | 0 |
| · Bodies external to Government | 3,551 | 0 | 12,547 | 5,479 |
| **Total balances at 31 March 2015** | **6,968** | **0** | **16,711** | **5,479** |

| | 2013-14 £000 | 2013-14 £000 | 2013-14 £000 | 2013-14 £000 |
|---|---|---|---|---|
| **Balances with:** | | | | |
| · Other Central Government bodies | 82 | 0 | 99 | 0 |
| · Local Authorities | 2,224 | 0 | 79 | 0 |
| · NHS bodies outside the Departmental Group | 260 | 0 | 1,659 | 0 |
| · NHS Trusts and Foundation Trusts | 104 | 0 | 1,590 | 0 |
| · Public corporations and trading funds | 0 | 0 | 0 | 0 |
| · Bodies external to Government | 2,243 | 0 | 10,738 | 3,083 |
| **Total balances at 31 March 2014** | **4,913** | **0** | **14,165** | **3,083** |

## 38. Related Party Transactions

Details of related party transactions with individuals are as follows:

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. This

- NHS England (including commissioning support units);
- NHS England
- NHS Yorkshire & Humber Commissioning Support Unit

- **NHS Foundation Trusts;**
  Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
  Sheffield Teaching Hospitals NHS Foundation Trust

- **NHS Trusts;**
  East Midlands Ambulance Service NHS Trust
  Hull & East Yorkshire Hospitals NHS Trust
  Leeds Teaching Hospitals NHS Trust

- NHS Litigation Authority; and,
- 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 North East Lincolnshire Council in respect of the provision of adult social care.

## 38. Related party transactions

**Details of related party transactions with individuals are as follows:**

| | Payments to Related Party | Receipts from Related Party | Amounts owed to Related Party | Amounts due from Related Party |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| Cathy Kennedy | | | | |
| Deputy Chief Executive | | | | |
| • Husband is employed by Yorkshire and Humber Commissioning Support | 2,496 | 0 | 222 | 0 |
| • HFMA -President of Yorkshire branch & Chair of National Commissioning Faculty | 2 | 0 | 0 | 0 |
| Cllr Michael Burnett | | | | |
| Partnership board NELC nominated representative/Integrated Governance & Audit committee member | | | | |
| • Councillor for North East Lincolnshire Council | 4,108 | (18,060) | 137 | (2,369) |
| • Director of Lincs Inspire | 1 | 0 | 0 | 0 |
| Cllr Peter Wheatley | | | | |
| Partnership board NELC nominated representative/Integrated Governance & Audit committee member/Remuneration committee member | | | | |
| • Councillor for North East Lincolnshire Council | 4,108 | (18,060) | 137 | (2,369) |
| Dr A Nayyar | | | | |
| Partnership Board GP representative | | | | |
| • Director of Core Care Links Ltd | 2,163 | 0 | 48 | 0 |
| • GP at Roxton Practice | 1,286 | (5) | 55 | 0 |
| Dr D Hopper | | | | |
| Partnership Board Vice Chair/Remuneration committee member/ Chair of Council of Members | | | | |
| • GP at Fieldhouse Medical Group | 295 | 0 | 31 | 0 |
| Dr K Severin | | | | |
| Council of Members/ Integrated Governance & Audit Committee | | | | |
| • GP at Birkwood Medical Centre | 142 | 0 | 20 | 0 |
| Dr P Melton | | | | |
| Clinical Chief Officer | | | | |
| • Wife is employed by 360 Care Ltd | 521 | 0 | 43 | 0 |
| • GP at Roxton Practice | 1,286 | (5) | 55 | 0 |

## 38. Related party transactions (Continued)

| | Payments to Related Party £'000 | Receipts from Related Party £'000 | Amounts owed to Related Party £'000 | Amounts due from Related Party £'000 |
|---|---|---|---|---|
| Dr R Pathak | | | | |
| Partnership Board GP representative | | | | |
| • Director at 360 Ltd | 521 | 0 | 43 | 0 |
| • Director of Core Care Links Ltd | 2,163 | 0 | 48 | 0 |
| • GP at Raj Medical Centre | 84 | 0 | 38 | (2) |
| • Wife is a GP at Raj Medical Centre | 84 | 0 | 38 | (2) |
| • Director of M & R Medical Ltd / Wife Co-Director of M & R Medical Ltd | 0 | 0 | 0 | 0 |
| Dr R T Maliyil | | | | |
| Vice Chair Council Of Members/ Partnership Board GP Representative | | | | |
| • Director of Core Care Links | 2,163 | 0 | 48 | 0 |
| • GP at Scartho Medical Centre | 188 | 0 | 35 | 0 |
| • Wife is Practice Manager at Blundell Park Surgery | 16 | 0 | 4 | 0 |
| • Wife is Practice Manager at Healing Health Centre | 21 | 0 | 5 | 0 |
| Geoff Barnes | | | | |
| Partnership Board NELC Officer member | | | | |
| • Acting Director of Public Health, NELC | 4,108 | (18,060) | 137 | (2,369) |
| Helen Kenyon | | | | |
| Deputy Chief Executive | | | | |
| • Personal interest of close friend - working at LINCs | 76 | 0 | 0 | 0 |
| Joanne Hewson | | | | |
| Partnership Board NELC Officer member | | | | |
| • Employed at NELC | 4,108 | (18,060) | 137 | (2,369) |
| Juliette Cosgrove | | | | |
| Partnership board registered nurse | | | | |
| • Husband is Consultant at Lancashire Teaching Hospital NHS Trust | 0 | 0 | 0 | 0 |
| • Employed at Calderdale & Huddersfield NHS Foundation Trust | 5 | 0 | 0 | 0 |

**38. Related party transactions (Continued)**

| | Payments to Related Party | Receipts from Related Party | Amounts owed to Related Party | Amounts due from Related Party |
|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 |
| Mandy Coulbeck | | | | |
| Partnership Board locally practicing nurse / Council of Members | | | | |
| • Nurse at Quayside Open Access Centre | 84 | 0 | 2 | 0 |
| Mark Webb | | | | |
| CCG chair/Partnership board member/Remuneration committee member | | | | |
| • Director E-Factor Ltd | 1 | 0 | 0 | 0 |
| Mr Perviz Iqbal | | | | |
| Partnership Board secondary care specialist doctor | | | | |
| • Consultant at Doncaster & Bassetlaw NHS Foundation Trust | 57 | 0 | 0 | 0 |
| Stephen Pintus | | | | |
| Partnership Board NELC Officer member | | | | |
| • Director of Public Health NELC | 4,108 | (18,060) | 137 | (2,369) |

Note that these amounts are full year though some of the individuals worked for the CCG part year. This information can be found on the Salaries & Allowances table

The payments made to GP's are not in relation to their GP core contract, which is managed by NHS England, but are in relation to reimbursement of GP drugs, enhanced services and service improvement plans.

## 39. Events after the end of the reporting period

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1st April 2015. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View to deliver a new deal for primary care and another step towards plans set out by NHS England early last year to give patients, communities and clinicians more involvement in deciding local health services.

North East Lincolnshire CCG has assumed responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1st April 2015 but these will be discharged under joint decision making processes through a Joint Committee of NHS England and the CCG.

## 40. Losses and special payments

### 40.1 Losses

The CCG Had no losses during 2014-15. (2013-14 : None ).

Please see note 17.2 for details of the provison for impairment of receivables

### 40.2 Special payments

The CCG had no special payments cases during 2014-15 (2013-14: None )

## 41. Third party assets

The CCG held no third party assets as at 31 March 2015 (31 March 2014: None )

## 42. Financial performance targets

CCG's have a number of financial duties under the NHS Act 2006 (as amended).

The CCG's performance against those duties was as follows:

| National Health Service Act Section | Duty | 2014-15 Target £'000 | 2014-15 Performance £'000 | 2013-14 Target £'000 | 2013-14 Performance £'000 |
|---|---|---|---|---|---|
| 223H(1) | Expenditure not to exceed income (reported surplus £6,533k) | **222,168** | **215,635** | 214,522 | 208,489 |
| 223I(2) * | Capital resource use does not exceed the amount specified in Directions | **65** | **0** | 0 | 0 |
| 223I(3) | Revenue resource use does not exceed the amount specified in Directions | **220,307** | **213,774** | 212,602 | 206,569 |
| 223J(1) * | Capital resource use on specified matter(s) does not exceed the amount specified in Directions | **0** | **0** | 0 | 0 |
| 223J(2) | Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | **0** | **0** | 0 | 0 |
| 223J(3) | Revenue administration resource use does not exceed the amount specified in Directions | **4,297** | **3,594** | 4,100 | 3,898 |

* The £65k funding was paid back to NHS England in March 2014.

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

It should be noted that the table above only relates to NHS funding. The CCG also receives £48m from North East Lincolnshire Council. This is a pooled budget arrangement under Section 75 of the National Health Service Act 2006, see note 35.

## 43. Impact of IFRS

Accounting under IFRS had no impact on the results of the CCG during 2014-15 financial year.

## 44. Analysis of Charitable Reserves

The CCG held no charitable reserves as at 31 March 2015 (31 March 2014: None).

## 45. FRS Accounting Information - Pensions

The disclosures in this note relate to the East Riding Pension Fund (the Fund). The CCG participates in the Local Government Pension Scheme. The Local Government Pension Scheme is a defined benefit scheme based on final pensionable salary.

In accordance with International Accounting Standards- IAS 19 Employee Benefits disclosure of certain information concerning assets, liabilities, income and expenditure related to pension schemes is required.

The actuaries report states that the market value of the assets of the Pension fund as at 31 March 2015 was £28.8 million **(**31 March 2014 was £26.4 million).

| **Assets** | **Value at 31 March 2015 £000** | **Value at 31 March 2014 £000** |
|---|---|---|
| Equity Securities | **11,381** | 11,406 |
| Debt Securities | **2,890** | 2,540 |
| Private Equity | **1,544** | 1,211 |
| Real Estate | **2,453** | 1,623 |
| Investment Funds & Unit Trusts | **9,576** | 8,151 |
| Cash & Cash Equivalents | **930** | 1,479 |
| **Total** | **28,774** | 26,410 |

**Funding Position**

The following amounts, needed for reconciliation to the balance sheet, were measured in accordance with the requirements of IAS19:

| **Fair Value** | **31 March 2015 £000** | **31 March 2014 £000** |
|---|---|---|
| Fair Value of Employer Assets | **28,774** | 26,410 |
| Present Value of Funded Obligations | **(34,253)** | (29,493) |
| **Net Asset/(Liability)** | **(5,479)** | (3,083) |

| **Recognition in the profit or loss** | **31 March 2015 £000** | **31 March 2014 £000** |
|---|---|---|
| Current service cost | **27** | 42 |
| Interest Cost | **1,255** | 1,570 |
| Expected Return on Employer Assets | **(1,123)** | (1,257) |
| Past Service Cost / (Gain) | **0** | 0 |
| Losses / (Gains) on Curtailments and Settlements | **0** | 0 |
| **Total** | **159** | 355 |

| **Reconciliation of defined benefit obligation** | **31 March 2015 £000** | **31 March 2014 £000** |
|---|---|---|
| **Opening Defined Benefit Obligation** | **29,493** | 35,164 |
| Current Service Cost | **27** | 42 |
| Interest Cost | **1,255** | 1,570 |
| Contribution by Members | **10** | 11 |
| Actuarial Losses/(Gains) | **4,092** | (6,712) |
| Past Service Costs / (Gains) | **0** | 0 |
| Losses / (Gains) on Curtailments | **0** | 0 |
| Estimated Benefits Paid | **(624)** | (582) |
| **Closing Defined Benefit Obligation** | **34,253** | 29,493 |

## 45. FRS Accounting Information - Pensions (Continued)

| Reconciliation of fair value of employer assets | 31 March 2015 £000 | 31 March 2014 £000 |
|---|---|---|
| **Opening Fair Value of Employer Assets** | **26,410** | 28,209 |
| Expected Return on Assets | **1,123** | 1,257 |
| Contributions by Members | **10** | 11 |
| Contributions by the Employer | **43** | 53 |
| Actuarial Gains/(Losses) | **1,812** | (2,538) |
| Estimated Benefits Paid | **(624)** | (582) |
| **Total actuarial gain (loss)** | **28,774** | 26,410 |

| Amounts for the current and previous accounting periods | 31 March 2015 £000 | 31 March 2014 £000 |
|---|---|---|
| Fair Value of Employer Assets | **28,774** | **26,410** |
| Present Value of Defined Benefit Obligation | **(34,253)** | **(29,493)** |
| Surplus / (deficit) | **(5,479)** | **(3,083)** |
| Experience Gains/(Losses) on Assets | **1,812** | **(2,538)** |
| Experience Gains/(Losses) on Liabilities | **(457)** | **0** |

| Cumulative Statement of Recognised Gains / Losses | 31 March 2015 £000 | 31 March 2014 £000 |
|---|---|---|
| Actuarial Gains and Losses | **1,812** | (2,538) |
| Effect of Surplus Recovery Through Reduced Contributions | **(4,092)** | 6,712 |
| Actuarial Gains / (Losses) recognised in STRGL | **(2,281)** | 4,174 |
| Cumulative Actuarial Gains and Losses | **(5,904)** | (3,624) |

## 46. Cash Flow Workings

| | £'000 |
|---|---|
| Net operating costs for the financial year (per SOCNE) | **(213,774)** |
| Impairment of receivables | **454** |
| Pension charge | **115** |
| Net operating costs for the financial year per cash flow | **(213,205)** |

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