NHS
North East Lincolnshire
Clinical Commissioning Group

Annual Reports and Accounts

2013/2014

Delivering joined up solutions

innovation
consistency
quality

NHS
North East Lincolnshire
Clinical Commissioning Group

Annual Report and Accounts 2013/2014 Contents

Annual Report

NHS
North East Lincolnshire
Clinical Commissioning Group

Statements by the Accountable Officer

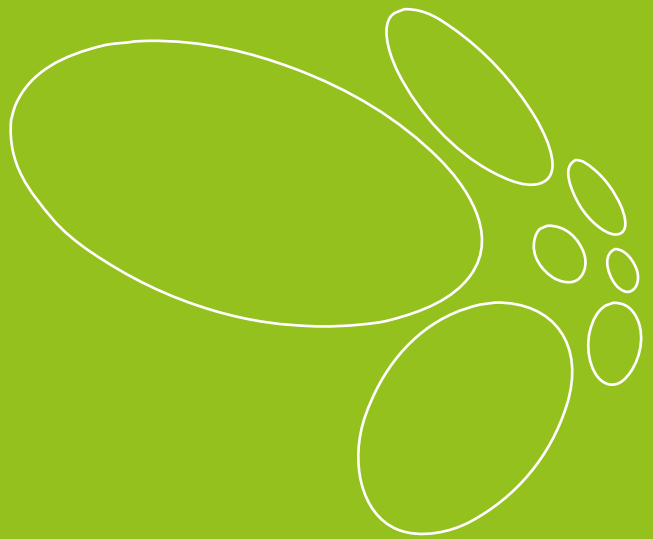
Annual Accounts

North East Lincolnshire Clinical Commissioning Group

2013/14 Annual Report

NHS
North East Lincolnshire
Clinical Commissioning Group

INTRODUCTION



This last year has been an eventful one. Since April the North East Lincolnshire CCG has been the statutory body responsible for Commissioning Health and Social care on behalf of our community after being authorised by the Government. Our CCG has retained the legal partnership with North East Lincolnshire council and together we have created an approach to commissioning that is engaging, transparent, innovative and effective. We decided from the outset that our CCG would be clinically led and the GPs in this area have certainly risen to that challenge, we also decided that it would be shaped by the community we served. To do this we created a structure that involved members of the public in everything we do. Whilst in other parts of the country community involvement is in the shape of consultations which happen at the end of a process, we choose to involve the community in all aspects of our work, in the questions we ask, in the ideas we have and in the decisions we make. The decisions we make about shaping the services for this area are made in collaboration with our community and 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 care services. We have created seven key areas of service delivery:

- Planned Care
- Women and Children
- Older People
- Disabilities and Mental Health
- Medicines and Prescribing
- Health and Wellbeing
- Unscheduled Care

Each of these areas is driven by a named GP, a service lead manager and a member of the community forum. These three work together in their respective area bringing different perspectives to the discussions but all sharing a common aim, to find the best way to deliver services which are clinically sound, affordable and meaningful to the people using them. 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.

NEL Council of Members (CoM) is the arena in which all 30 member practices within NEL have the opportunity to come together to consider and advise on the service commissioning agenda for Health & Social Care, ensure that the continued development of the CCG is aligned to the principles and aspirations of the constituent practices, shape the organisations strategic direction and key objectives and approve service strategies and significant service change proposals.

NEL CoM have been heavily involved in the shaping, engagement and communication of the Healthy Lives Healthy Futures programme via CoM meetings and via attendance at additional events. Clinical lead members within CoM have also helped improve services for patients including – Glaucoma referral refinement scheme within which the first 6 months of operations over 70% avoided hospital without incurring increased practice workloads; reductions in paediatric emergency admissions by 30%; Children's community nursing service accessibility being extended to 8:00am – 10pm 7 days a week with a seamless pathway across primary and secondary care.

The CCG set out an ambitious range of objectives for delivery during 2013/14 and fully achieved 85% of these objectives. The remaining 15% are ongoing items which cross over into 2014/15 (and some of them beyond this timeframe) and will be completed in due course.

The Corporate Business Plan comprises more than 60 projects and initiatives each of which has milestones and key performance indicators used to measure progress and achievement. The areas of work described below are headline achievements for the organisation which reflect a cumulative achievement of these 60+ projects and initiatives.

Objective	Commentary
Delivery of options, engagement and consultation for Healthy Lives	Progress with the Healthy Lives, Healthy Futures Programme has been considerable and has been achieved in conjunction with commissioners and providers across Northern Lincolnshire. Two successful engagement exercises have been conducted, leading to options on service developments for • Ear, Nose and Throat • HyperAcute Stroke A formal consultation process will be held, commencing in June 2014
Shift to self-care and community based care begun	A range of service developments has been undertaken to facilitate this "shift to the left", including (but not limited to): • Development and implementation of the award-winning Community Paediatric Nursing service • Implementation of wrap around care at End of Life, through the Haven team • Market reshaping for Learning Disabilities • Implementing Dementia champions programme in secondary care • Establishment of Community Based Prevention initiatives programme
ExtraCare Housing moved to implementation	The first scheme for ExtraCare Housing commenced construction in July 2013, with further schemes designed to come on line over the next five years
Reduce Excess mortality in NEL	Progress has been achieved in reducing excess mortality in NEL – hospital SHMI has reduced to 109
Effective information systems in place to support commissioning decisions	A range of different systems and process have been implemented during 2013/14, including(but not limited to): • Quality Framework for Care Homes • Performance framework reporting identifying trends and outliers • Public health core offer reporting

The Governing Body/Partnership Board, in line with governance requirements and good practice, is required to review its effectiveness and use the information gathered to inform future development, this has taken place. During 2013/14, the Partnership Board has actively reviewed its effectiveness via the annual risk assessment workshop and the 2014/15 Partnership Board development plan

The overall objective of the annual risk assessment workshop was to take an overview of the risk management process to ensure it was relevant and robust to assist the management and decision-making of the CCG.

The specific aims of the workshop were as follows:

- Update the Partnership Board with regard to the risk register process and content;
- Risk analysis, evaluation and challenge of a sample of higher value risks (focussed on those scored >12) and their mitigation; and
- Consideration of partnership risks and comparative issues across the health economy to provide context to and triangulation of the CCGs risk register.

The session was very productive, resulting in the reduction of risk rating for two of the CCG's high level risks and a general improvement in the overall awareness of the CCG's risk profile.

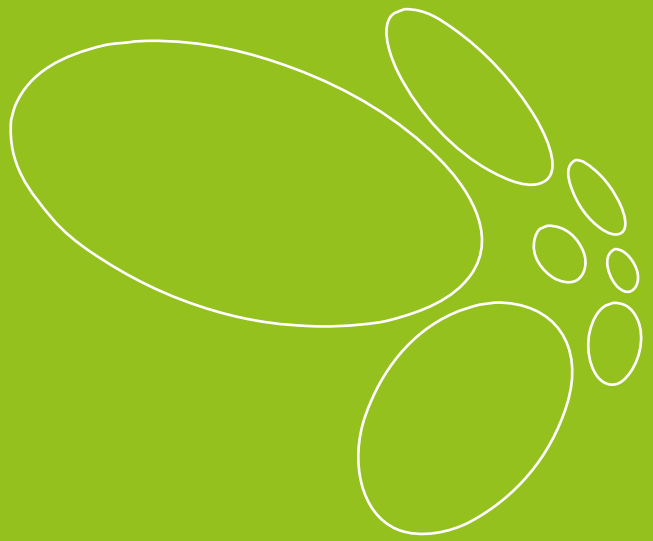
The Board development plan, reflects a review of the responsibilities of the board and governing body as set out in the constitution and terms of reference, key corporate issues and risks, the outcome of individual board member self-assessments and common elements drawn from personal development plans and a series of opportunities have been scheduled for 2014/15 to meet these learning and knowledge needs.

To complement the continuous process of reflection, learning and improvement, Partnership Board members will be asked to complete a checklist of effectiveness that has been created for the CCG by the Yorkshire & Humber Commissioning Support Unit. The checklist is based on the Audit Committee Handbook and has been mapped to the main principles set out in the UK Corporate Governance Code. The responses provided will be reviewed by members of the Partnership Board and feedback will be mapped to CCG strategy to inform future development.

Mr Mark Webb

Chair, NELCCG

STRATEGIC REPORT



Statement of structure and 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.

All CCGs came into operation in England on 1st April 2013, and the North East Lincolnshire CCG comprises thirty member practices. The CCGs constitution sets out the membership and governance arrangements of the organisation, and can be found at: "http://www.northeastlincolnshireccg.nhs.uk/data/uploads/publications/north-east-lincolnshire-ccg-constitution.pdf"

The CCG headquarters is located at Athena Building, Saxon Court, Gilbey Road, Grimsby which the organisation occupies under a lease arrangement with NHE Property Services. The CCG does not own or occupy any other premises.

The CCG operated in shadow form during 2012/13 and underwent the national authorisation processes during that year. It achieved full authorisation without any conditions prior to being established on 1st April 2013.

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 NEL 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 NEL 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.

At 1st April 2013 the adult social work service was directly provided by the CCG, and the associated staff were directly employed by the organisation. At 1st September this service was separated from the CCG into a social enterprise called 'focus', and the associated staff transferred into that organisation. 'focus' operates independently from the CCG but retains a strong partnership relationship.

CCG's mission, aims and plans for future development

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, 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.

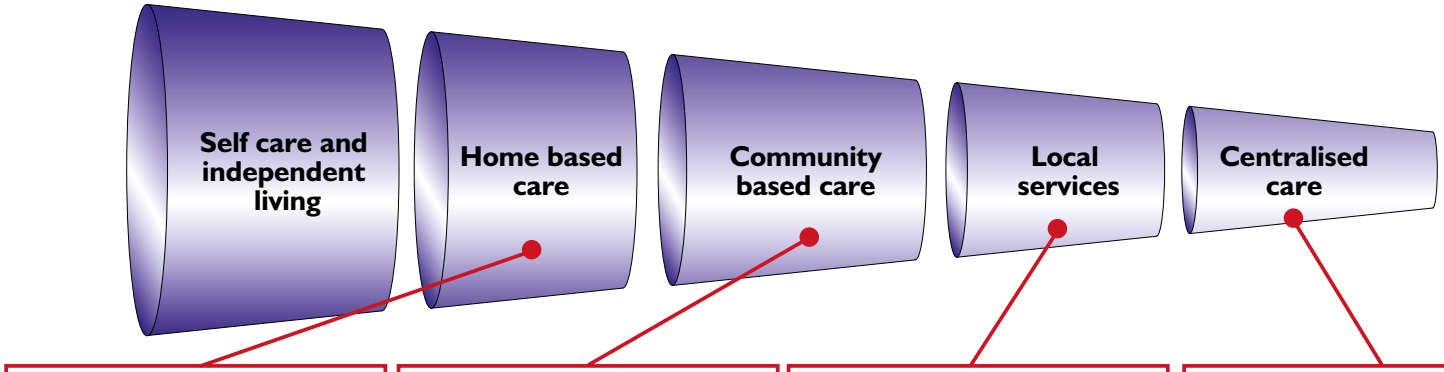
We are determined to deliver the best possible choice, quality and consistency in health and social care whilst driving down costs and offering real value for money. We will continue to lead the way in the development, adoption and diffusion of innovative approaches in the way we work – to enable the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

Plans for future development

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.

Figure 1 – The Healthy Lives, Healthy Futures Shared Vision



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 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.

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.

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 2012, local commissioners and clinicians began to discuss the key steps towards achieving sustainable services. These discussions led to the publication of the Healthy Lives, Healthy Futures case for change in July 2013. A Stakeholder Summit was held on 22 July 2013 to give key stakeholders the opportunity to understand the work being carried out and to discuss how it may impact upon their organisation. This was complemented by 40 individual 1-1 visits with organisations where they had the opportunity to provide feedback on the vision, direction of travel and criteria that will form the foundations for this work.

The Healthy Lives, Healthy Futures Team have also hosted a series of road shows, throughout North East Lincolnshire during 2013/14 aimed at involving and informing the public about how services may change in the future to provide higher quality and value for money.

Healthy Lives, Healthy Futures is being led by North Lincolnshire CCG and North East Lincolnshire CCG working with organisations such as the Northern Lincolnshire and Goole Hospitals NHS Foundation Trust 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.

The options being considered may mean significant changes in the way healthcare services are delivered locally and the CCGs were keen to test these ideas as widely as possible.

Please see the link below for further information on this initiative, including examples of public engagement and consultation: HYPERLINK “http://www.healthyliveshealthyfutures.nhs.uk” www.healthyliveshealthyfutures.nhs.uk

Adult Social Care strategy: Meeting the needs of the local population

NEL Clinical Commissioning Group 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 alongside Health resources to deliver integrated solutions. The Adult Social Care Strategy sets 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.

The strategy describes the necessary changes in the commissioning and delivery architecture, it also describes the continuity in strategic themes, namely;

- Managing Demand
- Promoting efficiency through smart procurement
- Raising Income - the CCG is currently consulting on:
- Reshaping supply

For more information please see the Adult Social Care local account website:

http://www.northeastlincolnshireccg.nhs.uk/data/uploads/local-account-brochure-2013.pdf

Access to Information

During the period 1 April 2013 to 31 March 2014, the CCG processed the following requests for information under the Freedom of Information Act (FOI) 2000

Number of FOI requests processed	224
Percentage of requests responded to within 20 working days*	99.5%
Average time taken to respond to an FOI request	13.2 days

*One request took longer to comply with, in agreement with the requester, due to the complex nature of the subject matter.

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

http://www.northeastlincolnshireccg.nhs.uk/freedom-of-information/publication-scheme/

Quality & 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, NHS England and Local Area Teams in relation to a large number of indicators. These include performance in tackling;

- healthcare acquired infections like MRSA and Clostridium Difficile, increasing breastfeeding and reducing cancer treatment waiting times and;
- adult social care measures such as enhancing quality of life for people by helping people 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.

The latest performance table is available on our website at: www.northeastlincolnshireccg.nhs.uk.

In addition to this a number of indicators were picked locally to measure the success of our Health and Social Care Strategy. The dashboard, see figure 2 below represents an overview of performance and risk for health and social care services across North East Lincolnshire. The dashboard consists of seven domains that incorporate all areas on which the organisation strives to improve.

Figure 2: The performance dashboard

The key performance challenges faced by the CCG are as follows:

Friends and Family Test – Inpatient and A and E response rates

Currently this indicator is off target and the stretch target is unlikely to be realised for this year. An automated call back to the patient post discharge has been implemented which should increase the response rate going forward.

Percentage of people who have depression and/or anxiety disorders accessing psychological therapies

There are currently an insufficient number of referrals into the IAPT commissioned service to meet the target. We have reviewed the pathways and developed QAF incentives to encourage more referrals into the accredited service.

Ambulance response times Category A 8 and 19 minutes standards (EMAS)

This measure is EMAS wide performance not just NELCCG and as such is impacted by poor performance in other geographical areas. Within NELCCG performance is being realised however this will be continually closely monitored to ensure the level of performance remains high.

Summary Hospital Mortality Index (SHMI) – NLAG

Northern Lincolnshire and Goole NHS Foundation Trust overall SHMI rate has improved over the past 12 months and performance is anticipated to continue to improve going forward. However this is a measure that we will continue to monitor closely to ensure there is no slippage in performance.

Estimated diagnosis rate for people with dementia

A national target of achieving 67% by March 2015 has been set for this measure. This presents a significant challenge for North East Lincolnshire with our performance currently being significantly below this expectation.

Adult Social Care

The challenges we face going forward in adult social care include the emergence of a new framework measuring peoples short and long term support and also changes to existing measures or new measures being implemented to compliment this emerging framework. NELCCG will continue to work closely with our partners 'focus', Care Plus Group and Navigo who deliver adult social care services in North East Lincolnshire to ensure our performance aspirations are realised going forward.

The CCG has a number of financial duties under the National Health Service Act 2006 (as amended) and the CCG's performance against these duties was as follows:

NHS Act Section	Duty	Maximum £'000	Performance £'000	Duty achieved?
223H(1)	Expenditure not to exceed income (reported surplus £6,033k) **	214,522	208,489	Yes
223I(3)	Revenue resource use does not exceed the amount specified in Directions	212,602	206,569	Yes
223J(3)	Revenue administration resource use does not exceed the amount specifies in the Directions	4,100	3,898	Yes

** the CCG had no capital resource in 2013/14

CCG 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. The Premium is paid to CCGs in 2014/15 to reflect the quality of the health services commissioned by them in 2013/14 and will be based on four national measures and three local measures (see table below).

A CCG will have its quality premium reduced if the providers from whom it commissions services do not meet four patient rights or pledges set out in the NHS Constitution (25% reduction for each).

The quality premium payment is in addition to a CCG's main financial allocation and running costs allowance.

The regulations have set out the purposes for which the CCG is able to spend the quality premium payment. Under the regulations, CCGs must use the funding awarded to them under the quality premium in ways that improve quality of care or health outcomes and/or reduce health inequalities.

CCGs will have to publish details of how they spend quality premium payments, so that they are accountable to the public and their local community.

Based on our current performance against these measures it is anticipated that NELCCG will receive circa £230k out of the total potential available of £819k (table i) on the assumption that the CCG has managed within its total resources for 2013-14 and that there are no serious quality failures.

Table i

	Measure	Quality Premium Value	
National Measures	Potential years of life lost	12.5%	£102,403.75
	Avoidable emergency admissions	25.0%	£204,807.50
	Friends and family test	12.5%	£102,403.75
	Infection control	12.5%	£102,403.75
Local Priorities	Non face-to-face outpatient follow-ups	12.5%	£102,403.75
	Proportion of people dying at home	12.5%	£102,403.75
	Community based preventative support	12.5%	£102,403.75
	Total before NHS Constitution deductions		**£819,230.00**
Constitution Rights and Pledges	Referral to treatment times	25.0%	
	A&E four hour wait	25.0%	
	Cancer waiting times	25.0%	
	Ambulance response times	25.0%	
	Adjustment for failure		
	QUALITY PREMIUM TOTAL		

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. Please note that a summary of the CCG's discharge of its statutory functions is also provided at page 64 of the Annual Governance Statement.

The CCG's 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 NELCCG. The CCG has robust processes in place for managing the quality agenda. The day to day management of this rests with the Strategic Lead for Quality and Experience who is also a Senior Registered Nurse.

Key achievements in 2013/14 include the following:

- Appointment of a Strategic Lead for Quality and Experience
- Appointment of a Quality and Contracting Officer to ensure there are clear links between the Quality Team and our contracting initiatives
- Formation of a Clinical Quality Committee ensuring that the CCG has robust governance processes in place that places quality at the heart of the clinical agenda
- Appointment of an experienced GP as Clinical Lead for Quality, Governance and Caldicott Guardianship
- Appointment of a Customer Care and Client Experience Manager
- Development of a Quality Framework to inform commissioning intentions and drive up the quality of care in the local care home sector
- 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
- Engagement with providers to improve mortality rates across the health and social care community and to ensure that each provider achieved their CQUINS (Commissioning for Quality Improvement Scheme) target
- Creation of a Practice Nurse Forum, this Forum is also used as a vehicle for disseminating good practice in primary care nursing
- Developing a range of cultural and organisational behaviours we expect CCG staff to uphold

Objectives, in relation to quality, for 2014/15 are as follows:

- Full delivery and achievement of the national CQUINS for 2014/15
- Implementing and full achievement of the dementia screening tool aligned with leadership around dementia
- Implementation of the Sepsis 6 care bundle
- A reduction in the number of pressure sores (specifically grade 3 and 4)
- Year on year reductions in the number of patients diagnosed with Clostridium difficile
- An audit and linked improvement plans to the quality of discharge letters
- Formulate a clinically led local Mortality Group to further improve the "out of hospital" mortality rates
- Develop a structured framework to support clinicians and lay members undertaking commissioner led visits
- Work with our providers to reduce clinical incidents
- Work with our providers to increase and improve the quality of information around "Friends and Family Tests and the patient experience agenda
- Develop mechanisms for engaging with Allied Healthcare Professionals, linking them in to key work areas of the CCG
- Appoint a Clinical Support Manager to support the work in the Quality and Experience Team
- We will undertake a training needs analysis with GP Practice Nurses to ensure that they are proactively supported to deliver high quality care
- Continue with our work on the Quality Framework agenda to support the commissioning of high quality care for those in local care homes, helping to reshape the market to drive up high quality care

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

Please see the Equality & Diversity Report at page 23 of this report for evidence of compliance with this duty.

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

Please see the Healthy Lives, Healthy Futures summary at pages 5 & 6 of this report for evidence of compliance with this duty.

14Z15(2)(b): CCGs must contribute to the delivery of the joint health and wellbeing strategy

A Health and Well-being Board has been established to drive health improvement in North East Lincolnshire. Chaired by Councillor Wheatley, the council's cabinet member for health,

well-being and adult social care; membership includes executive officers from the council, the clinical commissioning group and voluntary sector and community representatives.

All partner organisations have signed up to the health and well-being strategy, the final draft of which is available via the North East Lincolnshire Council website, see link below. The membership of the Health & Wellbeing Board is also available via the link below. The strategy sets out a new approach to health and well-being, focussing more on prevention and early intervention and outlining a possible increasing role for individuals and groups to play a much greater role in their own health and that of the wider community.

http://www.nelincs.gov.uk/resident/health-and-social-care/getting-better-together/

In addition to the above, the CCG also achieved its financial targets for 2013-14.

We 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).

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 directly procure services which meet their particular need.

North East Lincolnshire is unique in providing an opportunity for adult health and social care expenditure to be commissioned by one organisation, rather than separating out 'health care' from 'social care'. While these differ, and different funding arrangements exist between the two, the aims of both, and the constrained financial context within which both need to be delivered, are mainly the same.

Benefits of this integrated commissioning are already evidenced. These include aligning fee rates and quality requirements for people in long term care irrespective of whether payment is from health or social care funds, and enabling services to increase integration when people contact us in time of crisis or when there are support needs on leaving hospital.

The CCG commissions a range of support services from external organisations. The most significant of these in terms of range, volume and cost are provided by North Yorkshire & Humber Commissioning Support Unit. Other significant providers are NEL council, and Northumbria Foundation Trust.

The CCG has a legal duty to comply with the Public Procurement Regulations 2006 and subsequent revisions included within the National Health Service (Procurement, Patient Choice and Competition) Regulations 2013 (No. 2) and the Monitor substantive guidance on the Procurement, Patient Choice and Competition Regulations 2013.

These regulations ensure that the CCG;

- engages with all stakeholders and relevant parties when procurement is undertaken
- undertakes and understands relevant guidance regarding procurement type (e.g. Any Qualified Provider/full tender/single provider tender)
- ensure quality of services are achieved and maintained
- enables extended choice for patients by expanding the number of qualified providers
- achieves value for money in its procurement activities or Most Economically Advantageous Tender
- makes the appropriate decision on whether procurement is necessary
- avoids possible conflicts of interest where primary care may be a potential provider
- gives consideration as to whether the use of a framework agreement, including the use of approved lists, is the most appropriate means of appointing providers.

At each stage of the procurement process, the CCG ensures that the project is authorised in accordance with the CCGs governance arrangements, this process is managed via the Service Proposal Tool, see the Annual Governance Statement for further details.

In addition to the national and local key performance indicators mentioned at page 13 of this report, the CCG ensures that a set of bespoke key performance indicators are embedded within each provider contract. For further details on these indicators, and for any queries relating to performance, please contact the CCG Performance Team via nel.pim@nhs.net

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

Resources

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

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 NEL Council as part of its annual resource and priorities process.

Staffing

CCG staff

The CCG has a staffing establishment of 57.48 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 £1.350m in 2013/14. The sickness rate at the CCG headquarters was consistently below 1% for the previous thirteen months and all absences were short term. Turnover rate of employees in November 2013 was 1.43%, a reduction of 1.55% since August 2013.

Breakdown of gender (as at 31 March 14)

The number of persons of each sex who sit on the Governing Body	Male 10	Female 6
The number of persons of each sex who sit on the Council of Members	Male 24	Female 6
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 14	Female 58

Support Services

The largest of these arrangements is with the North Yorkshire and Humber Commissioning Support Unit which provides a wide range of services to NEL 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 NEL council.

Formal Partnership Arrangements

The CCG has had two formal partnership arrangements in place in 2013/14. The first is the legal Partnership Agreement between NEL 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 NEL council and the NEL Care Trust Plus.

The second is the partnership agreement between NEL 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.

Clinical leadership

The CCG has established a number of clinical leadership arrangements to take forward its objectives. This includes having a Clinical Chief 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 member practice, and is responsible for determining service strategy and the constitution arrangements of the organisation. There are also eight clinical leads, one for each of our services themes, who work with a community contact and a service lead to form a leadership 'Triangle' for each theme and drive our service improvement plans.

Community Governance

The CCG has established extensive community involvement in its governance arrangements which are critically supported by its Accord membership scheme; this was originally established by the previous Care Trust Plus organisation. The CCG draws a range of volunteers and roles from Accord to participate in its governance including:

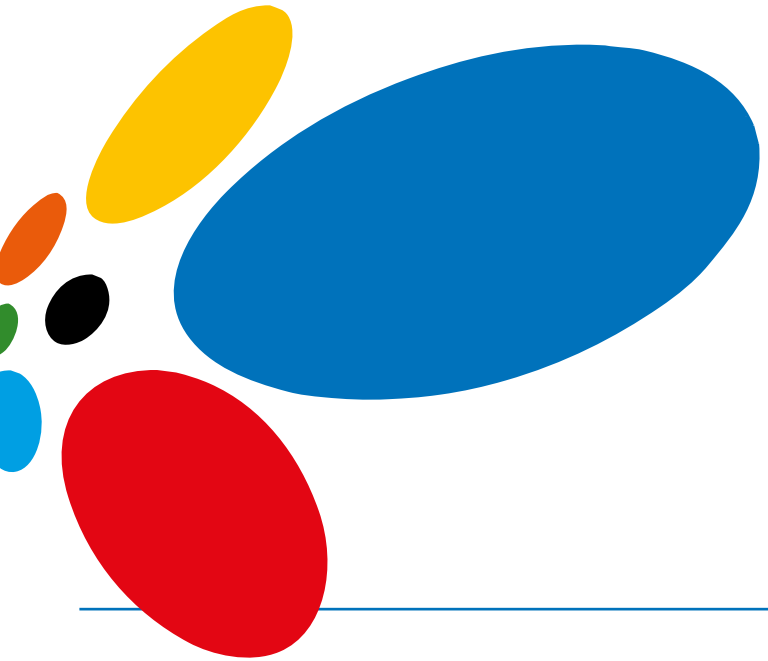
- The lay member on the board with the lead for Patient Participation and Involvement
- A community contact for each of our service theme Triangles
- Members of corporate groups and committees

The partnership board also has two elected councillors as members, nominated by NEL council.

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

Risk management is an increasingly important business driver and stakeholders have become much more aware of the impact that good risk management has on the organisation. Risk may be a driver of strategic decisions, it may be a cause of uncertainty in the organisation or it may simply be embedded in the activities of the organisation. An integrated approach to risk management 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.

The significant risks described below (as at 20/03/14) have been identified by the CCG as the principal issues that may affect strategy & development.



The following 3 risks are **operational** risks and sit within the CCGs risk register:

1: Failure to achieve Accident and Emergency 4 hour targets

A 4 hour target in emergency departments was introduced by the Department of Health for NHS acute hospitals in England. The target requires that at least 98% of patients attending an A&E department must be seen, treated, admitted or discharged in under four hours.

Summary of action taken:

The CCG Commissioning Team is overseeing performance on a weekly basis. Unscheduled Care Group jointly focussed on performance group includes NL&G Acute Trust intermediate Care and commissioners. Action Plans are in place, focussing on all issues with potential impact on 4 hour A&E wait performance. An action plan is in place to manage the activity of the Urgent Care Board.

2: 18 week referral to treatment performance

The NHS Improvement Plan (June 2004) set out the requirement that, by December 2008, there would be a maximum acceptable waiting time of 18 weeks from referral to start of hospital treatment (Referral To Treatment). From 2009/10 Trusts are expected to maintain a maximum waiting time of 18 weeks RTT for 90% of admitted patients, 95% of non-admitted patients and 92% of incomplete patients

Summary of action taken:

Monthly engagement meetings are in place with providers to ascertain (in relation to specialities which are underperforming) any factors contributing to underperformance. An action plan is in place to manage this process.

3: NHS Continuing Healthcare and Funded Nursing Care

Financial risk due to delays in assessment of eligibility for NHS Continuing Healthcare including the completion of retrospective requests received as a result of the Department of Health closure timescales.

Summary of action taken:

A dedicated CHC team is in the process of being appointed. Finance arrangements monitored on a monthly basis. National Governance arrangements in place via NHS England, National quarterly benchmarking reports provided and local monitoring through internal CCG governance processes.

The following 2 risks are **strategic** risks and sit within the CCGs assurance framework:

1: Risk that Healthy Lives, Healthy Futures (hereafter HLHF) will not deliver the quality and financial sustainability outcomes in the requisite timeframe.

HLHF 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 and affordable for years to come. HLHF is being led by North Lincolnshire Clinical Commissioning Group and North East Lincolnshire Clinical Commissioning Group working with organisations such as the Northern Lincolnshire & Goole Hospitals NHS Foundation Trust and other health and social care organisations.

Summary of action taken:

HLHF Programme Board in place to oversee progress with the programme Governance framework provided by HLHF programme board, engagement core group and assurance sub group in place. The HLHF Programme Board reviews progress monthly towards financial and clinical sustainability goals for Northern Lincolnshire. The Programme Board reviews the programme risk log on a monthly basis and has also established an assurance sub group to identify key areas of concern and recommend remedial action. With regards to financial sustainability the Executive group of the Programme board meets weekly virtually and receives on-going reports and assurance on the updated financial position.

2: Possible reduction in performance

This relates to the possibility of the CCG being unable to maintain performance and delivery whilst establishing the new statutory organisation.

Summary of action taken:

CCG Delivery Assurance Committee meets regularly to discuss all elements of performance including provider performance. Regular reports submitted to the Governing Body on items considered to be a risk to the CCG.

For further details on the CCGs risk process, please see the ‘risk assessment’ section in the Annual Governance Statement.

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 2013/14

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, the previous organisation the CTP occupied 1.5 buildings in 2012/13 and 2 buildings in 2011/12. 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. The CCG is unable to provide data in the current year regarding properties now owned by NHS Property Services and Community Health Partnerships, this data will be provided in the next report.

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 water consumption from 1.4.13 to 28.11.13 (the latest period for which we have the figures) was 211 cubic metres. The total cost for this period including sewerage was £1205.55.

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.

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. NEL 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.

NEL CCG has an approved Equality Plan which sets out the vision for NEL CCG to take equality and diversity forward. The document sets out how NEL 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 Clinical Commissioning Group (NEL 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 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, NEL 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) review and revise 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

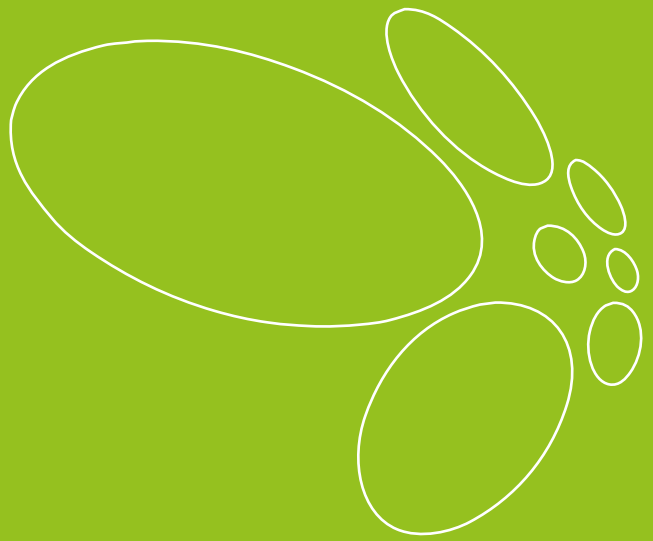
NEL CCG works proactively with local protected groups to ensure that their interests and their viewpoints are included within thinking and strategy development for the CCG and that staff are kept updated with current issues and emerging trends to tackle health inequalities. The CCG provides leadership 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.

NEL CCGs governing body receives regular updates on progress related to the organisation's Equality plan and provides active leadership on this agenda.

As an organisation, NEL CCG is committed to equality and valuing diversity within its existing and potential workforce. As such, NEL 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.

Dr Peter Melton
Accountable Officer
4 June 2014

MEMBER'S REPORT



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, Integrated Governance & Audit Committee 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 2013/14 up to the signing of the Annual Report & Accounts.

Name	Designation
Mr Mark Webb	Chair, NELCCG
Dr Peter Melton	Chief Clinical Officer, NELCCG

The table opposite provides details of the GP Member Practices of the CCG (as at April 2014).

Practice Name	Address
Dr E Amin	Weelsby View Health Centre, Ladysmith Rd,Grimsby, DN32 9SW
Dr A Hussain (rep Dr Hussain)	Weelsby View Health Centre, Ladysmith Rd,Grimsby, DN32 9SW
Ashwood Surgery	Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW
Dr PS Babu	Weelsby View Health Centre, Ladysmith Rd,Grimsby, DN32 9SW
Beacon Medical	Beacon Medical, Cleethorpes Primary Care Ctr, St Hughs Ave, Cleethorpes, DN35 8EB
Birkwood Medical Centre	Birkwood Medical Ctr, Westward Ho, Grimsby, DN34 5DX
Dr B Biswas & Partner	142-144 Grimsby Road, Cleethorpes, DN35 7DL
Drs Chalmers & Meier	Weelsby View Health Centre, Ladysmith Rd,Grimsby, DN32 9SW
Chantry Health Group (Bamgbala)	Chantry Health Group, Cartergate, Grimsby, DN31 1QZ
Chelmsford Medical Centre	Chelmsford Medical Centre, 128 Chelmsford Ave, Grimsby, DN34 5BA
Clee Medical Centre	Clee Medical Centre, 323 Grimsby Rd, Grimsby, DN35 7XE
R Kumar	Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH
Field House Medical Group	Field House Medical Centre, Freshney Green Primary Care Ctr, Sorell Rd, Grimsby, DN34 4GB
Healing Health Centre	Healing Health Centre, Wisteria Drive, Healing, DN41 7PU
Dr Jethwa, Weelsby View Health Centre	Weelsby View Health Centre, Ladysmith Rd,Grimsby, DN32 9EF

Practice Name	Address
Dr S Kumar and Partners	Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE
Open Door	Open Door, 13 Hainton Ave, Grimsby, DN32 9AS
Raj Medical Centre	RAJ Medical Centre, 307 Laceby Road, Grimsby, DN34 5LP
Pelham Medical Group	Pelham Medical centre, Church View Health Centre, Cartergate, DN31 1QZ
Humberview Surgery	Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE
Roxton Practice	The Roxton Practice, Pilgrim Primary Care Centre, Pelham Road, Immingham, DN40 1JW
Dr S Saha & Dr G De	Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH
Scartho Medical Centre	Springfield Road, Scartho, Grimsby, DN33 3JF
Dr Dijoux and Partners	Taylors Avenue Medical Centre, Taylors Avenue, Cleethorpes, DN35 0LJ
Dr Singh & Dr Mathews	Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE
Woodford Medical Centre	Woodford Medical Centre, Freshney Green Medical Ctr, Sorrell Road, Grimsby, DN34 4GB
Dr MA Zaro	6-7 Aspen Court, Cleethorpes, DN35 0SJ
Quayside Open Access	76B Cleethorpes Road, Grimsby, DN31 3EF
Dr Bedi	New Waltham Surgery, New Waltham, Grimsby, South Humberside, DN36 4QG

Composition of the Council of Members

Representative	Practice
Dr E Amin	Dr E Amin
Dr A Hussain/Debra Bradwell	Dr Hussain
Dr Reeta Singh	Ashwood Surgery
Jayne Bilton/Dr PS Babu	Dr PS Babu
Dr Elmer Molave and/or Dr Laura Bernal-Gilliver	Beacon Medical
Dr Karin Severin	Birkwood Surgery
Dr P Ray & Dr B Biswas	Dr B Biswas & Partner
Dr I Chalmers/ Dr V Meier/ Jonathon Aisthorpe	Drs Chalmers & Meier
Dr A M Bamgbala	Chantry Health Group (Bamgbala)
Dr SN Keshri	Chelmsford Medical Centre
Dr Andrew Stead	Clee Medical Centre
Dr R Kumar	Dr R Kumar, Cromwell Primary Care Centre
Dr D Hopper	Field House Medical Group
Dr KS Koonar	Healing Health Centre
Dr Hasmuck Jethwa	Dr Jethwa, Weelsby View Health Centre
Dr AP Kumar	Dr S Kumar and Partners
Dr Nathalie Dukes	Littlefield Surgery
Rob Baty	Open Door
Dr R Pathak	Raj Medical Centre
Dr David Elder	Pelham Medical Group
Dr David Elder	Humber View
Dr Arun Nayyar	Roxton Practice
Dr Sinha	Dr G De & Dr Sinha
Dr R T Maliyil	Scartho Medical Centre
Dr Sylvere Dijoux	Dr Sharma and Partners
Dr R K Mathews	Dr Mathews
Dr Julian Clarke	Woodford Medical Centre
Dr Zaro	Dr S M Zaro
Mandy Coulbeck	Quayside Open Access
Dr Bedi	Dr Bedi
Joe Warner - ASC vote	“focus” adult social work Community Interest Company

Composition of the Governing Body

Please note: the CCG operated in shadow form between 2011 and 1st April 2013.

Name	Role	Date member joined
Mark Webb	Chair NEL CCG	19 May 2011
Dr Peter Melton	Chief Clinical Officer	19 May 2011
Cathy Kennedy	Deputy Chief Executive/Chief Financial Officer	19 May 2011
Dr Derek Hopper	Vice Chair/Chair of Council of Members	19 May 2011
Helen Kenyon	Deputy Chief Executive	19 May 2011
Philip Bond	Lay Member Community Engagement	16 June 2011
Dr Arun Nayyar	GP representative	16 June 2011
Dr Rakesh Pathak	GP representative	16 June 2011
Susan Whitehouse	Lay Member Governance and Audit	17 November 2011
Mr Perviz Iqbal	Secondary Care Specialist Doctor	30 November 2012
Juliette Cosgrove	Registered Nurse	1 April 2013
Joe Warner	Social Care representative	1 September 2013
Dr Thomas Maliyil	Vice Chair Council of Members/GP representative	1 February 2014
Dr Sudhakar Allamsetty	GP representative	13 September 2013
Dr Geoff Barnes	Interim Director of Public Health	1 January 2014
Dr Cate Carmichael	Director of Public Health	11 October 2012

Composition of the Partnership Board (those who are not members of the Governing Body)

Geoff Lake	Adult Social Care Strategic Advisor	19 May 2011
Joanne Hewson	Jack Blackmore until Aug 13 Strategic Director People and Communities	1 September 2013
Councillor Peter Wheatley	NELC representative, portfolio holder for Health, Wellbeing and Adult Social Care	24 May 2013
Councillor Michael Burnett	NELC representative, portfolio holder for Tourism, Leisure & Culture	21 July 2011

Please refer to the Membership Body & Governing Body Profiles section of the Remuneration Report for details of conflicts of interest.

Composition of the Integrated Governance & Audit Committee

Please note: the CCG operated in shadow form between 2011 and 1st April 2013.

Members Name	Role
Mrs Sue Whitehouse	Chair & Governing Body lay member
Councillor Mick Burnett	Partnership Board lay member
Councillor Peter Wheatley	Partnership Board lay member
Mr Philip Bond	Governing Body lay member

In Attendance Name	Role
Dr Karin Severin	GP
Mrs Cathy Kennedy	Deputy Chief Executive, NELCCG
Miss Benita Jones	Director of Audit Services, East Coast Audit Consortium
Ms Laura Whitton	Deputy Chief Finance Officer, NELCCG
Mr Shaun Fleming	Counter Fraud Manager/Local Counter Fraud Specialist
Mr Peter Hanmer	Head of NELC Audit, NELC
Mrs Jackie Rae	Manager, Public Sector Audit, KPMG
Mrs Chloe Nicholson	Corporate Governance Manager, NELCCG
Mr John Prentice	Director, Public Sector Audit, KPMG
Mr Paul Webster	Acting Audit Manager, East Coast Audit Consortium

Governing Body Profiles

Please note: the CCG operated in shadow form between 2011 and 1st April 2013. The profiles below are accurate as at 01/04/14.

Mark Webb – Chair NELCCG

Mark Webb spent a number of years in publishing and now runs his own commercial property and business support company. Having spent many years in the commercial sector, Mark 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 Economic and Growth Board, Mark brings 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 CCG's clinically led commissioning decisions. He joined the Governing Body in May 2011.

Dr Peter Melton – Chief Clinical Officer

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 in May 2011.

Cathy Kennedy – Deputy Chief Executive and Chief Financial Officer

Cathy Kennedy 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 in May 2011.

Dr Derek Hopper – Vice Chair/Chair of Council of Members

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 in May 2011.

Helen Kenyon – Deputy Chief Executive

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 the commissioning and contracting of Adult Social Care and Health services within the CCG. She joined the Governing Body in May 2011.

Philip Bond – Lay Member Community Engagement

Philip Bond 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 a chain of Academy schools. He joined the Governing Body in June 2011.

Dr Arun Nayyar – GP Representative

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 in June 2011.

Dr Rakesh Pathak – GP Representative

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 in June 2011.

Susan Whitehouse – Lay Member Governance and Audit

Susan Whitehouse 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.

Perviz Iqbal – Secondary Care Specialist Consultant.

Perviz Iqbal is consultant in Obstetrics and Gynaecology at Doncaster Royal Infirmary. He joined the Governing Body in November 2012.

Juliette Cosgrove – Registered Nurse

Juliette Cosgrove is the Assistant Director to the Nurse and Medical Directors at Calderdale and Huddersfield Foundation Trust where she leads on Quality Governance and Improvement. She joined the Governing Body in April 2013.

Joe Warner – Governing Body Social Care Representative

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.

Joanne Hewson – Partnership Board, NELC Officer member

Joanne Hewson 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 NELC Strategic Director People and Communities she holds responsibility for the DASS and the DCS covering both the adults' and children's agenda. She joined the Governing Body in September 2013.

Dr Thomas Maliyil – GP Representative/Vice Chair Council of Members

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 thirteen 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.

Councillor Peter Wheatley – Partnership Board, NELC representative

Peter Wheatley is Chair of Health, and Wellbeing Board and NELC Portfolio Holder for Adult Social Care. He worked as a sales director for a large media company from which he recently retired. He is a very experienced councillor having held the positions of Leader of the Council, Deputy Leader and various chairmanships of a variety of disciplines.

Councillor Michael Burnett – Partnership Board, NELC representative

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 CCG on 21 July 2011.

The following Governing Body & Partnership Board members have resigned from their position during 2013/14

Please note: the CCG operated in shadow form between 2011 and 1st April 2013.

Name	Date member joined the CCG	Date member left the CCG
Councillor Rosalind James (Partnership Board only) NELC Portfolio Holder for Housing and Well Being	14 June 2012	22 May 2013
Geoff Lake Adult Social Care Strategic Advisor	19 May 2011	31 August 2013
Jack Blackmore NELC Strategic Director People and Communities	15 September 2011	31 August 2013
Dr Sudhakar Allamsetty GP representative	13 September 2013	07 November 2013
Dr Cate Carmichael Director of Public Health	11 October 2012	31 December 2013

Details of members of other committees and sub-committees and details on all committees and subcommittees can be found in the Annual Governance Statement (2013/14)

Pension Liabilities

Further details in relation to the treatment of pension liabilities can be found in note 1.9.2 in the Financial Statements and the Remuneration Report.

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. As part of the CCGs commitment to the health, safety and welfare of their employees they undertook the HSE stress survey in 2013, with very positive results.

Please note, the sickness data shown within note 4.3 of the Financial Statements has been provided to the CCG by NHS England and only represents 9 months of data.

Staff in post (including focus)

The tables below reflect sickness absence data between April 13 and March 14

Average FTE from Apr13-Mar14	132.4

Total days available	Total days lost	Average sick days per FTE	12 month SA average %
41,173.43	1,006.22	7.60	2.44%

Staff in post (after focus Transfer of Undertakings (Protection of Employment) Regulations transfer)

The tables below reflect sickness absence data between October 2013 and March 2014

Average FTE from Oct13-Mar14	69.67

Total days available	Total days lost	Average sick days per FTE	6 month Average % at March 14
11,180.14	45.85	0.66	0.40%

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.

External audit

Our external auditor is KPMG who is appointed by the Audit Commission. Auditors' remuneration in relation to April 2013 to March 2014 totalled £73,200.00 (including 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 Audit and Integrated Governance 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).

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

Work undertaken by the external auditor during financial year 2013/14 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). The cost of this work should be disclosed

Disclosure of serious untoward incidents

The CCG has not had any serious untoward incidents or lapses in data security during 2013/14.

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 quarterly reporting process to the Integrated Governance & Audit (IG&A) Committee. An annual report on complaints, which were received by the CCG, is submitted to and endorsed by the IG&A Committee before submission to NE 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 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 complaint not occurred.

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 North Yorkshire and Humber Commissioning Support Unit.

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.

Disabled employees

As an organisation, NEL CCG is committed to equality and valuing diversity within its existing and potential workforce. As such, NEL 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.

Emergency preparedness, resilience & response

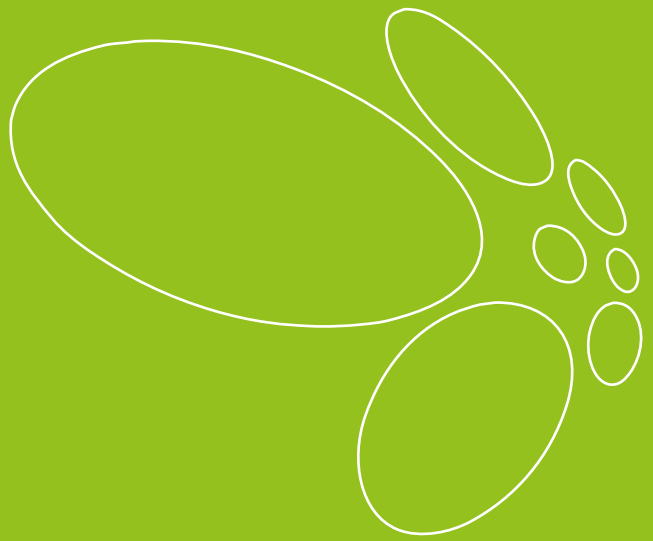
North Yorkshire and Humber Area Team has incident response plans in place, which are compliant with the NHSCB Emergency Preparedness Framework 2013. To support this, the CCG has business continuity plans in place and supports with capacity and control plans for incidents. The CCG is assured that the North Yorkshire and Humber Local Area Team regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan locally

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The clinical commissioning group regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Partnership Board.

The section below provides details on the CCGs account. The accounts have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended by the 2012 Act).

Dr Peter Melton
Accountable Officer
4 June 2014

REMUNERATION REPORT



Members and dates of remuneration committee

	Meeting Dates		
	11/04/2013	10/10/2013	24/04/2014
Voting Members:			
Mark Webb, CCG Chair - meeting chair	Yes	Yes	Yes
Sue Whitehouse, Lay member for Governance & Audit	Yes	Yes	Yes
Cllr Ros James, Partnership Board NELC nominated representative (Left 22 May 13)	Yes	n/a	n/a
Cllr Peter Wheatley, Partnership Board NELC nominated representative (Started 24 May 13)	n/a	Apologies	Yes
Dr Derek Hopper, Chair of Council of Members / Governing Body member	Yes	Yes	Yes
Other attendees:			
Cathy Kennedy, Chief Financial Officer/ Deputy Chief Executive*	Yes	Yes	Yes
Emma Kirkwood, Human Resources Business Partner, Commissioning Support Unit **	Apologies	Yes	Apologies
Janet Thacker, Head of Workforce, Commissioning Support Unit (on behalf of Emma Kirkwood)	n/a	n/a	Yes
Karen Stamp, PA to Executive Office - Taking notes	Apologies	Yes	Yes

* attends to present papers from the CCG

** attends to advise the panel on HR implications

Senior managers pay was set in line with “Clinical Commissioning Groups: Remuneration Guidance for Chief Officers (where the senior manager also undertakes the Accountable Officer role) and Chief Finance Officer’s guidance”.

Senior managers are eligible for a non-consolidated bonus under the VSM framework. Any decision to pay a bonus is a remuneration committee decision and would be calculated in line with the VSM framework.

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

Salaries & Allowances (subject to audit)

* An element of the individual's salary has been paid to a corporate body
** Salary has been paid to a corporate body

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.

2013-14 Name and Title	Salary & Fees (bands of £5,000)	Taxable benefits (bands of £5,000)	Annual Performance Related Bonus (bands of £5,000)	Long-term Performance Related Bonus (bands of £5,000)	All pension related benefits (bands of £2,500) see note below for more detail	Total (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
Jack Blackmore, Partnership Board NELC Officer Member (left 31/08/13)	10-15					10-15
Susan Whitehouse, Lay Member Governance & Audit	5-10					5-10
Cllr Peter Wheatley, Partnership Board NELC Nominated Representative (started 24/05/13)	0-5					0-5
Cllr Rosalind James, Partnership Board NELC Nominated Representative (left 22/05/13)	5-10					5-10
Dr Sudhakar Allamsetty, GP Representative-Caldecott (left 7/11/13)	0-5					0-5
Dr Thomas Maliyil, GP Representative (started 01/02/14)	0-5				20.0-22.5	20-25
Mandy Coulbeck, Partnership Board Locally Practicing Nurse	0-5 *					0-5
Dr Cate Carmichael, Director Public Health (left 31/12/13)	0-5					0-5
Dr Geoff Barnes, Interim Director Public Health (started 01/01/14)	0-5					0-5
Mr Perviz Iqbal, Secondary Care Specialist Doctor	5-10					5-10
Juliette Cosgrove, Registered Nurse	5-10					5-10
Jo 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

Pensions Benefits (subject to audit)

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 march 2014 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2014	Real increase in Cash Equivalent transfer value	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	105-110	582	628	9	
Helen Kenyon, Deputy Chief Executive	0.0-2.5	(0.0-2-5)	25-30	80-85	357	408	18	
Dr Arun Nayyar, GP Representative	0.0-2.5	(0.0-2-5)	10-15	30-35	105	165	28	
Dr Rakesh Pathak, GP Representative	0.0-2.5	(0.0-2-5)	5-10	25-30	77	113	17	
Dr Thomas Maliyil, GP Representative (started 01/02/14	0.0-2.5	(0.0-2-5)	0-5	10-15	45	53	3	

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 2013, 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.

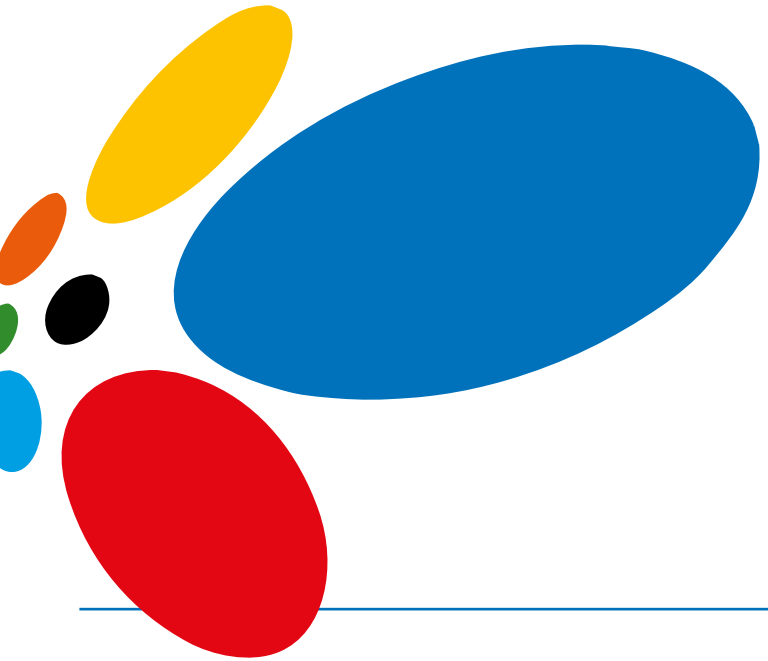
Cash Equivalent Transfer Values A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the 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.

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 start and end of the period.

Pay multiples (subject to audit)

Year	2013/14
Band of highest paid directors' total remuneration (£'000)	121-125
Median total	24,949
Ratio	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 2013-14 was £121,000 - £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 5.0 times the median remuneration of the workforce, which was £24,949.

In 2013-14, no employees received remuneration in excess of the highest-paid director as per the remuneration table. Remuneration ranged from £6,406 to £101,103.

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.

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 2014, for more than £220 per day and that last longer than six months are as follows:

the number that have existed	Number
- for less than one year at the time of reporting	0
- for between 1 and 2 years at the time of reporting	17
- 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 years at the time of reporting	0
Total number of existing engagements as of 31 March 2014	17

	Number
Number of new engagements, of those that reached 6 months in duration, between 1 April 2013 and 31 March 2014	1
Number of new engagements which include contractual clauses giving the CCG the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which, the number:	
- For whom assurance has been received	0
- For whom assurance has not been received	0
- That have been terminated as a result of assurance not being received	0

Assurances with regard to the one new engagement will be requested.

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant responsibility, during the financial year	3
Number of individuals that have been deemed “Member 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)	23

Dr Peter Melton
Accountable Officer
4 June 2014

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Clinical Officer to be the Accountable Officer of the Clinical Commissioning Group.

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Manual for Accounts issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

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

Peter Melton

Accountable Officer

4 June 2014

NHS
North East Lincolnshire
Clinical Commissioning Group

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

Introduction & Context

North East Lincolnshire Clinical Commissioning Group (hereafter 'The CCG') was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006.

The CCG operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the CCG taking on its full powers. As at 1 April 2013, the CCG was licensed without conditions.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCGs policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I am also responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *Clinical Commissioning Group Accountable Officer Memorandum*.

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. This Governance Statement is intended to demonstrate how the clinical commissioning group had regard to the principles set out in the Code considered appropriate for clinical commissioning groups.

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". This is achieved in the following ways:

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. Our constitution includes:

- Our membership
- The area we cover
- The arrangements for the discharge of our functions and those of our Governing Body
- The procedures we will follow in making decisions and securing transparency in decision making
- Arrangements for discharging our duties in relation to registers of interests and managing conflicts of interests
- Arrangements for securing the involvement of persons who are, or may be, provided with services commissioned by the Group in certain aspects of those commissioning arrangements and the principles that underpin these

Our constitution is a living document, an annual review of the constitution has recently been carried out by the Chief Finance Officer and was submitted the Council of Members for approval on 6 March 2014 and presented to the Governing Body on 13 March 14. The final version will be submitted to NHS England for formal approval by 30 May 2014. The proposed changes include further emphasis on whistleblowing, guidance on the administration of public petitions, amendments to the Standards of Business Conduct section and the Conflict of Interests section, amendment of the Governing Body membership to formally include the role of the Practicing Nurse and to alter the requirement from 'Director of Public Health' to 'Public Health Consultant, arrangements for the nomination of a public health consultant and arrangements for the Adults Social Care vote.

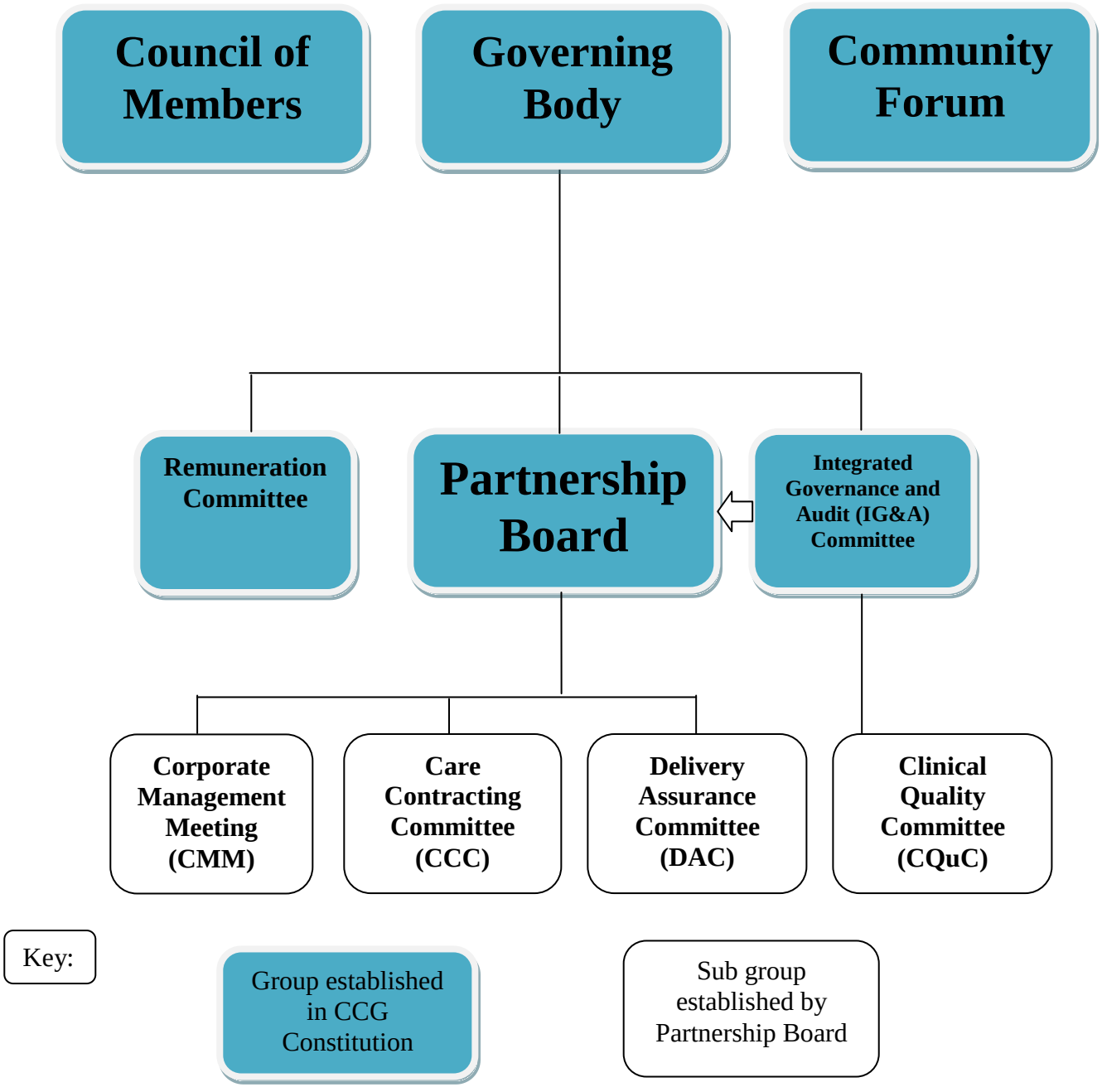
2. The Governing Body and the Committee governance structure

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 the Council and the CCG. The Governing Body has met during the year, and was quorate. The Partnership Board has met in public six times throughout the year and was quorate at each meeting.

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 7 themes. This ensures engagement of Member Practices in the work of their Governing Body.

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 of each formal Committee. Attendance records are maintained for each Committee to ensure quoracy and clinical representation. Performance / highlights for each Committee are also captured in the table below:

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. The Governing Body met during 2013/14. Attendance records demonstrate that the meeting was quorate. For Governing Body performance highlights, see partnership board section below.
Partnership Board	The Partnership Board is responsible for those matters delegated within the constitution, its principle functions are: - effective discharge of the CCGs' statutory duties for the commissioning of health and health care services - effective discharge of the CCG's responsibilities for Adult Social Care as defined in the legal Partnership Agreement with North East Lincolnshire Council The Partnership Board met six times throughout 2013/14. Attendance records demonstrate that every meeting was quorate. Performance/highlights: In addition to its core business (E.g. Reviewing the CCG Assurance Report, monitoring the functions of its committees, overseeing the Healthy Lives, Healthy Futures agenda), the Partnership Board has effectively overseen the following key areas of work (*Please note: This list is not exhaustive*): • CCG's response to Keogh Review recommendations • Progress with the Summary Hospital Mortality Indicator action plan • Review of local stroke care pathways (In response to the Keogh Review) • Local leadership arrangements to oversee compliance with the public sector equality duty (Defined in the Equality Act 2010) • Commissioning strategy for Adult Mental Health Services in N E Lincs
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. The Community Forum met every month throughout 2013/14. Attendance records demonstrate that each meeting was quorate. Performance/highlights *(Please note: This list is not exhaustive)*: • Review of members roles and responsibilities

	• Instrumental in the review of car parking charging at the Diana Princess of Wales Hospital • Contributed to changes in specific areas such as Unplanned Care i.e. improvements in A & E to help reduce waiting times. • Contributed to the development of Dementia Strategy • Involved in supporting the Paediatric Assessment Unit to plan a comprehensive user survey to get the views of parents and where appropriate young people using the unit • Member representation on local TV channel, Estuary TV • Members attended a workshop with local care providers to establish support and communication links • Members attended an Information Governance training session, facilitated by the CCG • Contributing to NAVIGO work around the elderly and their carers • Gathering feedback from the public on health and social care matters including Healthy Lives, Healthy Futures and GP experience • Contributed as the "voice of the community" in Healthy Lives, Healthy Futures reviews
Council of Members	The Council of Members is the arena in which all member practices have the opportunity to come together to: - consider and advise on the service commissioning agenda for Health & Social Care - ensure that the continued development of the CCG is aligned to the principles and aspirations of the constituent practices - shape the organisation's strategic direction and key objectives - approve service strategies and significant service change proposals The Council of Members met every month, except for January, throughout 2013/14. Attendance records demonstrate that each meeting was quorate. Performance/highlights include: - Considerable increase in the number of practice representatives attending the meeting, with 90% of GP practices being represented on a regular basis, which reflects improved engagement between the CCG and member practices - Review and update of amendment to the CCG's constitution - Input into the evaluation of the following service (re)design proposals *(Please note: This list is not exhaustive)*: • Community dermatology services • Continence products in community nursing • Stroke services in the local area • Ultrasound Service for DVT
Integrated Governance & Audit Committee (IG&A)	The IG&A Committee is responsible for the CCG's governance, risk management and internal control arrangements. The IG&A Committee met four times throughout 2013/14. Attendance records demonstrate that each meeting was quorate. Performance/highlights include *(Please note: This list is not exhaustive)*: - 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)

	- Review of the Committees Terms of Reference - Approval of a significant number of policies and standing operating procedures to ensure a safe procedural basis for all CCG activities - Development of the IG&A work programme - Revision of the organisations Risk Register and Assurance Framework - Implementation of the Counter Fraud risk based plan
Remuneration	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 group, and on determinations about allowances under any pension scheme that the group 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. The Remuneration Committee met twice throughout 2013/14. Attendance records demonstrate that each meeting was quorate. Performance/highlights: Review of remuneration and terms of service/reference for the following number of key roles: - Clinical leads - Registered Nurse (Practicing) - Chair of the Community Forum

The Clinical Commissioning Group Risk Management Framework

Governance and internal control of the organisation is an on-going process designed to identify and prioritise risk to the achievement of the policies, aims and objectives of the CCG and to evaluate the likelihood of those risks being realised and the impact should they be realised. The CCG *Risk Management Framework* is in place to ensure that these risks are managed efficiently, effectively and economically.

The CCG's *Risk Management Framework* was approved in August 2012 whilst the CCG was in shadow form, and was formally adopted by the CCG at its Governing Body meeting on 14th March 2013 as part of a suite of governance arrangements. The Integrated Governance and Audit committee, at its meeting on 7th March 2013, considered and approved the proposal that all elements of the governance framework which were in place for the shadow CCG (i.e. those of the Care Trust Plus) should be adopted from 1st April 2013 including all policies and procedures, unless and except where the CCG has specifically agreed a replacement.

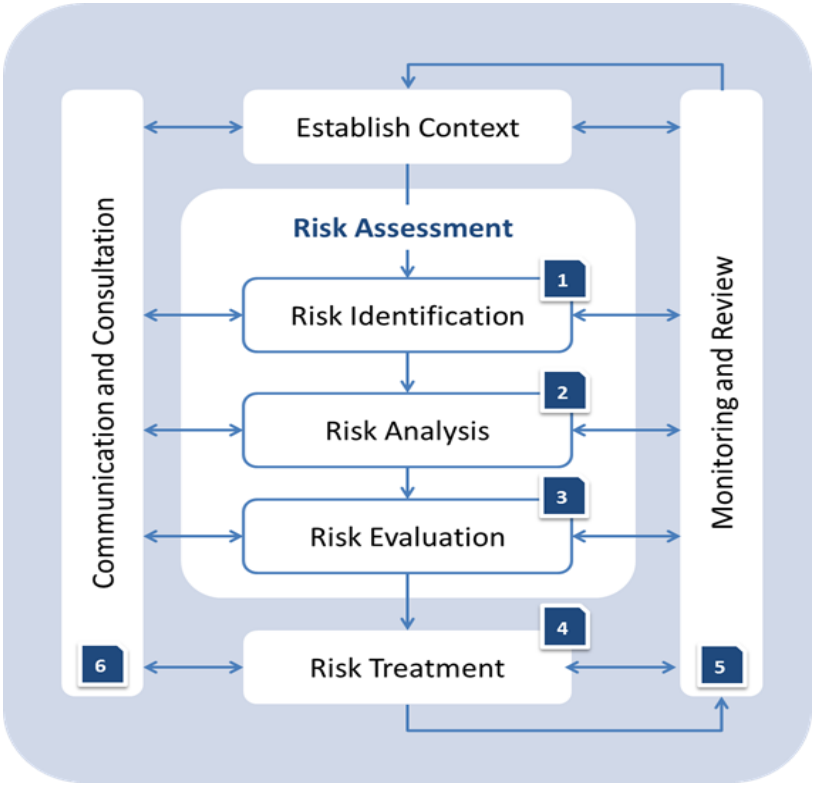
The Risk Management Frameworks aim is to control risks to patients, to staff and to the organisation as far as is reasonably practicable and in accordance with current guidance, legislation and best practice.

All members and staff of the CCG are responsible for ensuring that the principles of risk management are integrated within their service area, however the Chief Clinical Officer has overall accountability for ensuring that 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 risk management framework.

The framework is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve the organisations aims and objectives; it can therefore only provide reasonable

and not absolute assurance of effectiveness. This is achieved through the CCG's risk management process, see Figure 2 below.

Figure 2: NELCCG Risk Management Process - NEL CCG has adopted principles of ISO 31000 risk management process within the risk management context of our organisation. The table below provides a high-level diagram of the risk management process from ISO 31000.



In order to support the Governing Body in carrying out its duties effectively, the Integrated Governance and Audit Committee and the Delivery Assurance Committee provide assurance, via regular risk reports, that corresponding robust and adequately progressed risk treatment plans exist and that risks are regularly reviewed and updated.

Summary of developments, in the risk management process, throughout 2013/14

Throughout 2013/14, there have been various developments in the local risk management system; the key highlights are described below.

The CCG's risk register and Assurance Framework has been reformatted to reflect the six CCG assurance framework domains for assurance of organisational health and capability (as defined within the CCG Assurance Framework 2013/14, published by NHS England May 2013). It was felt that, by making these changes, the CCG would forge greater links between performance and risk data. This has proved to be extremely valuable in the identification of new risks and the management of existing performance related risks. All current CCG risks sit within the six domains and are fairly evenly spread amongst the groups; the assurance domains provide a robust, credible and flexible framework to organise our risks.

The CCG risk register has been divided into strategic and operational risks, risks which were deemed to be a strategic risk have been allocated to the assurance framework and risk owners asked to identify assurances on control; positive assurances; gaps in control and gaps in assurance**.** The operational risks form the content of the risk register. This system provides the

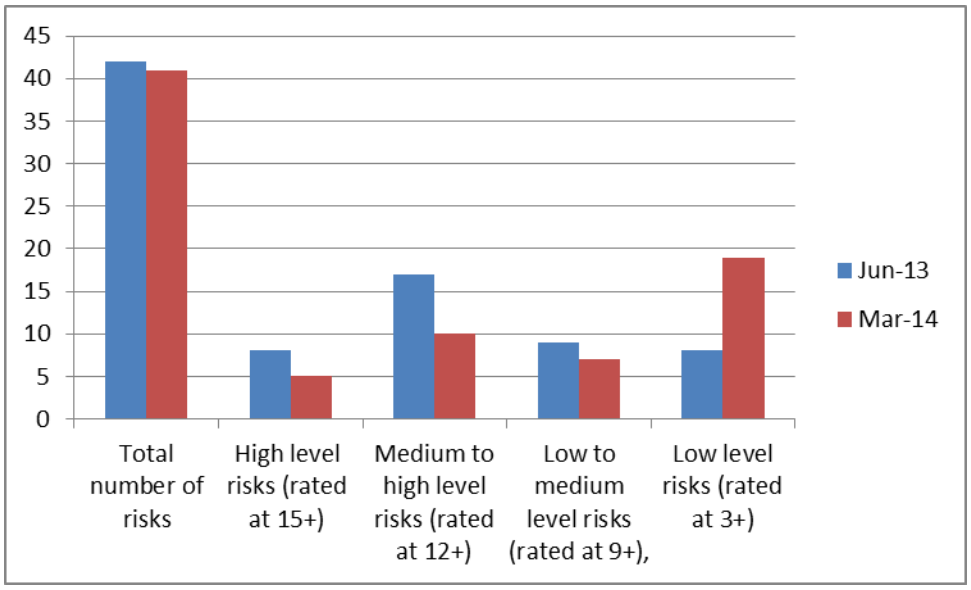
CCG with positive assurance that its strategic and operational risks are being managed appropriately.

During 2013/14, the newly established CCG Corporate Governance Team has formed closer links with risk owners, within the CCG, resulting in improved awareness of the risk process throughout the CCG. Risk is actively reviewed at two CCG meetings, see page 12 for details, and risk owners are becoming increasingly proactive in their approach to risk management. The CCGs risk management system is robust & current developments, summarized below, will strengthen arrangements already in place.

Priority areas for development during 2014/15 include:

- Development of the risk workshop and coaching programme for risk owners
- Further development of the Assurance Framework facility on the electronic Covalent risk management system
- Undertake a review of the strategic risk register. The aim of this review is to improve the quality of information provided in the following areas of the assurance framework template:
    - Description of risk
    - Internal controls
    - Target risks
    - Gaps in controls
    - Gaps in assurances

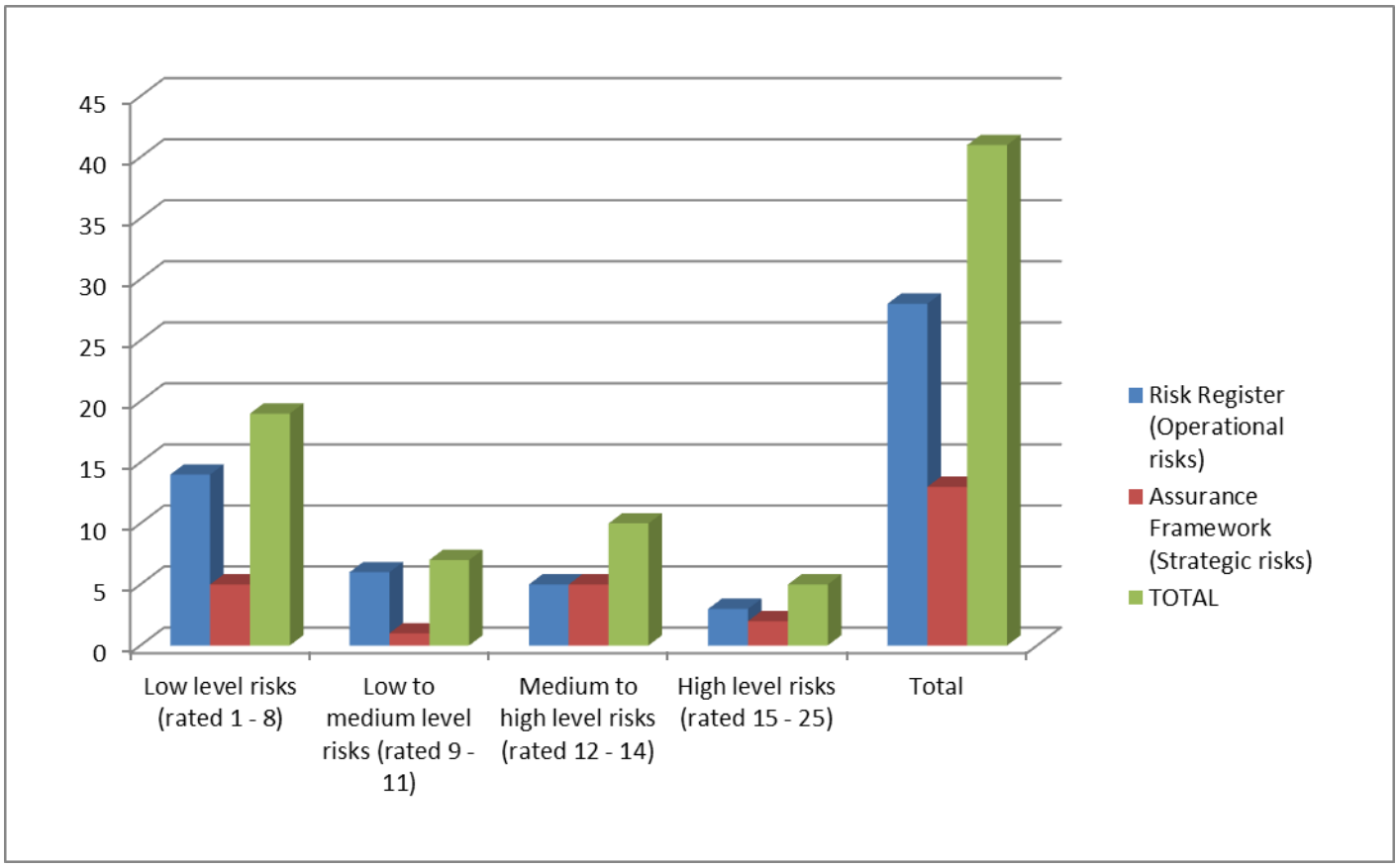
The graph below reflects the total number of risks and risk rating, held of the CCG risk register, at June 13 and March 14



Since 28th June 2013, twelve risks have been closed and their details have been archived in the electronic risk management system.

As you will see, the total number of risks at March 14 is similar to that at June 2013, whilst several risks have been closed; new risks have been added throughout the year.

The graph below details the split of risks, as at March 14, between those that are “strategic” and those that are “operational”



Embedding the risk management framework

Following these developments, risk management has become more embedded within the activities of the CCG. The risk registers (both operational and strategic registers) are reviewed at the monthly Service Leads meeting and at the Integrated Governance and Audit Committee on a quarterly basis, which ensures that the process is kept live and relevant.

The CCG works in partnership with the Yorkshire & Humber Commissioning Support Unit to manage its incident reporting process. CCG employees and member practices are encouraged to report incidents, concerns/risks and accidents through the online incident reporting process. Any risks identified as part of the review of incident data are uploaded to the electronic risk management system via the CCG Corporate Governance Team and submitted to the IG&A Committee for monitoring on a quarterly basis.

New risks identified for inclusion on the risk register and assurance framework are assessed for likelihood and impact using a standard 5 x 5 risk matrix, see figure 3 below. This matrix is embedded within all CCG activities, the (operational) risk register and the (strategic) Assurance Framework. This is in accordance with the CCG Risk Management Framework.

Figure 3: Standard 5 x 5 risk matrix

	Likelihood				
Impact	**1**	**2**	**3**	**4**	**5**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15

2 Minor	2	4	6	8	10
1 Insignificant	1	2	3	4	5

1 – 6	Low to Moderate Risk
8 – 10	Moderate Risk
12	High Risk
15 – 25	Significant Risk

Risks to data security are managed through a suite of information governance policies and all CCG staff have undertaken the Connecting for Health Information Governance training. Any data security incidents are reported through the CCGs incident reporting system and notified to the CSU Information Governance Manager for investigation.

In addition to the risk management process described above, robust assessment processes are in place as part of the key decision making processes within the CCG. Further details are provided in the sub sections below.

1) Service Proposal Management Tool

   The service proposal management tool is a new 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. See Section 9 for further details.

2) Equality & Diversity Impact Assessment Process

   The Equality Act 2010 states that all policies, procedures, projects, functions and services within the CCG must complete an Equality Impact Assessment. Please see section 4 of the Strategic Report for further information on our requirements under the Equality Act 2010. Equality impact assessments are considered as part of the planning process for all contracting, commissioning and project plans developed by the CCG and are in place to ensure that the author has analysed and assessed the equality and diversity impact of the matter.

3) 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.

4) Human Resources (HR) policies

   The CCG has a range of HR policies in place to demonstrate, both internally and externally, that it meets requirements for diversity, ethics and training as well as its commitments in relation to the regulation and corporate governance of its employees.

5) 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.

6) Data Security Risks

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.

7) Performance dashboard (as detailed on page 3)

8) Emergency Preparedness

The North Yorkshire and Humber Area Team has incident response plans in place, which 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 CCG is assured that the North Yorkshire and Humber Local Area Team regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan locally.

9) Partnership and Public Engagement

The CCG strongly believes that effective partnership and public engagement is integral to the development of sound mechanisms of internal control and good governance. The CCG actively engages with public stakeholders for example:

- Partnership working with the Local Authority through the Health and Wellbeing Board
- The CCG has an active community membership scheme (Accord)
- Council of Members which is made up of a healthcare representative from each CCG member practice. The Council of Members participate and are engaged in the development of the CCG Strategy and plans
- The Community Forum which is the meeting of all community lay members engaged in the governance and service triangles of the CCG

The CCG has undergone a period of significant change over the last year and the arrangements described above highlight some of these changes. 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 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 is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the CCG, 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 has been in place in the CCG for the year ended 31 March 2014 and up to the date of approval of the Annual Report & Accounts.

Information Governance

The CCG has not had any serious untoward incidents or lapses in data security during 2013/14.

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 undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

Pension Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, Diversity & Human Rights Obligations

Control measures are in place to ensure that the clinical commissioning group complies with the required public sector equality duty set out in the Equality Act 2010.

Sustainable Development Obligations

The CCG is required to report its progress in delivering against sustainable development indicators. We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. We will ensure the CCG complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the

Public Services (Social Value) Act 2012. We are also setting out our commitments as a socially responsible employer.

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

In assessing a risk, we look at potential hazards, which are situations with the potential to cause harm; and risks, which are defined as the probability that a specific adverse event will occur in a specific time period or as a result of a specific situation.

The CCG Assurance Framework has been developed throughout the year and 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 is mapped to our strategic objectives, these objectives are grouped into four categories, and these categories are:

1. Sustainable Services
2. Empowering people
3. Supporting communities
4. Delivering a fit for purpose organisation

The Assurance Framework maps out the key controls to mitigate the risks and provides a mechanism to inform the Governing Body of the assurances received about the effectiveness of these controls. The strategic risks to compliance with the CCG licence are captured in the Assurance Framework.

Strategic risks, which form the Assurance Framework (as at 20/03/14), are summarised in the table below:

Ref	Title
CCG2001	Failure to establish CCG identity within local population
CCG3008	Risk that Healthy Lives, Healthy Futures will not deliver the quality and financial sustainability outcomes in the requisite timeframe
CCG3005	Instability in partnership finances or services/costs leads to unaffordable consequences for members of the health care system
CCG3003	Financial challenges
CCG4001	Possible reduction in performance
CCG4004	Recruitment, retention and succession planning
CCG4006	Potential conflict of interest compromises planning process
CCG4007	Failure to meet nationally laid out deadlines for contract development and sign off as a result of transition turbulence in the health system
CCG5002	Summary Hospital Mortality Indicator (SHMI) organisational risk
CCG5003	Ineffective planning mechanisms across new systems, including CCG, PHE networks, senates, Propco and NHSCB
CCG5004	Lack of effective risk sharing with other CCG's, including financial risk sharing and strategic service planning
CCG5005	Impact of the Dilnot Report (Government proposals for social care funding reform)
CCG6003	Lack of engagement with non GP clinicians

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. Each risk on the Assurance Framework is owned by a Service Lead who regularly reviews and updates the risk.

Risks rated as high/significant (15 and above) at 31 March 2014 are summarised in the table below:

Risk	**risk rating**	**target risk rating**	**Actions taken to mitigate the risk**
Failure to achieve Accident and Emergency 4 hour targets	16	8	The CCG Commissioning Team is overseeing performance against the A&E 4 hour wait target on a weekly basis. Action plans are in place, focussing on all issues with potential impact on 4 hour A&E wait performance, and are overseen by the Urgent Care Board.
18 week RTT performance	16	1	Monthly engagement meetings with providers are in place to ascertain (in relation to specialities which are underperforming) factors contributing to underperformance. Action plan are also in place to manage this process.
NHS Continuing Healthcare (CHC) and Funded Nursing Care	16	8	The CCG is in the process of recruit a dedicated CHC team. Finance arrangements are monitored on a monthly basis. National CHC governance arrangements are in place via NHS England and quarterly benchmarking reports are provided by the national team and monitored locally via the internal CCG governance processes.
Risk that Healthy Lives, Healthy Futures (HLHF) will not deliver the quality and financial sustainability outcomes in the requisite timeframe	16	9	A HLHF Programme Board is in place to oversee progress with the programme Governance framework provided by HLHF programme board, engagement core group and assurance sub group in place. The HLHF Programme Board reviews progress monthly towards financial and clinical sustainability goals for Northern Lincolnshire. The Programme Board reviews the programme risk log on a monthly basis and has also established an assurance sub group to identify key areas of concern and recommend remedial action. With regards to financial sustainability the Executive group of the Programme board meets weekly virtually and receives on-going reports and assurance on the updated financial position.
Possible reduction in performance	16	8	The CCG Delivery Assurance Committee meets regularly to discuss all elements of performance including provider performance. Regular reports are escalated to the Partnership Board in order to review

			items considered to be a risk to the CCG.

Each risk, identified in the table above, is reviewed and updated monthly. Risk reports are presented at the Service Leads Meeting on a monthly basis, Integrated Governance and Audit Committee on a quarterly basis and the Partnership Board on a bimonthly basis.

The CCG has a robust process for the identification and mitigation of risks and where there have been serious incidents, responds to them quickly and ensures that lessons learnt from them are implemented swiftly across the CCG.

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 delegates 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.

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 Tool, which is briefly discussed at page 10, 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 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. Once the endorsement panel has evaluated the business case it will either be rejected or asked for more information or passed to the Care Contracting Committee for approval. This sub-committee of the board will validate the assumptions and approve the progression of the service to either a pilot stage or identify that it needs to be part of a procurement exercise as set out in the policies and procedures of the CCG.
For established contracts, the contracts team and contract leads monitor progress on a monthly basis. The Contracts team for Adult Social care will 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 Clinical Governance 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 Development Proposal Tool also considers any possible equality & diversity implications of the proposed service, further reducing potential risk to the organisation. Pilot schemes have clearly defined timeframes and evaluation methodology; including sufficient time for ensuing procurement to ensure continuous service delivery should the evaluation prove positive. The proposal documentation is designed to allow proposers to demonstrate compliance against all requirements and to think through the

implementation of their proposal. Wherever a business case involves, or has an impact upon adult social care resources it will require discussion and agreement with the lead officer for Adult Social Care in the CCG and may (depending on scale and impact) require agreement by NEL council. The proposal will then be considered by the senior team/Care Contracting Committee for approval, subject to the group being satisfied that there is no impact or implication that requires wider organisation or partnership consideration. All approved business cases will be required to complete Post Implementation Reviews six months and twelve months after implementation to allow for suitable evaluation of the service/transformation.

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.

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 processes, and more specifically the Assurance Framework outlined in the policy, and summarised above, as a means to help it achieve 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 two main groups, listed below. This is in order to ensure a holistic approach to risk management, whilst recognising that there are distinct and specialist risks within.

- Integrated Governance & Audit Committee – 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. Responsible for agreeing and monitoring the Internal Audit work plan and seeking assurance to ensure development of the Annual Governance Statement.

- 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.

There are other Committees 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.
- Clinical 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.

The Chief Finance Officer has delegated responsibility 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 and the Assurance Framework and Risk Register of North East Lincolnshire CCG.

The Strategic Lead for Quality & Experience 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 managing the development and implementation of clinical risk management, clinical governance and patient safety.

Risk Training

An interactive risk management workshop session was held with members of the Partnership Board on 12th December 2013. Alongside the CCG's Corporate Governance Manager, this workshop was facilitated by East Coast Audit Consortium (Internal Audit) and its strategic partner Mersey Internal Audit Agency (MIAA). The overall 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.

The aim of the session was to analyse, evaluate and challenge a sample of higher value risks (focusing on those scored >12) and their mitigation; and consider partnership risks and comparative issues across the health economy to provide context to and triangulation of the CCGs risk register.

In light of the positive outcome of the risk workshop, all CCG staff will be offered risk management training commensurate with their duties and responsibilities throughout 2014/15.

As an organisation, we are constantly seeking to develop our risk management processes by working with our Internal Auditors, participating in benchmarking exercises and attending relevant best practice workshops.

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 Clinical Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Service Leads and managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance via the monthly Central Management Meeting. The 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 Audit Committee, the Annual Management Letter and overview of cost effectiveness within the CCG.
- 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 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 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.

The following Committees and Officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2013/14 and have managed risks assigned to them.

Integrated Governance & Audit (IG&A) Committee

Responsible for providing an independent overview of the arrangements for risk management within the organisation, with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews Internal and External Audits, the Assurance Framework and financial governance reports. The CCG became a statutory body at 1 April 2013 and therefore the committee has only been in place, undertaking its full role, since that point in time. It was previously operating in shadow form but with limited responsibilities as there was a formal audit committee operating separately as part of the Cluster Board arrangements. The Integrated Governance and Audit Annual Report, which was presented to the Governing Body at its March 2014 meeting, presented the outcomes of the review of the effectiveness of the Board's sub committees. The report relates to the activities of the committee from 1 April 2013 to December 2013. 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 principles of good governance. The IG&A Committee reviews the terms of reference of all Partnership Board sub committees to assure overall governance and assurance arrangements.

The IG&A Committee Chair and Chief Financial Officer meet with the CCG Chair at least once a year to discuss audit committee effectiveness, and agreed actions are reported to the committee and evidenced through subsequent agendas/papers.

Partnership Board

Responsible for ensuring the delivery of the mission, values, aims, culture and strategic direction of the CCG

Chief Clinical Officer

As Accountable Officer for the whole of the CCG, the Chief Clinical Officer is responsible for achieving the organisational objectives in the context of sound and appropriate business processes and reporting risks to the Partnership Board.

Chief Finance Officer

As Senior Responsible Officer for NHS finances across the CCG, the Chief Finance Officer is responsible for ensuring that the organisation complies with the Standing Financial Instructions to achieve financial balance and reports financial risks to the Governing Body.

Service Leads

Each Service Lead is responsible for ensuring that risks have been properly identified and assessed across their work areas, paying particular attention to cross-cutting risks. They are responsible for agreeing the Risk Register entries for their work areas and for ensuring that appropriate arrangements are made to manage the risk.

Head of Internal Audit

The Head of Internal Audit has a central role in the process of securing this Annual Governance Statement, and in advising the Chief Officer and the IG&A Committee on the "health" of North East Lincolnshire CCG's risk management processes. As part of Internal Audit work, reviews are carried out to assess the robustness of the implementation of Risk Management across the organisation. They provide information on the various strengths and weaknesses of the approach adopted by the CCG, and provide advice on where improvements are necessary and desirable for the good governance of the organisation.

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. 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 most notably in relation to continuing healthcare, residential care and response to Francis 2.

During the year the Internal Audit issued the following audit reports with a conclusion of limited assurance:

Continuing Healthcare

The objective of the audit was to provide an opinion on the CCG's approach to continuing healthcare. In particular;

- All retrospective cases were being progressed within adequate timescales,
- Current assessments were being undertaken within an adequate time frame,
- Policies and Procedures were in place for partnership working,
- Systems and processes were in place prior to the introduction of the Personal Health Budgets in April 2014.

Internal Audit provided **partial** assurance on the effectiveness control environment, they made this judgement because although some key controls are in place, for example the retrospective cases are in the process of being reviewed, there are weaknesses in the control environment which need to be addressed, including:

- Assessments for CHC not being undertaken within the 28 day timescale between referral for assessment and decision;

- Governance documentation required for the introduction of the `right to ask' for a Personalised Health Budget in April 2014 not being in place at the time of audit (although we acknowledge that they have subsequently shared with the Audit and Governance Committee in March 2014); and

- Policies and procedures requiring review following on from the transfer of CHC to the CCG.

Residential Home Contract Management

The objective of the audit, completed in August 13, was to provide assurance that the residential care contracts are appropriately monitored and all expenditure is made in accordance with the set fees and care provided

Internal Audit provided **partial** assurance on the overall control effectiveness of Residential Care Contract Monitoring due to there being no evidence of monitoring visits in the majority of the homes tested.

A follow up review was carried out, late in 2013, to ensure that the agreed actions to address the risk exposures had been implemented in full. This review concluded that significant progress had been made in respect of the implementation of agreed actions. Following on from the approval of the Quality Framework the Contract Monitoring Officers have begun an intensive review of all residential homes which will set the baseline for future inspections. This is still a work in progress, with the target completion date of all homes April 2014. Overall, based on their follow up findings, internal audit were able to give significant assurance to the overall control effectiveness of the Residential Care Contract Monitoring.

Francis 2 Response (*Please note: This report is currently at draft stage)*

The objective of the audit was to review the NELCCG response to the Francis 2 report recommendations for timeliness and infrastructure to ensure that lessons learned have been considered locally.
Internal Audit provided **partial** assurance as they felt that there was insufficient evidence of a sound control environment that supports the CCG's response to the Francis 2 Report recommendations. Five recommendations were raised, which are in the process of being discussed / agreed by CCG management.

Data Quality

Data is collated and managed by North Yorkshire & Humber CSU 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. The CSU 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 CSU processes, a root cause analysis is undertaken, corrective actions put in place and on-going learning identified.

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.

Data Security

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.

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.

Through the work programme of the Integrated Governance & Audit Committee, the CCG has achieved a high level of assurance in relation to compliance with its statutory duties and regulatory requirements for 2013/14.

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 2013/14, three areas for improvement. Please refer to page 19 of this report for details.

Peter Melton
Accountable Officer
4 June 2014

Entity name:	NHS North East Lincolnshire Clinical Commissioning Group
This year	2013-14
Last year	2012-13
This year ended	31 March 2014
Last year ended	31 March 2013
This year commencing:	1 April 2013
Last year commencing:	1 April 2012

FOREWORD TO THE ACCOUNTS

NHS NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2014 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

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

We have audited the financial statements of North East Lincolnshire CCG for the year ended 31 March 2014 on pages 62 to 111. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service 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, set out on page 42, 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 2014 and of its net operating costs for the year then ended; and

- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service 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 policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service 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

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 any matters that prevent us from being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

- our review of the Governance Statement;

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the CCG; and

- locally determined risk-based work.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of 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
KPMG, 1 The Embankment, Neville Street, Leeds, LS1 4DW

5 June 2014

NHS North East Lincolnshire Clinical Commissioning Group (CCG) only became a statutory body on 1st April 2013 and therefore there are no prior year comparatives.

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2014

	Note	**2013-14 £'000**	2012-13 £'000
Commissioning - Administrative Costs			
Other Operating Revenue	2	**(1,642)**	0
Gross Employee Benefits	4.1.1	**2,556**	0
Other Costs	5	**2,984**	0
Commissioning - Programme Costs			
Other Operating Revenue	2	**(54,175)**	0
Gross Employee Benefits	4.1.1	**2,160**	0
Other Costs	5	**254,686**	0
Net Operating Costs before Financing		**206,569**	0
Financing			
Investment Revenue	8	**0**	0
Other Gains & Losses	9	**0**	0
Finance Costs	10	**0**	0
Net Operating Costs for the Financial Year		**206,569**	0
Net (Gain) Loss on Transfer by Absorption	11	**0**	0
Retained Net Operating Costs for the Financial Year		**206,569**	0
Other Comprehensive Net Expenditure			
Impairments & reversals		**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		**(4,176)**	0
Reclassification Adjustments:			
On disposal of available for sale financial assets		**0**	0
Total Comprehensive Net Expenditure for the Financial Year		**202,393**	0

The notes on pages 74 to 111 form part of this statement.

The discontinued operations extract is shown within note 45.

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £'000	31 March 2013 £'000
Non-current Assets			
Property, Plant & Equipment	13	**0**	0
Intangible Assets	14	**0**	0
Investment Property	15	**0**	0
Trade & Other Receivables	17	**0**	0
Other Financial Assets	18	**0**	0
Total Non-current Assets		**0**	0
Current Assets			
Inventories	16	**0**	0
Trade & Other Receivables	17	**4,913**	0
Other Financial Assets	18	**0**	0
Other Current Assets	19	**0**	0
Cash & Cash Equivalents	20	**67**	0
		4,980	0
Non-current Assets held for Sale	21	**0**	0
Total Current Assets		**4,980**	0
Total Assets		**4,980**	0
Current Liabilities			
Trade & Other Payables	23	**(14,165)**	0
Other Financial Liabilities	24	**0**	0
Other Liabilities	25	**0**	0
Borrowings	26	**0**	0
Provisions	30	**(336)**	0
Total Current Liabilities		**(14,501)**	0
Total Assets less Current Liabilities		**(9,521)**	0
Non-current Liabilities			
Trade & Other Payables	23	**(3,083)**	0
Other Financial Liabilities	24	**0**	0
Other Liabilities	25	**0**	0
Borrowings	26	**0**	0
Provisions	30	**0**	0
Total Non-current Liabilities		**(3,083)**	0
Total Assets Employed		**(12,604)**	0
Financed by Taxpayers' Equity			
General Fund		**(6,833)**	0
Revaluation Reserve		**0**	0
Other Reserves		**(5,771)**	0
Charitable Reserves		**0**	0
Total Taxpayers' Equity		**(12,604)**	0

The notes on pages 74 to 111 form part of this statement.
The financial statements on pages 70 to 73 were approved by the Integrated Governance and Audit Committee on 2 June 2014 and signed on its behalf by:

Peter Melton

Accountable Officer

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2014

2013-14	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Total £'000
Balance at 1 April 2013	**0**	**0**	**0**	**0**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**(9,947)**	**(9,947)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	**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 & 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**
Net gain (loss) on revaluation of assets held for sale	**0**	**0**	**0**	**0**
Impairments and reversals	**0**	**0**	**0**	**0**
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**
Transfer between reserves in respect of assets transferred under absorption	**0**	**0**	**0**	**0**
Reserves eliminated on dissolution	**0**	**0**	**0**	**0**
Net actuarial gain/(loss) on pensions	**0**	**0**	**4,176**	**4,176**
Net Recognised Expenditure for the Financial Year	**(206,569)**	**0**	**(5,771)**	**(212,340)**
Net funding	**199,736**	**0**	**0**	**199,736**
Balance at 31 March 2014	**(6,833)**	**0**	**(5,771)**	**(12,604)**

Other reserves figure is the Local Government Pension Scheme reserve.

Statement of Cash Flows for the Year Ended 31 March 2014

	Note	2013-14 £'000	2012-13 £'000
Cash Flows from Operating Activities			
Net operating costs for the financial year (see note 46)		**(206,186)**	0
Depreciation and amortisation		**0**	0
Impairments and reversals		**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
Increase (decrease) in inventories		**0**	0
Increase (decrease) in trade & other receivables		**705**	0
Increase (decrease) in other current assets		**0**	0
Increase (decrease) in trade & other payables		**9,336**	0
Increase (decrease) in other current liabilities		**0**	0
Provisions utilised		**(650)**	0
Increase (decrease) in provisions		**336**	0
Net Cash Inflow (Outflow) from Operating Activities		**(196,459)**	0
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		**(196,459)**	0
Cash Flows from Financing Activities			
Net parliamentary funding received		**199,736**	0
Other loans received		**0**	0
Other loans repaid		**0**	0
Net modified absorption accounting transfer through reserves (see note 11)		**(3,210)**	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		**196,526**	0
Net Increase (Decrease) in Cash & Cash Equivalents		**67**	0
Cash & Cash Equivalents at the Beginning of the Financial Year		**0**	0
Effect of exchange rate changes on the 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	20	**67**	0

During the year "Focus Independent Adult Social Work CIC" was established as a social enterprise. The analysis of cash relating to this discontinued operation can be found in note 45.

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 2013-14 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.

In accordance with the Directions issued by NHS England comparative information is not provided in these financial statements.

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.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.5 Charitable Funds

From 2013-14, 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 clinical commissioning group 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 clinical commissioning group 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 the extent that, performance occurs, and is measured at the fair value of 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 should be 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 (Continued)

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 are 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.

1.17.1 The CCG as Lessee (Continued)

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 (PFT) 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 arrangement, following the principles of the requirements of IFRIC12. The CCG therefore recognises the PFR 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 clinical commissioning group'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. When 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 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

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

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

1.21 Provisions (Continued)

The accounting arrangements for health balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only health legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other health legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 11 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements.

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 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.

1.25 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.

1.26 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.

1.26.1 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.

1.26.2 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.

1.26.3 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 re 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.

1.26.4 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.

1.27 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.

1.27.1 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.

1.27.2 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.

1.27.3 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.

1.28 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.

1.29 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.

1.30 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.

1.31 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).

1.32 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'.

1.33 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'.

1.34 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'.

1.35 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.

1.36 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.

1.37 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 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

2. Other Operating Revenue

	2013-14 Admin £'000	2013-14 Programme £'000	2013-14 Total £'000	2012-13 Total £'000
Recoveries in respect of employee benefits	**0**	**0**	**0**	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**	**108**	**108**	0
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	**0**	**0**	**0**	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*	**1,642**	**54,067**	**55,709**	0
Total	**1,642**	**54,175**	**55,817**	0

* This includes £45m in relation to the adult social care partnership agreement and £9m in relation to adult social care private client revenue.

3. Revenue

	2013-14 £'000	2012-13 £'000
From rendering of services	**55,817**	0
From sale of goods	**0**	0
Total	**55,817**	0

4. Employee Benefits & Staff Numbers

4.1.1 Employee benefits expenditure

	2013-14			2012-13		
	Permanent Employees	**Other**	**Total**	Permanent Employees	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Salaries and wages	**3,411**	**606**	**4,017**	0	0	0
Social security costs	**271**	**0**	**271**	0	0	0
Employer contributions to the NHS Pension Scheme	**419**	**0**	**419**	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	**9**	**0**	**9**	0	0	0
Gross employee benefits expenditure	**4,110**	**606**	**4,716**	0	0	0
Less: Recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**	0	0	0
Net employee benefits expenditure including capitalised costs	**4,110**	**606**	**4,716**	0	0	0
Less: Employee costs capitalised	**0**	**0**	**0**	0	0	0
Net employee benefits expenditure excluding capitalised costs	**4,110**	**606**	**4,716**	0	0	0

4.1.2 Recoveries in respect of employee benefits

	2013-14			2012-13		
	Permanent Employees	**Other**	**Total**	Permanent Employees	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Salaries and wages	**0**	**0**	**0**	0	0	0
Social security costs	**0**	**0**	**0**	0	0	0
Employer contributions to the NHS Pension Scheme	**0**	**0**	**0**	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	**0**	**0**	**0**	0	0	0

4.2 Average number of people employed

	2013-14			2012-13		
	Permanent Employees Number	**Other Number**	**Total Number**	Permanent Employees Number	Other Number	Total Number
Total	**106**	**9**	**115**	0	0	0
Of the above:						
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0	0	0

On the 1st of September 2013, 110 whole time equivalent staff transferred from the CCG to Focus Independent Adult Social Work CIC. The average number of permanent employees at the CCG excluding the staff who transferred is 61 whole time equivalent.

Other includes 2 whole time equivalent CCG head quarters staff and agency specialist contractors used to provide expertise that are not available in-house.

4.3 Staff sickness absence and ill health retirements

	2013-14 Number	2012-13 Number
Total days lost	**509**	0
Total staff years	**133**	0
Average working days lost	**4**	0

The staff sickness absence data only relates to 9 months being April 2013 - December 2013.

	2013-14 Number	2012-13 Number
Number of persons retiring on ill health grounds	**0**	0

Ill-health retirement costs are met by the NHS Pension Scheme.

	2013-14 £'000	2012-13 £'000
Total additional pensions liability accrued in the year	**0**	0

Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme.

4.4 Exit packages and severance payments agreed in the financial year

Exit package cost band (including any special payment element)	Compulsory Redundancies		Other Agreed Departures		Total		Departures where Special Payments have been made	
	Number	£	Number	£	Number	£	Number	£
Less than £10,000	0	0	1	9,336	1	9,336	0	0
£10,001 to £25,000	0	0	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0	0	0
Total	0	0	1	9,336	1	9,336	0	0

Analysis of Other Agreed Departures		
Voluntary redundancies including early retirement contractual costs	1	9,336
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following employment tribunals or court orders	0	0
Non-contractual payments requiring HM Treasury approval	0	0
Total	1	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 www.nhsbsa.nhs.uk/pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

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

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.
On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation. Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.
The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data. 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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

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:

4.5.3 Scheme provisions (continued)

- 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;
- 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 statement of comprehensive net expenditure at the time the CCG commits itself to the retirement, regardless of the method of payment; and,
- Members can purchase additional service in the 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 costs of the employers 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 employers contribution 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:

	31 March 2014
	% p.a.
Pension Increase rate	**2.8%**
Salary Increase rate*	**4.1%**
Discount Rate	**4.3%**

* Salary increases are assumed to be 1% p.a. until 31 March 2015 reverting to the long term assumptions shown thereafter

Mortality Assumptions	Males Years	Females Years
Current Pensioners	21.9	24.1
Future Pensioners**	24.2	26.7

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

4.5.4 Local Government Pension Scheme (Continued)

Sensitivity Analysis

Change in assumptions at year ended 31 March 2014	Approximate % increase to Employer liability	Approximate monetary amount £'000
0.5% decrease in Real Discount Rate	10%	3,012
1 year increase in member life expectancy	3%	885
0.5% increase in the Salary Increase Rate	0%	75
0.5% increase in the Pension Increase Rate	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 2015 will be approximately £41,000.

Employer membership statistics

	31 Dec 2013
	Number
Actives	**4**
Deferred pensioners	**285**
Pensioners	**141**
Total	**430**

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

5. Operating Expenses

	2013-14 Admin £'000	2013-14 Programme £'000	2013-14 Total £'000	2012-13 Total £'000
Gross Employee Benefits				
Employee benefits excluding governing body members	**2,239**	**2,160**	**4,399**	0
Executive governing body members	**317**	**0**	**317**	0
Total gross employee benefits	**2,556**	**2,160**	**4,716**	0
Other Costs				
Services from other CCGs and NHS England	**1,300**	**1,530**	**2,830**	0
Services from foundation trusts	**34**	**99,782**	**99,816**	0
Services from other NHS trusts	**0**	**16,710**	**16,710**	0
Services from other NHS bodies	**0**	**0**	**0**	0
Purchase of healthcare from non-NHS bodies	**0**	**55,603**	**55,603**	0
Social Care from Independent Providers	**0**	**52,507**	**52,507**	0
Chair and Lay Membership Body and Governing Body Members	**150**	**0**	**150**	0
Supplies and services – clinical	**0**	**0**	**0**	0
Supplies and services – general	**75**	**1,623**	**1,698**	0
Consultancy services	**491**	**0**	**491**	0
Establishment	**236**	**312**	**548**	0
Transport	**7**	**2**	**9**	0
Premises	**98**	**202**	**300**	0
Impairments and reversals of receivables	**0**	**147**	**147**	0
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	**73**	**0**	**73**	0
Other auditor's remuneration				0
• Internal audit services	**64**	**0**	**64**	0
• Other services	**0**	**0**	**0**	0
General dental services and personal dental services	**0**	**0**	**0**	0
Prescribing costs	**0**	**25,775**	**25,775**	0
Pharmaceutical costs	**0**	**0**	**0**	0
General ophthalmic costs	**0**	**0**	**0**	0
GPMS/APMS and PCTMA	**0**	**0**	**0**	0
Other professional fees (excluding audit)	**418**	**69**	**487**	0
Grants to other public bodies	**0**	**0**	**0**	0
Clinical negligence	**0**	**0**	**0**	0
Research and development (excluding staff costs)	**0**	**0**	**0**	0
Education and training	**38**	**111**	**149**	0
Change in discount rate	**0**	**0**	**0**	0
Interest (Local Government Pension Scheme)	**0**	**1,570**	**1,570**	0
Expected Return on Assets (Local Government Pension Scheme)	**0**	**(1,257)**	**(1,257)**	0
Other expenditure	**0**	**0**	**0**	0
Total other costs	**2,984**	**254,686**	**257,670**	**0**
Total operating expenses	**5,540**	**256,846**	**262,386**	0

6. Better Payment Practice Code

6.1 Measure of compliance

	2013-14		2012-13	
	Number	**£'000**	Number	£'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	**34,023**	**113,792**	0	0
Total Non-NHS trade invoices paid within target	**29,454**	**108,030**	0	0
Percentage of non-NHS trade invoices paid within target	**86.57%**	**94.94%**	0	0
NHS Payables				
Total NHS trade invoices paid in the year	**1,255**	**117,371**	0	0
Total NHS trade invoices paid within target	**1,226**	**117,352**	0	0
Percentage of NHS trade invoices paid within target	**97.69%**	**99.98%**	0	0

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

	2013-14	2012-13
	£'000	£'000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

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 2014 (31 March 2013: £NIL).

9. Other Gains & Losses

The CCG had no other gains and losses as at 31 March 2014 (31 March 2013: £NIL).

10. Finance Costs

The CCG had no finance costs as at 31 March 2014 (31 March 2013: £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. The closure of North East Lincolnshire Care Trust Plus on 1st April 2013 resulted in adult social care balances transferring to NHS England. These balances have transferred to the CCG through reserves using modified absorption accounting. The balances transferred were trade debtors £5,697k, trade creditors £3,180k, local government pension scheme creditor £6,955k, provisions £650k and pension reserve £9,947k. These figures have been reflected in the cash flow movements within the cash flow from operating activities section. The modified absorption reserve balance totalled £4,859k in relation to the above balances, £1,650k was offset against this as a result of the cash payments by NHS England for adult social care payables.

12. Operating Leases

12.1 As lessee

The CCG occupies property owned and managed by NHS Property Services Ltd. For 2013-14, a transitional occupancy rent based on annual property cost allocations was agreed. This is reflected in Note 12.1.1.

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 includes only the known future minimum lease payments from other rental arrangements.

12.1.1 Payments recognised as an expense

	2013-14				2012-13
	Land	**Buildings**	**Other**	**Total**	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000
Minimum lease payments	**0**	**178**	**8**	**186**	0
Contingent rents	**0**	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	**0**	0
Total CCG	**0**	**178**	**8**	**186**	0

12.1.2 Future minimum lease payments

Payable:

• Not later than one year	**0**	**0**	**9**	**9**	0
• Between one and five years	**0**	**0**	**6**	**6**	0
• After five years	**0**	**0**	**0**	**0**	0
Total CCG	**0**	**0**	**15**	**15**	0

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 2014 (31 March 2013: £NIL).

13. Property, Plant & Equipment

The CCG had no property, plant & equipment as at 31 March 2014 (31 March 2013: £NIL).

14. Intangible Assets

The CCG had no intangible Assets as at 31 March 2014 (31 March 2013: £NIL).

15. Investment Property

The CCG had no investment property as at 31 March 2014 (31 March 2013: £NIL).

16. Inventories

The CCG had no inventories as at 31 March 2014 (31 March 2013: £NIL).

17. Trade & Other Receivables

	Current		Non-current	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£'000	£'000	**£'000**	£'000
NHS receivables: Revenue	**241**	0	**0**	0
NHS receivables: Capital	**0**	0	**0**	0
NHS prepayments and accrued income	**123**	0	**0**	0
Non-NHS receivables: Revenue	**2,604**	0	**0**	0
Non-NHS receivables: Capital	**0**	0	**0**	0
Non-NHS prepayments and accrued income	**2,222**	0	**0**	0
Provision for the impairment of receivables	**(2,672)**	0	**0**	0
VAT	**82**	0	**0**	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	**2,313**	0	**0**	0
Total CCG	**4,913**	0	**0**	0
Total CCG Current and Non-current	**4,913**	0		
Included in CCG NHS receivables are pre-paid pension 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 necessary.

Other receivables include £2,199k in relation to the adult social care partnership agreement.

17.1 Receivables past their due date but not impaired

	31 March 2014 £'000	31 March 2013 £'000
By up to three months	**(276)**	0
By three to six months	**(230)**	0
By more than six months	**(14)**	0
Total	**(520)**	0

17.2 Provision for impairment of receivables

	2013-14 £'000	2012-13 £'000
Balance at 1 April 2013	**0**	0
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**(2,593)**	0
Adjusted Balance at 1 April 2013	**(2,593)**	0
Amounts written off during the year	**68**	0
Amounts recovered during the year	**736**	0
(Increase) decrease in receivables impaired	**(883)**	0
Transfer (to) from other public sector body	**0**	0
Balance at 31 March 2014	**(2,672)**	0

Provision for impairment of receivables relates to two main areas of debt, house sale income and adult social care aged debt.

House sale income is collected as a contribution from clients for residential and nursing care. Invoices are raised after the cost of care has been incurred and only when the house has been sold. £1,477k brought forward relates to this, a further £547k provision has been created this year for any income which has not been invoiced for in this year, £736k has been released during the year. £673k of the provision at the 31st March 2014 relates to debt over 12 months old. Provision for adult social care aged debt (excluding house sale) is £1,452k of which £1,301k relates to debt over 12 months old.

	31 March 2014 %	31 March 2013 %
Receivables are provided against at the following rates:		
NHS debt	**0**	0
7 to 9 months	**25%**	0
10 to 12 months	**50%**	0
1 to 2 years	**75%**	0
over 2 years	**100%**	0

18. Other Financial Assets

The CCG had no other financial assets as at 31 March 2014 (31 March 2013: £NIL).

19. Other Current Assets

The CCG had no other current assets as at 31 March 2014 (31 March 2013: £NIL).

20. Cash & Cash Equivalents

	2013-14 £'000	2012-13 £'000
Balance at 1 April 2013	**0**	0
Net change in year	**67**	0
Balance at 31 March 2014	**67**	0
Made up of:		
Cash with the Government Banking Service	**67**	0
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	**67**	0
Bank overdraft: Government Banking Service	**0**	0
Bank overdraft: Commercial banks	**0**	0
Balance at 31 March 2014	**67**	0
Patients' money held by the CCG, 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 2014 (31 March 2013: £NIL).

22. Analysis of Impairments & Reversals

The CCG had no impairments or reversals of impairments recognised in expenditure during 2013-14 (2012-13: £NIL).

23. Trade & Other Payables

	Current		Non-current	
	31 March 2014 £'000	31 March 2013 £'000	**31 March 2014 £'000**	31 March 2013 £'000
Interest payable	**0**	0	**0**	0
NHS payables: Revenue	**2,382**	0	**0**	0
NHS payables: Capital	**0**	0	**0**	0
NHS accruals and deferred income	**867**	0	**0**	0
Non-NHS payables: Revenue	**1,077**	0	**0**	0
Non-NHS payables: Capital	**0**	0	**0**	0
Non-NHS accruals and deferred income	**9,614**	0	**0**	0
Social security costs	**28**	0	**0**	0
VAT	**0**	0	**0**	0
Tax	**32**	0	**0**	0
Payments received on account	**0**	0	**0**	0
Other payables	**165**	0	**3,083**	0
Total	**14,165**	0	**3,083**	0

Total Current and Non-current	**17,248**	0
Included in CCG NHS payables are pre-paid pension contributions	**0**	0

Other payables include £42k outstanding pension contributions at 31 March 2014 (31 March 2013: £NIL).

Other non-current trade payables relate to the Local Government Pension Scheme £3,083k.

24. Other Financial Liabilities

The CCG had no other financial liabilities as at 31 March 2014 (31 March 2013: £NIL).

25. Other Liabilities

The CCG had no other liabilities as at 31 March 2014 (31 March 2013: £NIL).

26. Borrowings

The CCG had no borrowings as at 31 March 2014 (31 March 2013: £NIL).

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

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 2014 (31 March 2013: None).

28. Finance Lease Obligations

The CCG had no finance lease obligations as at 31 March 2014 (31 March 2013: None).

29. Finance Lease Receivables

The CCG had no finance lease receivables as at 31 March 2014 (31 March 2013: None).

30. Provisions

	Current		**Non-current**	
	31 March 2014	31 March 2013	**31 March 2014**	31 March 2013
	£'000	£'000	**£'000**	£'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	**0**	0
Continuing care	**336**	0	**0**	0
Other	**0**	0	**0**	0
Total	**336**	0	**0**	0

Total Current and Non-current	**336**	0

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
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**650**	**650**
Adjusted Balance at 1 April 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**650**	**650**
Arising during the year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**336**	**0**	**336**
Utilised during the year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(650)**	**(650)**
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 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**336**	**0**	**336**
Expected timing of cash flows:										
Within one year	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**336**	**0**	**336**
Between one and five years	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
After five years	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Other provisions relate to adult social care provisions made by the Care Trust Plus in 2012-13, which were fully settled in 2013-14 of which;

- £350k was in relation to the establishment of the social work practice
- £300k was in relation to redundancy costs to be incurred by Navigo. This is as a direct result of a tendering exercise that took place in 2012/13 which resulted in them losing the contract to provide the service and the agreement to fund redundancy costs is as specified under the terms of the Business Transfer Agreement the Care Trust Plus had with them.

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 2014 is £2,450k.

31. Contingencies

The CCG had no borrowings as at 31 March 2014 (31 March 2013: £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 2014 (31 March 2013: £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 2014 (31 March 2013: £NIL).

33. Financial Instruments

33.1 Financial risk management

International Financial Reporting Standard 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's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG's 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 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's revenue comes from parliamentary funding, the CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.4 Liquidity risk

The CCG is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament.

The CCG draws down cash to cover expenditure, from NHS England, as the need arises, unrelated to its performance against resource limits. The CCG is not, therefore, exposed to significant liquidity risks.

33.2 Financial assets

	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	£'000	£'000	£'000	£'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**
Embedded derivatives	0	0	0	0
Receivables:				
• NHS	0	0	0	0
• Non-NHS	0	0	0	0
Cash at bank and in hand	0	0	0	0
Other financial assets	0	0	0	0
Total at 31 March 2013	0	0	0	0

33.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	£'000	£'000	£'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**
Embedded derivatives	0	0	0
Payables:			
• NHS	0	0	0
• Non-NHS	0	0	0
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 2013	0	0	0

34. Operating Segments

The CCG consider they have two segments: commissioning of healthcare services and commissioning of adult social care services.

	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 (see note 35)	**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)**

*The income includes £1,528k funding from the partnership agreement.

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 services within North East Lincolnshire.

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

	2013-14	2012-13
	£'000	£'000
Section 75 Partnership agreement	**45,861**	0
Client contributions	**8,036**	0
Adult social care expenditure	**(53,897)**	0
Total	**0**	0

36. NHS LIFT Investments

The CCG had no NHS LIFT investments as at 31 March 2014 (31 March 2013: £NIL).

37. Intra-Government & Other Balances

	Current Receivables £'000	Non-current Receivables £'000	Current Payables £'000	Non-current Payables £'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 at 31 March 2014	**4,913**	**0**	**14,165**	**3,083**
Balances with:				
• Other Central Government bodies	0	0	0	0
• Local Authorities	0	0	0	0
• NHS bodies outside the Departmental Group	0	0	0	0
• NHS Trusts and Foundation Trusts	0	0	0	0
• Public Corporations and Trading Funds	0	0	0	0
• Bodies external to Government	0	0	0	0
Total at 31 March 2013	0	0	0	0

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. For example:

- NHS England (including commissioning support units);
  - NHS England
  - NHS North Yorkshire & Humber Commissioning Support Unit
  - NHS Greater Huddersfield CCG
- NHS Foundation Trusts;
  - Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
  - Sheffield Children's 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
  - United Lincolnshire 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 (Continued)

	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				
• Trustee of HFMA	4	0	0	0
• Husband is employed by NHS North Yorkshire & Humber Commissioning Support Unit	2,165	0	2	2
Dr P Melton				
Accountable Officer				
• Principal GP at Roxton	766	0	139	0
• Wife was Clinical Lead of Ultrasound at Northern Lincolnshire and Goole NHS Trust	97,690	0	464	0
• Wife is ultra sonographer at 360 Care Ltd	451	0	46	0
Paul Kirton-Watson				
Strategic Lead Quality and Experience				
• Partner works for Focus Independent Adult Social Work CIC	3,798	819	24	4
Joe Warner				
Partnership board social care representative				
• Director PRAXIS: Social Care Solutions Ltd	2	0	0	0
Mark Webb				
CCG chair/Partnership board member/Remuneration committee member				
• Director E-Factor Limited	1	0	0	0
Cllr Michael Burnett				
Partnership board NELC nominated representative/Integrated Governance & Audit committee member				
• Councillor for North East Lincolnshire Council	3,439	19,238	77	2,224
Juliette Cosgrove				
Partnership board registered nurse				
• Worked for Leeds Teaching Hospital	940	0	144	0
Dr Sudhakar Allamsetty				
Partnership board member, GP representative (left 7/11/13)				
• Out of hours sessions Core Care Links	1,539	0	0	0
• GP at Scartho Medical Centre	190	0	17	0
Mr Perviz Iqbal				
Partnership board secondary care specialist doctor				
• Consultant at Doncaster & Bassetlaw NHS Foundation Trust	82	0	7	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
Cllr Peter Wheatley				
Partnership board NELC nominated representative/Integrated Governance & Audit committee member/Remuneration committee member				
• Councillor for North East Lincolnshire Council	3,439	19,238	77	2,224
Joanne Hewson				
Partnership board NELC officer member				
• Employee for North East Lincolnshire Council	3,439	19,238	77	2,224
Philip Bond				
Partnership board Lay member Community Engagement/Integrated Governance & Audit committee member				
• Director of Tollbar Academy	0	0	0	0
Dr D Hopper				
Partnership Board Vice Chair/Remuneration committee member				
• GP at Fieldhouse Medical Group	371	0	60	0
Dr R Pathak				
Partnership Board GP representative				
• GP at Raj Medical Centre	107	0	6	0
• Director of Core Care Links	1,539	0	0	0
• Director 360 Primary Care	451	0	45	0
• Director M & R Medical Ltd	23	0	0	0
• Wife GP partner at Raj Medical Centre	107	0	6	0
Dr A Nayyar				
Partnership Board GP representative				
• GP at Roxton	756	0	139	0
• Director of Core Care Links	1,539	0	0	0
• Director of Yarborough Clee	1,353	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
Dr R T Maliyil				
Partnership Board GP representative				
• GP at Scartho Medical Centre	190	0	17	0
• Director at Core Care Links	1,539	0	0	0
Mandy Coulbeck				
Partnership Board locally practicing nurse				
• Nurse at Quayside Open Access	0	0	0	0

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 Reporting Period

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

40. Losses & Special Payments

The CCG had no losses and special payments cases during 2013-14 (2012-13: None).

41. Third Party Assets

The CCG held no third party assets as at 31 March 2014 (31 March 2013: None).

42. Financial Performance Duties

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended).

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

National Health Service Act Section	Duty	2013-14 Maximum £'000	2013-14 Performance £'000	Duty achieved?
223H(1)	Expenditure not to exceed income (reported surplus £6,033k)	**214,522**	**208,489**	**Yes**
223I(2)	Capital resource use does not exceed the amount specified in Directions	**0**	**0**	**Yes**
223I(3)	Revenue resource use does not exceed the amount specified in Directions	**212,602**	**206,569**	**Yes**
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	**Yes**
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	**Yes**
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	**4,100**	**3,898**	**Yes**

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 £46m 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 the 2013-14 financial year.

44. 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 2014 was £26.4 million **(**31 March 2013 was £28.2 million).

Assets	**Value at 31 March 2014 £000**
Equity Securities	**11,406**
Debt Securities	**2,540**
Private Equity	**1,211**
Real Estate	**1,623**
Investment Funds & Unit Trusts	**8,151**
Cash & Cash Equivalents	**1,479**
Total	**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 2014 £000**
Fair Value of Employer Assets	**26,410**
Present Value of Funded Obligations	**(29,493)**
Net Asset/(Liability)	**(3,083)**

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

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

44. FRS Accounting Information - Pensions (Continued)

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

Amounts for the current and previous accounting periods	31 March 2014 £000
Fair Value of Employer Assets	**26,410**
Present Value of Defined Benefit Obligation	**(29,493)**
Surplus / (deficit)	**(3,083)**
Experience Gains/(Losses) on Assets	**(2,538)**
Experience Gains/(Losses) on Liabilities	**75**

Cumulative Statement of Recognised Gains / Losses	31 March 2014 £000
Actuarial Gains and Losses	**(2,538)**
Effect of Surplus Recovery Through Reduced Contributions	**6,712**
Actuarial Gains / (Losses) recognised in STRGL	**4,174**
Cumulative Actuarial Gains and Losses	**(3,624)**

45. Discontinued Operations - Establishment of Focus

Following a 5 month period, since April 2013, when adult social work in North East Lincolnshire had been operating as a Social Work Practice pilot (one of seven established nationally through the Department of Health) a free standing social enterprise was established on the 1st September 2013.

The establishment of "Focus Independent Adult Social Work CIC" as a Social Enterprise from 1st September 2013 means that the financial and non-financial operational risks rest with the Social Enterprise and not with the CCG. From the 1st September the CCG as a commissioning organisation, manages it's relationship with Focus Independent Adult Social Work CIC through a partnership agreement and service specification.

The adult social work services operations represented a separate discrete business for the CCG and as a result of the establishment of Focus Independent Adult Social Work CIC, these operations have been treated as discontinued operations for the year ended 31 March 2014. The Income and Expenditure for the discontinued operation has been reported separately on Note 34: Operating segments. The position for 2013/14 was breakeven. There was no surplus or loss recognised on the measurement to fair value on disposal. The performance of the discontinued operation is shown below:

Statement of Comprehensive Net Expenditure

	2013-14 £000
Employee benefits	**1,399**
Other costs	**171**
Income	**(42)**
	1,528

45. Discontinued Operations - Establishment of Focus (Continued)

Presentation and accounting treatment of the assets and liabilities relating to the social enterprise has been given specific consideration. The debtor/creditor balances of the CCG in relation to adult social work as they exist at completion including the book debts and the retained liabilities did not transfer to the Social Enterprise.

The cash flow statement for 2013/14 includes cash flows for both continued and discontinued operations the analysis of the cash relating to the discontinued operation is included in the table below:

Discontinued Operation Cash flow:

	2013-14 £000	2012-13 £000
Net operating cost before interest	**(1,528)**	0
Movement in Working Capital	**0**	0
Net cash outflow from operating activities	**(1,528)**	0
Partnership agreement funding	**1528**	0

Note 38 on related party transactions includes disclosure of those relating to the discontinued operation for adult social work services.

46. Cash Flow Workings

	£'000
Net operating costs for the financial year (per SOCNE)	**(206,569)**
Impairment of receivables movement	**79**
Pension charge	**304**
Net operating costs for the financial year per cash flow	**(206,186)**