2015/16 Annual Report & Accounts

NHS
North East Lincolnshire
Clinical Commissioning Group

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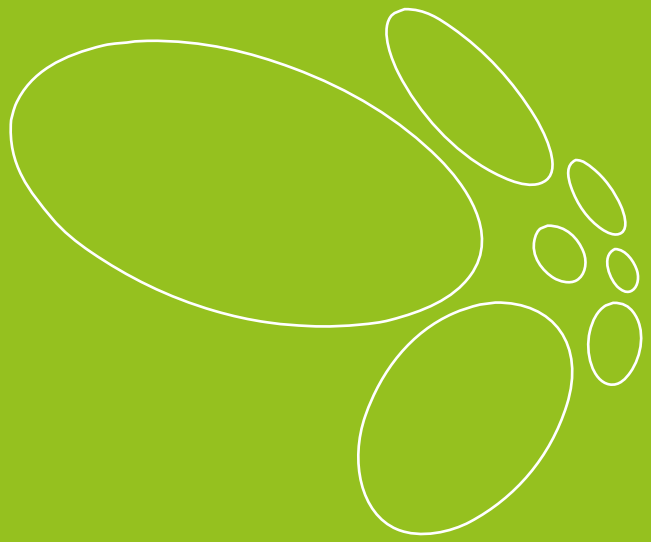


PERFORMANCE REPORT 1.0

1.1 Overview

Welcome to the Annual Report and Accounts of North East Lincolnshire Clinical Commissioning Group (CCG) for 2015/16.

NHS organisations like the CCG must publish an annual report and financial accounts at the end of each financial year. The format has been updated this year by NHS England to include an overview, a useful summary of the Annual Report that summarises what our organisation is about and tells the story of the previous 12 months between 1 April 2015 and 31 March 2016, including achievements and challenges and sets out some of the risks we believe might hinder us achieving our objectives for the coming year. More detailed information about the CCG's performance, the way decisions are made and our structure and staffing is available in the body of the Annual Report and as ever the Financial Statements for the year 2015-16 are presented at the end.

Both the Overview and the full Annual Report and Financial Statements are available for download in digital form from the CCG website. In the interests of sustainability, we do not routinely produce printed documents of the size of the full Annual Report and Accounts. However, this can be made available for you on request. The information contained in this report can also be provided in other languages and alternative formats, including audio, large print and Braille.

For further information, assistance or to request a copy of the report in your preferred format, please contact us at the address at the end of this section.

WELCOME

Welcome from the Chair and Clinical Chief Officer

Thank you for taking time to look at our Annual Report and Accounts for 2015/16. This publication sets out what we have achieved as a CCG in the past 12 months against the plans we have put in place to improve the advice, support and care services that will help local people have a good quality of life, recover from periods of ill health as close to home as possible, make healthier choices and remain active, engaged and independent for as long as they can. We also want to support local communities to do more for themselves and for each other.

Three years have passed since our organisation was first authorised and this third anniversary feels like a useful time to look in detail at our responsibilities and how we carry out our role as a CCG.

You are probably well aware that health and social care are facing significant challenges, both locally and nationally. However, not only do we need to protect essential services and ensure high quality, safe and compassionate care is available to our local population, especially the elderly, frail and most vulnerable amongst us, we also have a responsibility to move with the times. NHS services develop continuously with new treatments and ways of delivering these becoming available every year. Although service demand and costs continue to rise faster than our financial allocation, we must ensure people in North East Lincolnshire can benefit from new services and treatments.

Local health care must respond to the changing needs of the local population and our budget is based on a complex funding formula which looks at the overall health and wellbeing of people living in our area. People in North East Lincolnshire are living longer than ever before. It is good news that people are enjoying longer lives but it is also one of the challenges faced by the CCG as it means more people are experiencing one or more long-term and often complex health conditions.

This can take its toll on their independence and also places extra demand on services with an impact on waiting times and costs. The CCG and North East Lincolnshire Council want health and social care to work together to take care of people's needs in a way that is designed around our residents and reduces wasteful and frustrating duplication or gaps in services.

You can read in more detail about some of this innovative work later in this report, such as the latest Extra Care Housing development to open in Grimsby and the new Single Point of Access which has made it much easier for people to get the urgent care they need, whether it's a GP, nurse or social worker, mental health support or independent living advice.

The CCG is also a local employer itself, with a responsibility towards the people who work extremely hard for us. During 2015/16, we embarked on the Healthy Workplaces programme. A good job can provide an everyday boost to our mental, physical and emotional wellbeing. Simply put, we need good health to work and work is also one of the things that can help to give us good health. Supporting our workforce also makes sound economic sense in these challenging times as it aims to bring down sickness absence and reduce agency bills for interim cover which is an expense the whole NHS needs to address.

Some things matter to everyone. The health services and care that we or the people who are important to us need – whether it's now or things we may need in the future - are probably top of agenda for most of us.

Urgent care is a vital part of supporting our local population to stay fit and well and live as independently as possible. An urgent GP appointment is not always the most appropriate option because a patient may have, for example, urgent mental health, social care, or nursing needs. Therefore, during the evening, overnight or at weekends, depending on a patient's individual need, urgent care support can come from a range of services including an Out of Hours GP, a pharmacist, the mental health crisis team, a social worker or a community nurse. All of these services can now be accessed by North East Lincolnshire residents 24 hours a day, seven days a week by one phone call to the Single Point of Access (SPA) on 01472 256 256 which was rolled out during 2015/16.

We appreciate some patients may genuinely find it very difficult to attend their own doctor for routine appointments during normal working hours and therefore most local practices already offer extended working hours such as weekday evenings and early mornings. In addition, the CCG and NHS England have been working with local practices and listening to views of the public and Healthwatch to understand the needs of patients and as a result, a number of local practices will be piloting “7 Day” services in the coming months. This pilot will include offering access to advice and some planned appointments during weekends for registered patients. It would test the need for, and best way of providing, an additional service to the GP Out of Hours urgent appointment service across 7 days of the week.

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

Working closely with the council and the professional and voluntary organisations that provide care, enables us to respond quickly when unforeseen incidents occur. This was demonstrated last summer when serious concerns came to light about the quality and safety of the care being offered at the privately-run, Immingham care home, Hadleigh House. The CCG suspended new admissions and asked the CQC to inspect the home immediately and in the interim, the CCG and our local health and social care partners put professional support into the home to ensure the safety of the people already living there. The CQC closed the home at the end of June and the CCG and Council immediately put in place a dedicated team of nurses, social workers, care and mental health professionals to work with residents and their families to ensure the most appropriate alternative care was identified for each of them. All of the former residents were quickly settled in alternative homes.

One of our major responsibilities is to balance the books. Each year, CCGs are told by the Government how much money they have to spend. They then have to decide how to share this money across the wide range of services that local people need. These are services like life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health conditions. These include dementia, heart and breathing problems, diabetes and their complications, which we see a lot of in this area.

Across North and North East Lincolnshire the total healthcare community is currently spending £2 million per month more than it has coming in. That's a big affordability gap and we can't solve this just by making even more efficiency or productivity improvements (although we will always keep trying to be even more efficient in the way we spend public money).

There is no doubt that managing within our resources is an on-going challenge for us all. When we put more of our money into one area of care, there is of course less left for others. It is always going to be difficult to get the balance right when we are looking at the needs of the whole population which includes children and adults, mental health and physical health, frail elderly and patients with cancer.

One of the difficult decisions in the past 12 months was to bring the number of cycles of IVF funded by the NHS in North East Lincolnshire into line with the majority of CCGs in England to one. Demand for services and costs continue to rise faster than our financial allocation. This includes a rise in the number of people seeking IVF in North East Lincolnshire and this is expected to continue to grow. We very much value our fertility services and rather than see the service become unaffordable, we feel this decision will allow more families to have the opportunity of at least one attempt at IVF.

When organisations work together as one system, we can respond better to these challenges and make the budget go further. It is fortunate that all of our local leaders have been working together to develop new and innovative ways of working to maintain high quality care through these challenging financial times. As a CCG in 2015/16 we have delivered savings of £3.81million for health and £5.9 million for adult social care and continuing to deliver further efficiencies going forward will require all our skill and innovation as well as strong partnerships.

At the outset of the year, the CCG set out an ambitious range of actions for delivery during 2015/16 and we are pleased to say we have achieved 92% of these objectives. The remaining 8% are on-going actions which cross over into 2016/17 (and some of them beyond this timeframe). You can read about our performance in more detail, click here.

One of the major changes during 2015/16 was the establishment of co-commissioning of primary care services (family healthcare) with NHS England. Our Joint Commissioning Committee is now well established. The benefit of this is the ability to co-ordinate the planning and commissioning of wider primary care services. In the last quarter, the Committee has been able to reach decisions regarding the future shape of specific enhanced services, to avoid duplication and ensure most effective use of resources. For example, the CCG and NHS England are working together on developing a single specification for the commissioning of general practice services to support vulnerable patients (previously two separate enhanced services). This also ensures that services support the development of strategic service changes. The ability to take joint decisions regarding requests for things such as variations to core contract, list mergers and premises developments, is that they can be taken in light of their fit with CCG strategic direction, rather than in isolation.

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

We continue to recognise that people should be at the forefront of their own care services and we are committed to actively listening, understanding and responding to any feedback received. All feedback is seen as an opportunity to review the services we plan and commission to ensure they are fit for purpose and meet the needs of the people who live and work in North East Lincolnshire.

On behalf of the entire CCG Board we present our annual report and place on record our sincere thanks to our members, managers, staff, community members, and partners for their valued support throughout 2015/16.

Our Year in Brief

APR

April saw the launch of the new Joint Commissioning Committee. Co-commissioning primary care aims to support the development of more joined-up services both in and out of hospital, offering the best possible service to local people. The public can attend these meetings which are made up of members of the CCG, NHS England, North East Lincolnshire Council, with community representation and a standing invitation to Healthwatch.

MAY

In May, a new seven-day a week nursing team was established to help children, including those with long term health conditions, stay out of hospital. Many health problems, while serious, can be treated successfully at home if parents or carers have the right level of support and advice. The new team was created by the CCG with Northern Lincolnshire and Goole NHS Foundation Trust to provide both general nursing support as well as more specialist care for children with conditions such as chronic constipation, gastroenteritis, bronchiolitis, asthma and epilepsy and eczema.

JUNE

June saw a visit to Grimsby by Luke Clements, a national legal expert in the rights of people experiencing social exclusion. Professor Clements met with young carers and young people in receipt of extra support to answer questions about the Care Act and how it will affect carers and their families.

"It can be really confusing knowing what help you're entitled to ask for," said one young carer. "When you're busy taking care of someone, you don't really have time to sit down and take these things in. But now the law has changed and there are new rights for carers, it's really important to understand what they mean for you. This was a great chance to learn from an expert."

JULY

In July we were named Small Employer of the Year at the national Employers Network for Equality and Inclusion (enei) awards. The CCG was also highly commended for Inclusive Procurement (the way we purchase services and goods from other organisations) and the way we organise flexible and agile working for our teams.

AUG

Sean Duffy, National Clinical Director for Cancer with NHS England, was so impressed by rates of diagnosis and screening for some cancers and the aftercare that is available to help people get on with their lives after treatment, he visited us in August to find out why we have been so successful in North East Lincolnshire. Mr Duffy attended a meeting where professionals from four local health organisations showcased what was being done to prevent, identify and treat the disease and help people live well and get their lives back on track after cancer treatment.

"Not only is it very impressive how different professional agencies are working so well together to a common purpose but there is a community element in North East Lincolnshire that is trailblazing," said Mr Duffy. "The level of voluntary and community support here is just incredible."

SEPT

The ribbon was cut in September on a new apartment building designed and built to help elderly people keep their cherished independence and their own front door. The 60 bedded Extra Care Housing Scheme in the East Marsh area of Grimsby is the culmination of four years of work and planning between the CCG and Ashley House, a specialist developer of health and social care schemes.

"Keeping their independence is extremely important to most people as they get older," explained Jake Rollin, Assistant Director of Care and Independence at North East Lincolnshire CCG. "The new residents are people with significant care needs who might otherwise have been looking at having to move into a residential care home. Instead, each person or couple has a purpose designed apartment with their own front door with a professional team on hand to support them with daily health and wellbeing needs."

OCT

Health, wellbeing and independence are really important and people should not face difficulties looking for advice they can trust. That's why October saw the launch the Single Point of Access (SPA). SPA has brought all the professional support and guidance around health, wellbeing and adult social work in North East Lincolnshire in one place that people can ring 24 hours a day, seven days a week (including Bank Holidays). 01472 256256 is the number to call for all adult health, wellbeing and social care queries. It is also the number to call if a patient thinks they may need to see a GP out of normal surgery hours.

NOV

A pilot scheme was launched in November to support people to get the most out of their medicines and make a better recovery. Patients at 12 local GP practices now have access to a clinical pharmacist who works alongside the doctors and nurses to ensure people always get to see the right health professional for their needs. The pharmacists will support people, especially those with long term health conditions who need to have regular treatment, to understand how their medicines should be used and why they have been prescribed, as well as solving any problems they may have with them.

DEC

In December the CCG and North East Lincolnshire Council announced a cash injection for local health and wellbeing projects. This will put much needed funds into projects that promote community led responses to maximising good health and minimise the impact of conditions such as Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Dementia on local people. The Big Lottery Fund has agreed to support this aim by meeting community groups in the area to advise them on funding available.

JAN

The CCG started 2016 by asking people what they thought about the draft Dementia Vision and Forward Plan. A consultation was launched in January to gather comments from people with dementia and their carers, people working with dementia patients and the wider community. Over recent months a range of professionals, community members and interested parties have been working together to draft an idea of what North East Lincolnshire's vision is for those with dementia and their carers. The discussions have included looking at the gaps, areas for improvement and what to date has worked well.

FEB

In February people were invited to nominate health and social care workers who make a huge difference to the lives of countless people across North East Lincolnshire. In 2015 the CCG held the successful Care Home Awards which gave recognition to staff who work in residential care. This year, the awards have been expanded to cover the whole of Health and Social Care.
This includes a huge range of people from doctors and nurses, those who provide care in people's homes, social workers, support workers and volunteers who give their own time to provide health and social care services to people. Nominations were invited for a total of 12 awards which pay tribute to innovation, professionalism, quality of care, compassion and encouraging people to keep their independence.

MAR

March saw a positive development in the effort to reduce diabetes. The CCG has joined forces with five other CCGs and three local authorities in Greater Lincolnshire to roll out the world's first nationwide Diabetes Prevention Programme in our area. Greater Lincolnshire is one of 27 areas in England to be selected to take part in the first wave of the programme which will support people at high risk of developing Type 2 diabetes to change their lifestyle and avoid the disease. GPs expect to begin to refer people they know to be at high risk during 2016.

Who we are and what we do

Clinical Commissioning Groups or CCGs were established in April 2013 and are made up of GPs alongside other people who work in health or care and members of the public who together decide what healthcare services there should be available in their local area. Our CCG is made up of 30 member practices that provide health services to families living in Grimsby, Cleethorpes, Immingham and rural North East Lincolnshire.

Our CCG is unique in England because it is not only responsible for most health care but also all adult social care services for our local population of more than 165,000 people. Like all other CCGs we are not responsible for commissioning preventative or some very specialist health services.

Each year, CCGs are told by the Government how much money they will have to spend on health services. They then have to decide how to share this money across the wide range of services that local people need. These are services like life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health conditions. Long term health conditions include dementia, heart and breathing problems, diabetes and their complications, which we see a lot of in this area. North East Lincolnshire CCG also receives funds from North East Lincolnshire council to pay for care and support services for adults who are in need of practical support due to illness, disability or old age. We work with our partners in the local council and public health, as well as with a panel of volunteers from our local community (known as the Community Forum) and the organisations that provide health care to appraise the health and social care needs of people in North East Lincolnshire and decide how to spend the money allocated.

Planning and buying both health and adult social care services means we are able to use the total funds we receive to get the very best value for money for our local population. It also means we can make the way that services are delivered across health and social care much more joined up. This helps us to make sure people don't experience wasteful and frustrating duplication of services and minimises the risk of people falling through gaps in services.

Because North East Lincolnshire is the only CCG in England responsible for adult social care as well as health services, it is built a little differently to other clinical commissioning groups. The range of NHS services commissioned for our population is set out in the Health and Social Care Act 2012. The responsibility for commissioning Adult Social Care to the local population is delegated to the CCG through a legal Partnership Agreement with North East Lincolnshire Council. The CCG Constitution sets out the membership of the CCG and describes the rules and the internal controls (Governance) that put quality – for example, patient safety, effectiveness of care and the experience of people who use commissioned services - at the heart of everything.

In 2015/16, the CCG was allocated £226.821 million by NHS England. This money 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 commissioned services.

The income to fund Adult Social Care is set by North East Lincolnshire Council as part of its annual resource and priorities process, and in 2015-16 the CCG received £38.491 million.

How to contact us

The CCG is always very keen to hear from people who use health or care services in North East Lincolnshire as well as their carers or families. Their experiences can effectively assist with improving and shaping future services.

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

By post:

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

By phone:

Switchboard
0300 3000 400

Media line
03300 249301

By email
nelccg.askus@nhs.net

Visit our website for more information about the CCG

Follow us on Twitter

What we want to achieve and the risks that could affect it

Our aim is to improve the advice, support and care services that will help local people to have a good quality of life, recover from periods of ill health as close to home as possible, make healthier choices and enjoy their independence for as long as they can. We also want to support local communities to do more for themselves and for each other.

However, health and social care are facing big challenges and services are under strain because increasing numbers of people need care which is also becoming more expensive. This means resources have to be stretched further. However, when organisations work together, it is possible to use the available budget more effectively in order to meet the challenges.

Commencing last year, the **CCG Strategic Plan** sets out the vision for the future of health and social care in North East Lincolnshire for the next five years. The plan provides the basis for the development of services that are **high quality, safe, affordable** and **delivered by skilled people who care about what they do**. The CCG is committed to a person-centred, joined-up way of providing health and social care in partnership with North East Lincolnshire Council and a wide range of local health and care providers. Working with local communities is taken very seriously to ensure different needs are met.

These principles will be met across four broad areas – **urgent and emergency care**, planned care **(management of long term conditions)**, planned care **(episodes of ill health)** and **women and children's care**.

To make sure this can be done against the difficulties described earlier, new ways of delivering services in order to offer optimum treatment may need to be introduced. This is already in practice in some services. This may mean sharing some health services with neighbours in other parts of Lincolnshire or the North Bank, for example, or by making better use of technology such as speaking to a doctor or nurse on the phone or through a video link instead of in person.

Most people are accustomed to using GP services and local hospitals for particular needs. However, when health and care organisations (both in the same area and in neighbouring towns and cities) work properly together, we can provide best care in a completely different way designed around what an individual patient needs. This works to support them to regain as much of their health and independence as possible, as quickly as possible.

Enabling people to take better care of themselves is equally important. Not only can it help them feel better and more in control of their lives and health, it can also ease the strain on services if we can prevent illnesses, avoid them getting worse or support people to manage their illness so they can stay as well and independent as possible. With North East Lincolnshire Council, we have a responsibility to actively promote wellbeing and independence and not wait until people reach a crisis point or suffer ill-health or for an existing condition to get worse before we encourage people to do something about it.

We believe great care can happen in four locations:

At or close to home	support, advice and treatment for most episodes of illness or injury
Local hospital or unit	if specialist support or treatment is needed
Bigger nearby hospital	if more complex tests or treatments are needed
Specialist Centre that can be some distance from home	if a person is very badly hurt or really poorly

Managing Risks

The CCG adopts an integrated approach to risk management which enables consideration of the potential impact of all types of risks on processes, activities, stakeholders and commissioned services. The CCG Risk Management Framework provides strategic direction and guidance on embedding the integrated risk management approach in all CCG business. Further analysis of the main risks, can be found in the 'risk assessment' section of the **Annual Governance Statement**.

Going Concern Basis

This Annual Report and Accounts have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended) on the going concern basis.

In addition:

Clinical Chief Officer: As Accountable Officer, the Clinical Chief Officer is accountable for achieving organisational objectives within an appropriate business framework.

Chief Financial Officer: As the Senior Responsible Officer for NHS finances, the Chief Financial Officer is accountable for compliance with Standing Financial Instructions to achieve financial balance.

North East Lincolnshire CCG where the money goes

Difficult choices

Across North & North east Lincolnshire, the total healthcare community currently spends £2 million per monthg more than is coming in!

Each year we find out from the Government how much money we can spend on health & care. This money has to be shared across the wide range of services that local people need

One of our duties is to "balance the books", still making sure local people have services that are high quality, safe, affordable & delivered by skilled people who care about what they do

Working Smarter & Saving Money

No one likes waste & inefficiency. Health & care organisations have been working together to develop new & innovative ways of working to maintain high quality care in what are challenging financial times.

In 2015/16 we saved

£5.9m in social care

£3.81m in health

Did you know

we are the only CCG to commission both health & adult social care?

Our local population & its needs

What does healthcare cost?

We plan and design health & social care for 165,000 people

Health service include life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health conditions including dementia, heart and breathing problems, diabetes.

Adult Social Care is about support services for adults who need practical support due to illness, disability or old age.

- A&E attendance - £107
- Outpatient first attendance - £156
- Outpatient follow-up attendance - £92
- Planned inpatient stay in hospital - £700
- Unplanned stay in hospital - £1,983

We are made up of 30 GP practices spread across North east Lincolnshire

1.2 Performance Analysis

1.2.1 Performance Measures

Our performance

Measuring our performance against national and local priorities helps ensure our services are being delivered to a high quality standard and provide value for money. North East Lincolnshire CCG is assessed continuously by the Department of Health and NHS England on a number of key financial and performance measures from within the various national frameworks.

The introduction of the Better Care Fund has required additional performance measures for the CCG which ensures we work closely with North East Lincolnshire Council to deliver improved outcomes for people.

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

- Local people receive good quality care. There are processes in place to measure quality of care under 3 domains of: Patient Safety including infection prevention and control and clinical incident reporting, Patient Experience including reviewing the messages in the Friends & Family Test, and Clinical Effectiveness including how providers of care ensure they are providing the most clinically effective care.
- Patient rights under the NHS constitution are being promoted. These include: waiting times for A&E, cancer treatment, elective surgery and ambulance calls; mixed-sex accommodation breaches and the mental healthcare programme approach.
- Local people receive good quality care and support for Adult Social Care services to enhance their quality of life by helping them to manage their own support as much as they wish, so that they are in control of what and how support is delivered to match their needs.

Areas of particular success in 2015-16 for North East Lincolnshire CCG

Estimated diagnosis rate for people with dementia - NELCCG 72.7%** against the national target of 66.7%).

Increasing the availability of community based preventative support - NELCCG 14%*** against local target of 11.70%.

Delayed transfers of care from hospital (Average number of patients) - NELCCG 5.4** against local target of 6.9.

Delayed transfers of care from hospital which are attributable to adult social care (Average number of patients) - NELCCG 1.15** against local target of 2.

The number of patients waiting six weeks or more for a diagnostic test - NELCCG 0.11%** against national target of 1.00%

Cancer waiting times

Two week wait for first outpatient appointment with suspected cancer (NELCCG 97.34%** against the national target of 93%).

Two week wait for first outpatient appointment with breast symptoms (NELCCG 97.1%** against the national target of 93%).

31 day wait for patients receiving first definitive treatment (NELCCG 99.56%** against the national target of 96%).

31 day wait for patients receiving subsequent treatment of surgery (NELCCG 96.64%** against the national target of 94%).

31 day wait for patients receiving a subsequent/adjuvant anti-cancer drug regimen (NELCCG 100%** against the national target of 98%).

31 day wait for patients receiving subsequent/adjuvant radiotherapy treatment (NELCCG 97.33%** against national target of 94%).

**NB Performance is at end of January 2016.

***NB Performance is at end of quarter 3 (December 2015).

Areas of particular scrutiny in 2015-16 for North East Lincolnshire CCG

A&E waiting times - North East Lincolnshire CCG's main emergency care provider is Northern Lincolnshire and Goole Foundation Trust (NLaG) has struggled to achieve the national standard of 95 per cent of patients (NELCCG 93.3 %*) waiting for no longer than four hours. A large proportion of the performance issues have been related to limited bed availability for admissions with this regularly impacting on waiting times in A&E. NLaG are working to set a trajectory to bring their performance back in line with the national standard in 2016/17.

Mixed sex accommodation breaches – There were *29 breaches in 2015/16 against the national target of zero, of these 4 were at Hull Royal Infirmary and 25 were at Diana, Princess of Wales Hospital. Northern Lincolnshire and Goole Foundation Trust (NLaG) (where 25 of these breaches occurred) is now implementing a revised policy to address this performance and it will be monitored through the Quality Contract Review meetings and quality reporting.

Cancer waiting times (62 Days) – Current 2015/16 performance is 80.87%* against the national standard of 85 per cent of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer. The Trust is working hard to try and reduce the amount of Cancer breaches and regular cancer performance meetings take place with a variety of audiences. NELCCG is now attending a regular collaborative meeting between local CCG's and providers to form action plans to bring performance back in line with the national standard for 2016/17.

Elective waiting time (Incomplete pathway) – North East Lincolnshire CCG (NELCCG) is working with the Trust to ensure that delivery of this key national target is achieved. The NHS operating standard for elective waiting times (incomplete pathway) is that 92 per cent of patients start their first definitive treatment within 18 weeks of referral. NELCCG's average performance across 2015/16 was 92.04%*, however recent months has seen performance below the national standard (February 2016 – 89.86 %*). NELCCG have control measures in place via the System Resilience Group which reviews this measure at speciality level to monitor and discuss performance with providers.

*NB Performance is at end of February 2016.

Our latest performance is available on our website

1.2.2 Our 2015/16 Objectives

The Corporate Business Plan is split into 4 Objective themes;

1) Urgent Care and Crisis Care System (out of hospital)

2) Proactive care models

3) Access & Diversion

4) Prevention and Early Intervention

The Corporate Business Plan comprises more than 50 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 50+ projects and initiatives.

Objective	Commentary
Urgent Care and Crisis care system (out of hospital)	To support the transformation of Out of Hospital care the following priorities for action in 2015/16 were identified: **Urgent and crisis care system (out of hospital)** • 1 hour response (24/7) - Single integrated provision across NEL, multidisciplinary - Single call handling via Single Point of Access (SPA) • Same day response (24/7) - Single call handling via SPA - May have shorter response requirements (e.g. 4 hours) where necessary - Multiple provision, but working as part of a single system
Proactive care models	• ACC rollout - For unstable 'top 2% • Complex / specialised / multiple Long Term Conditions (LTC's – focus in 2015/16 on chronic obstructive pulmonary disease (COPD) and Diabetes - Multi-Disciplinary Teams involving multi-provider teams arranged into a small number of 'hubs' for more complex cases (to be defined) - Practices continue to manage straightforward & stable patients, but with more consistent management (e.g. via networking across practices) with specialist nursing & specialist advice - Expert patients, third sector and non-professional support • Nursing / Care Home system - Multidisciplinary co-ordinated and proactive response to groups of care homes, reducing urgent admissions and length of stay in hospital - Will include proactive care planning incl end of life (EOL) - Anticipate co-ordination being led by Primary Care but working with community nursing, EOL, therapies and others , but through 1or a small number of 'hubs'

Objective	Commentary
Access & Diversion	• SPA - Continued development of the SPA as NELs single point of advice, access to information and the gateway to services; & - Development to enable the SPA to deliver the requirements of the urgent & crisis care system, (effectively operating the local solution to 111) • 7 Day Access - Primary Care, - Equipment via the Assisted Living Centre, - consistent community nursing response - NB need to also ensure appropriate infrastructure support is also in place (IT etc) • Extra Care Housing - Opening of the first scheme and commencing work on scheme2 • Mental Health - Moving to having the same waiting time target for mental health services as are in place for physical health
Prevention and Early Intervention	**Prevention and early intervention** • Prevention strategy and action plan (with NELC / Public Health) - Social Prescribing - Communications strategy about what we are already doing • Early intervention - Systematic identification and response **Other essential areas of work continued** • Domiciliary Care Tender • Quality Framework for Care Homes • Releasing Community capacity • Work on Prescribing practice • Embedding work related to End of Life Care

1.2.3 Financial Information

North East Lincolnshire CCG is in its third year of operation and this report covers the year ending 31 March 2016.

The financial performance in this year has built on the excellent performance of previous years, despite continued pressures on health and social care funding.

The CCG has a range of statutory and operational duties and all these have been met as shown in the table below.

Statutory Duties

- Revenue resource use does not exceed the amount specified in Directions (Surplus = £4.531m)
- **Achieved**
- Revenue administration resource use does not exceed the amount specified in Directions
- **Achieved**
- Capital resource use does not exceed the amount specified in Directions
- **Achieved**

Operational Duties

- Manage cash within 1.25% of monthly drawdown
- **Achieved**
- Partnership Agreement (Planned to break even)
- **Achieved**
- Meet the "Better Payment Practice Code" (95%)
- **Achieved**

Statutory Financial Duty

There are the following statutory (legal) financial duties for Clinical Commissioning Groups, as follows:

a) Revenue resource use does not exceed the amount specified in Directions (Surplus = £4.531m)

This duty requires the CCG to achieve an in year surplus equivalent to no less than 1% of its health allocation. The CCG's total health allocation for 2015/2016 was £226.821m, and had a planned surplus of £4.531m (2%). There were a number of significant pressures in year, despite this, as shown in the Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2016, this duty was met precisely.

b) Revenue administration resource use does not exceed the amount specified in Directions

This duty requires the CCG not to spend in excess of its Running Cost Allocation. This allocation for 2015/2016 was £3.923m, with the CCG spending £3.570m on running costs.

c) Capital resource use does not exceed the amount specified in Directions

The CCG received no capital resource in 2015/16.

Administrative Financial Duties

There are a number of administrative financial duties applied to all CCGs in the same way as all other NHS organisations. Although these are not statutory duties, they are critically important in determining the performance and financial health of the organisation. Therefore performance is rigorously monitored internally and externally.

d) Manage cash within 1.25% of monthly drawdown

The CCG is required to have a cash balance at the end of each month that is no greater than 1.25% of the cash drawn down in that month. This requirement was met every month.

e) Partnership Agreement (Planned to break even)

Under the Partnership Arrangements the CCG has with NELC with regard to Adult Social Care, the CCG achieved its planned break even position. There were a number of significant pressures in year, despite this, as shown in note 34. Operating Segments & note 35.Pooled Budgets this duty was met

f) Better Payment Practice Code

The Better Payment Practice Code states that 95% of invoices should be paid within 30 days of receipt of goods or a valid invoice (whichever is later). Performance is measured in terms of both numbers of invoices and value of invoices. For 2015/2016 the CCG, on average, paid 94.42% of invoices by number and 98.19% of invoices by value in compliance with the code.

Conclusion

North East Lincolnshire Clinical Commissioning Group has fulfilled all its statutory and administrative financial duties in its third year of existence. The consistent excellent performance is a credit to all the staff and members of the organisation.

This has given the organisation a strong basis from which to tackle the significant financial risks and pressures that continue to face us.

The CCG has a number of financial duties under the National Health Service Act 2006 (as amended). Please refer to finance performance duties note 42 within the annual accounts.

1.2.4 Commissioning Activity

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

- To commission and procure a range of health and social care services on behalf of local people.
- To empower individuals to procure services directly which meet their particular need.

North East Lincolnshire is unique as it has responsibility for commissioning both health and adult social care services on behalf of its registered population. In other areas adult social care is commissioned by the council.

North East Lincolnshire Council has delegated its responsibility to the CCG through a formal partnership agreement so that these two areas of care can be brought together with the aim of improving the services that individuals receive on a day to day basis.

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

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

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

In addition to commissioning health and social care services the CCG also commissions a range of support services from external organisations. Further information can be found in the **Annual Governance Statement**.

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

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

Examples of the service developments and improvements the CCG has undertaken during 2015/16 include:

An improvement in Dementia diagnosis.

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

The Creation of Extra Care Housing.

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

Assisted Living Centre.

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

1.2.4.1 Service Redesign

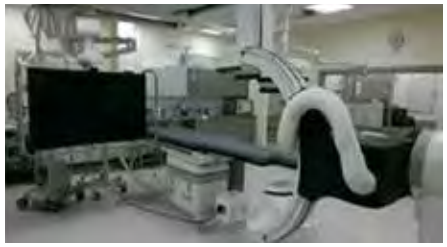
Our transformational change programme, Healthy Lives, Healthy Futures, (HLHF) has been undertaken in partnership with North Lincolnshire Clinical Commissioning Group and our local providers. This programme is a review of all services in the Northern Lincolnshire region. The review aims to make sure the services available to people in our area will be safe and of high quality for years to come. The vision for HLHF includes the following:

- 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.

During 2015/16, the programme has taken forward a number of service redesign areas across Northern Lincolnshire. In North East Lincolnshire in particular, the following service changes have been implemented:

- **The Cardiology Unit** was opened in July 2015 on the Diana Princess of Wales site which now offers state of the art cardiology services for the community. This has also allowed the service to more effectively recruit staff, moving from 3 cardiologists to 9, due to the better service provision and reputation. Further work is happening to develop services across sites to further enhance service delivery.

New entrance to CDCU and Cardiology Outpatient Department



Cath Lab

Procedure Room

- **The Home from Home** scheme in North East Lincolnshire is run by our Mental Health provider, NAViGO, working jointly with Northern Lincolnshire and Goole staff, and is based within the Diana Princess of Wales site. This was established to ensure that patients with confusion/ dementia who were admitted to hospital are cared for in an environment more suitable for their care, rather than the general wards, thus ensuring that they receive care appropriate to their need and have a timely assessment for their social care needs prior to discharge. This service has had a positive impact on both patient experience and quality of care. As a result of this scheme there are currently no delayed transfers of care from hospital for people with mental health issues in North East Lincolnshire. North East Lincolnshire are below the national average for hospital length of stay and confusion treatment.

Service changes that are planned for 2016/17 include the following:

- **Support to local Care Homes and their residents** - the aim of the Support to Care Homes and those with Multiple Long Term Conditions project is to offer support for those with complex long term conditions residing in the community, nursing or residential care, in which primary care, social care, mental health, allied health professionals, pharmacy and the third sector work together to provide a co-ordinated and proactive response to the individual's needs. This will include regular care reviews, an urgent (same day) response for deteriorating individuals, and support following a hospital stay/ period of re-enablement in intermediate care to facilitate an earlier discharge than would otherwise be possible. Support will include use of new technologies and telemedicine to ensure fast, effective clinical input.
- **Long term conditions management** – for patients with Chronic Obstructive Pulmonary Disease (COPD) and some Cardiology conditions, there will be a new model of care which will mean that more patients can be cared for within a community setting. Patients will be supported by a multi-disciplinary team of staff, including specialist support, who can support all of an individual's needs.

The CCG is now moving towards developing an accountable care approach for the North East Lincolnshire locality, which will mean local care providers taking responsibility for working together in an integrated way to deliver improved outcomes for the population they serve within the total budget for care. As part of this approach, the NEL locality will also work with other CCGs, as required.

Please see the link below for further information on the programme: **www.healthyliveshealthyfutures.nhs.uk**

1.2.5 Sustainable development

What is sustainability?

Sustainability is about the effective use of natural resources and behaving in a way that manages and minimises the impact we have on our environment. It requires us to pay particular attention to energy, travel, waste, procurement, water, infrastructure and buildings.

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

Mandate for sustainability reporting

In 2008 the Climate Change Act was introduced to ensure the UK cuts its carbon emissions by 80% by 2050. The 80% target is set against a 1990 baseline.

The act enables the UK to become a low carbon economy. It sets in place a legally binding framework allowing the government to introduce measures which will achieve carbon reduction and mitigate and adapt to climate change.

As we are part of the largest public sector emitter of carbon emissions, we have a duty to respond to meet these targets which are entrenched in law. Contributing to the Climate Change Act target with a 34% reduction in carbon emissions by 2020 is a key measure of the NHS's ambition across the country. In order to achieve these targets the NHS committed to reducing its carbon footprint by 10% by 2015. Between 2007 and 2015 the NHS carbon footprint has reduced by 11%. Reduced environmental impact will be measured against the target of 34% reduction in CO2e emissions by 2020 and be well placed to meet the 50% target by 2025.

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.

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 2015/16

The CCG has a policy for Agile Working which enables all CCG staff to work in the most flexible and efficient way. Staff have the option and ability to work from home or within the community supported by the CCG providing staff with mobile technology. This has reduced travel costs and CO2 emissions as staff do not have to work from designated buildings and meetings can be attended through teleconference.

The CCG occupies only one building; which allows us to minimise our carbon emissions. The CCG has a bike shed and encourages staff to cycle to work if they can. The building however is not on any public transport routes so car sharing is promoted wherever possible.

Waste Minimisation and Management:

It has been a priority for efforts on CO2 reductions to be aimed at organisational culture changes, as well as behaviour change amongst staff, in an effort to raise the profile of the sustainability agenda. Specific projects aimed at changing staff behaviour include the recycling strategy, where bins are provided so waste paper and dry mixed recycling can be recycled, and the printing strategy, where staff are positively encouraged not to print unless absolutely necessary. The dry mixed recycling process means that many different types of waste can be placed in one container which increases waste recycling rates while reducing costs by not disposing it to landfill. Paper and card are recycled separately and general waste is placed in a separate bin. There are appropriate bins inside and outside the building. The printing strategy is supported by the fact the only two printers in the building print exclusively double sided and in black and white. In addition, we now recycle ink cartridges via a company called Green Lights rather than disposing of them. From our confidential waste being shredded and recycled we have saved the equivalent of 3.828 trees for the year.

Procurement

As part of the procurement process the CCG takes social and environmental factors into consideration alongside financial factors in making decisions on the purchase of goods and the commissioning of services. Purchasing decisions where practicable consider whole life cost and the associated risks and implications for society and the environment. The sustainability/environmental procurement principle is to deliver sustainable social and environmental activities both within our organisation but also in our supply chain.

1.2.6 Statutory duties

- **14Z2 - Patient & Public Involvement**

This year the CCG reviewed and refreshed our Engagement Strategy developing strategic aims to further strengthen public and stakeholder involvement in our work:

- Effectively engage and communicate with Member practices
- Have a community that is well engaged, well informed and interested in local health, well-being and social care
- Effectively involve the public and stakeholders in commissioning decisions
- Ensure our partners and other key interested parties are kept engaged and informed
- Have supported and valued staff who are well informed and engaged
- Actively engage with local providers and secondary care clinicians

The new strategy was ratified by the Community Forum in March 2016 and available on the **CCG Website**

The Accord membership scheme is an integral part of North East Lincolnshire CCG's Engagement Strategy. The purpose of Accord is to provide local people with opportunities to influence decisions about local health and social care services that are safe, high quality and affordable.

People with an interest in health and social care who are registered with a GP in North East Lincolnshire can join Accord. Members tell us what topics they are interested in and how they want to be involved which can range from receiving and reviewing information at home, participating in on-line surveys, attending meetings and focus groups; up to formal appointment as a member of the Community Forum, part of the CCGs governance structure.

Ambassadors are members of Accord who wish to become more involved their role is to promote the membership scheme and opportunities for members to have their say. This year we recruited our first cohort of Accord Ambassadors who took part in over 50 hours of in-house training to equip them for their role. Some of the participants in the training went on to become Ambassadors and formed the first Accord Steering group.

The steering group provides a link between the wider membership base of Accord and the CCG to ensure that all members of the scheme have the opportunity to influence CCG decision making. The aim of the new steering group is to develop the strategic direction and priorities for Accord to deliver a vivid and attractive membership scheme for people in North East Lincolnshire; and increase the number of members actively participating in engagement opportunities.

Ambassador's achievements over the year included:

- Participation in community events to promote Accord such as Grimsby Pride and Good Neighbour events;
- Giving talks and presentations locally to community and support groups, PPGs and health and social care students;
- Supporting CCG engagement activity including the Focusing on MS event and hosting the Accord annual members meeting;
- Presenting to the CCG Partnership Board and participating in a Board workshop;
- Advising the CCG on engagement plans such as reviewing surveys and information for Accord members.

For more information about Accord visit our website

We continued to develop our extensive stakeholder list of local community groups, voluntary groups and organisations, including those that represent groups with protected characteristics. This is maintained and utilised to identify those people who may be interested in being involved in particular projects. Through the Accord and stakeholder databases our engagement can be targeted to relevant communities thus increasing the potential for more active engagement.

Between July and September 2015 in partnership with North Lincolnshire CCG we carried out engagement with communities across the area to inform the service specification for a joint-commissioning of non-emergency patient transport service. The intention of involving patients and others with an interest in health and care was to generate some recommendations of what the new service should look like and influence the procurement process of a new provider.

We talked to 535 people at the 23 communities and stakeholder groups we visited. We sent out a survey and information leaflet to 500 stakeholder contacts representing a wide range of stakeholders groups including those with protected characteristics under the Equality Act 2010. The survey was also sent to 2780 Accord and Embrace members (NL CCG patient involvement network) and it was promoted via Twitter and social media.

The full engagement report can be found on the **CCGs website**.

As well as telling us what we should include in the service specification we received a great deal of information about current experiences of travelling to medical appointments by patient transport and by other means. Some of this was incorporated into the service specification and other comments and ideas will be used to shape other areas of work.

A 'You Said, We Did' follow-up report with the CCGs responses to the engagement can be found on the **CCG's website**.

- **14T - Duty to reduce inequalities**

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

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

As a commissioner of health and social care services, North East Lincolnshire CCG works with other health and social care providers and contractors to ensure that valuing diversity and promoting fair access to services are core elements of care and that full consideration is given to all equalities issues when planning or redesigning services and when assessing the health needs of our local population.

As an employer, the CCG recognises and values people as individuals and accommodates differences wherever possible by making adjustments to working arrangements or practices.

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

Building on the comprehensive training undertaken by all members of staff in equality and diversity and the specialist training undertaken by our contracting team the CCG has taken some key actions this year to make progress towards eliminating inappropriate behaviour towards our staff and the service users for whom we commission services. These actions have included:

- Entering and excelling at the ENEI Awards (Employers Network for Equality and Inclusion) July 2015. We were highly commended for our commissioning and contracting work and flexible/agile working and we won small employer of the year
- Reviewing and refreshing the Bullying & Harassment Policy & Procedure
- Full deployment of Prevent Wrap training for health workers

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

As part of tackling health inequalities, North East Lincolnshire CCG has built in mechanisms to its service design process which ensure that disadvantages linked to protected characteristics are highlighted and mitigation measures are put in place. An equality impact assessment is undertaken for each service and our equality impact assessment panel (including community members) reviews and revises those assessments as necessary, ensuring relevant mitigating actions are taken. We shared our good practice with others this year in the form of providing key speakers at a regional networking conference. We set a regional benchmark in our contracting practice and received a number of requests for visits to the CCG and to share our Quality Framework approach for our work with care homes. We have also undertaken a review of our interpreting and translation arrangements and made good progress towards supporting our providers to implement the Accessible Information standards.

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

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

The CCG provides leadership to local commissioners and providers to work together to foster good relations between protected groups and the public at large. This collaborative working aims to maximise local impact for the equality agenda and ensure those groups who are most disenfranchised are cared for appropriately.

North East Lincolnshire CCGs Partnership Board receives regular updates on progress related to the organisations Equality and Diversity practice and provides active leadership on this agenda.

This year we have actively undertaken partnership working with the local Voluntary and Community sector to ensure that we engage appropriately with all local groups with protected characteristics and we share our practice as widely as possible

In relation to Health Inequalities, the need to reduce the gaps experienced by vulnerable groups is embedded in our service design and Equality Impact Assessment process and we have paid particular attention to those people affected by deprivation in our borough as we know this is where the greatest inequality occurs.

The effectiveness of our systems in relation to reducing health inequalities is monitored and evidenced through a number of mechanisms:

- Our on-going review of actions identified for services in their Equality Impact assessments – we check back with services that risks have been mitigated and outcomes are being achieved
- Our comprehensive Quality Framework process for Care Homes which requires evidence of how needs are being met for groups with protected characteristics and remedial action if required standards are not being met
- Our service design process includes targeting geographical communities of interest where health inequalities are experienced and putting in place measures and outcomes to tackle those inequalities

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

Quality, along with innovation and consistency is one of the core principles of North East Lincolnshire CCG.

The CCG has robust processes in place for managing the quality agenda. The day to day management of this rests with the Director of Quality and Nursing.

Key achievements in 2015/16 include the following:-

- Appointment of the Director of Quality and Nursing in July 2015 - responsible for the strategic leadership and effective Clinical Governance, Quality Assurance and Safeguarding arrangements.
- A new Quality Strategy has been developed and is in draft form. This should be complete by June 2016 and will establish the CCG's Quality Framework.
- An experienced GP has worked as part of the Quality Team and has developed a clinically led local Mortality Committee which has focused on improving joint working between primary and secondary providers and agreeing one strategic approach between partners.
- A Lead Nurse for Quality post is awaiting appointment but will develop more robust collaborative working with all our care providers, to influence the quality of care provided. They will provide professional expertise to nursing and quality business processes and lead and oversee the Clinical Governance Committee ensuring that the CCG has robust governance processes in place.
- A Clinical Support Manager (fixed term) was allocated to support the work in the Quality Team and develop links with practice GP's and Nurses, particularly in respect of infection prevention and control.
- Appointment to a new quality and nursing administrator post to support activities and functions connected to the Quality Committee or clinical governance activity.
- A Patient and Client Experience Manager was allocated to lead, manage and develop an integrated patient and client experience service across North East Lincolnshire's CCG
- Further development of the Quality Framework applied to Care Homes, to help inform commissioning intentions and drive up the quality of care in the local care home sector.
- Implementation and full achievement of the dementia screening tool and the Sepsis 6 care bundle
- Developing the role of Designated Nurses for Adults, Children and Looked After Children to strategically drive safeguarding leadership.

Objectives, in relation to quality, for 2016/17 are as follows:

The Quality Team will complete the Quality Strategy and Delivery Plan by June 2016, outlining the key objectives and pieces of work that the CCG will focus on during the following 12 and 24 months, to assist the CCG in the delivery of its accountabilities regarding the quality of care it commissions and supports. The Quality Strategy will outline areas where a strengthened CCG wide approach to service quality, in relation to clinical effectiveness, patient safety and patient experience will be embedded, with processes for assuring compliance, and exception reporting and escalation to the appropriate body. The delivery plan will identify key roles for the Quality Team and also for other key CCG personnel and will be monitored by the Quality Committee.

The key objectives for 2016/17, in relation to assuring quality within our internal processes and externally with our commissioned providers, are to:

- Create a new Clinical Governance group that will reduce the existing agenda of the Quality Committee, i.e. by taking Clinical Governance agenda items for example monitoring of Incident Reporting and Serious Incident reporting, complaints, medicines management and clinical effectiveness. The Clinical Governance group will provide on-going monitoring and will report up to the Quality Committee any areas of concern.
- Revise the Terms of Reference (TofR) for the existing Quality Committee to create a more pro-active committee that drives forward and challenges the quality agenda rather than monitoring and reacting to clinical governance related quality issues. The Quality Committee will monitor the implementation of the CCG Quality Strategy delivery plan.
- Support the delivery of higher quality of care by aiding the Commissioners and Commissioned Provider's in systematically working towards the implementation of all Legislation and Guidance/Quality Standards or NHS Guidance, identified by the CCG as mandatory or required, an example which the CCG would mandate is guidance from NICE or NHS Employers.
- Ensure the NEL CCG quality performance monitoring processes acknowledges key national or regional strategies and approaches to quality that are relevant and tailored to each provider.
- Develop Quality Profiles of each commissioned provider to enrich the intelligence available to the CCG commissioners and key stakeholders e.g. NHSE or CQC.
- Develop a focused or targeted approach to supporting service providers including general practice where there are gaps in quality or performance. This will include offering support to the service to develop quality or clinical governance systems and processes.
- The Patient Experience domain of quality must take on a new approach. NHS England, the Care Quality Commission and the Department of Health recognize that the Patient Experience domain of quality should also be inclusive of Staff Experience. The CCG will develop and widen its approach to capturing patient experience and will seek new and innovative ways to do this.
- Strengthen the approach to quality monitoring by the CCG with smaller providers to ensure that all commissioned services are able to demonstrate the delivery of quality services.
- Appoint to a new Quality Nurse post to support the delivery of the CCG Infection Prevention & Control strategy and to support the delivery of a clinical governance programme which may include clinical audit or other measures of clinical evaluation to improve the quality of care and services.

Further detail can be found in the NHS NEL CCG Quality Strategy and Delivery Plan 2016-2018. This document will be available on the CCG website from July 2016.

- **14Z15(2)(b) - CCG's must contribute to the delivery of the joint H&W Strategy**

The Health and Wellbeing Board has been established to drive health and wellbeing improvement for the population of North East Lincolnshire. It is chaired by the council's nominated cabinet member, who is also a member of the CCG Partnership Board. Its membership includes representatives from North East Lincolnshire Council, North East Lincolnshire Clinical Commissioning Group, NHS England, Provider representatives, Healthwatch, voluntary sector and community representatives.

The Health & Wellbeing Board has actively been engaged with the progress of the Annual Report via the Chairman of the Board and representation of the lay member on the CCG Partnership Board, and Integrated Governance & Audit Committee.

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

The CCG has set an ambitious range of actions to deliver their areas of the strategy, which are reflected in the CCG's corporate business plan. Examples specific to the Health and Wellbeing strategy include:-

- CCG joint work with the council to increase "community capacity", by supporting development of community groups to create more opportunities for individuals and groups to tackle key issues including social isolation, promotion of self-care and self-management, and healthy lifestyle choices; thus reducing dependency on statutory services.
- Development of Extra Care Housing facilities within NEL to support individuals to maintain their independence and minimise use of statutory services, with the first facility having opened in summer 2015.
- The development of proposals for social prescribing working with the Big Lottery Fund

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

1.2.7 Access to information (FOI)

During the period 1 April 2015 to 31 March 2016, the CCG processed the following requests for information under the Freedom of Information Act (FOI) 2000

	2015/2016
Number of FOI requests processed	279
Percentage of requests responded to within 20 working days	100%
Average time taken to respond to an FOI request	13.8

The CCG did not provide the information requested in 9 cases because an exemption was applied when information was accessible by other means, the cost of providing the information exceeded the limits set by the Freedom of Information Act, information was intended for future publication, the information was personal data or the information was accessible by other means. The CCG did not provide information in 45 cases where the CCG did not hold the information and, where possible, the applicant was redirected to the correct organisation for the information.

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

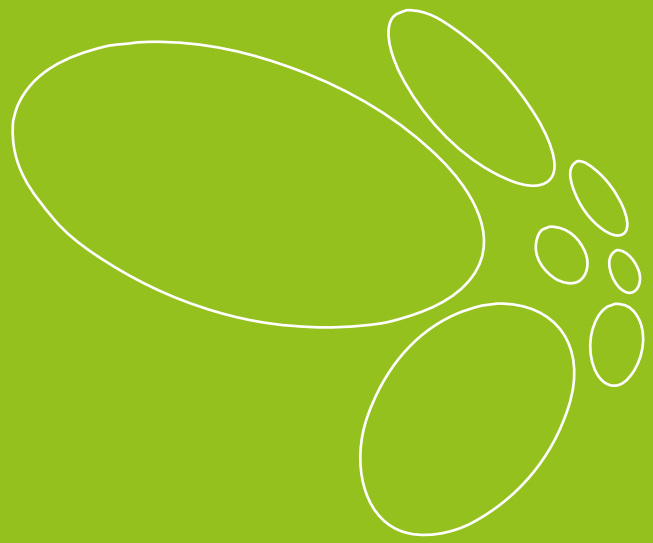
1.3 - Accountable Officer Declaration

I, as Accountable Officer, certify that the clinical commissioning group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

Dr Peter Melton
Accountable Officer

Date

ACCOUNTABILITY REPORT 2.0



2.1 Corporate Governance Report

2.1.1 Directors' & Members' Report

2.1.1.1 Disclosure Statement

The Directors and Members' Report has been prepared by the Partnership Board and provides an overview of GP practices who are members of the CCG, the composition of the Governing Body, Partnership Board and Council of Members, and a biography of members of the Governing Body & 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 as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

The annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

The table below provides details of the Chair and Accountable Officer during 2015/16 up to the signing of the Annual Report & Accounts.

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

2.1.1.2 Our member practices

We are a clinically-led organisation, which brings together 30 local GP Practices and other health professionals to plan and design services to meet local patients' needs. Our member practices are:

Practice	Representative/s	From – To
Dr E Amin, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr Amin	April 2013 - present
Dr A Hussain, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr Hussain	April 2013 - present
Roxton at Weelsby, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr Reeta Singh Dr Arun Nayyar	April 2013 -November 2015 December 2015 - present
Dr P Suresh – Babu, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr P Suresh –Babu	April 2013 - present
Beacon Medical, Primary Care Centre, St Hugh's Ave, Cleethorpes, DN35 8EB	Dr Laura Bernal-Gilliver	February 2014 - present
Birkwood Medical Centre, Westward Ho, Grimsby, DN34 5DX	Dr Karin Severin	April 2013 - present
Dr B Biswas & Partner, 142-144 Grimsby Road, Cleethorpes, DN35 7DL	Dr P Ray	April 2013 - present
Dr Chalmers & Dr Meier, Weelsby View Health Centre, Ladysmith Rd, Grimsby, DN32 9SW	Dr I Chalmers** Dr V Meier**	April 2013 - present April 2013 - present
Chantry Health Group, Cartergate, Grimsby, DN31 1QZ	Dr A M Bamgbala	April 2013 - present
Chelmsford Medical Centre, 128 Chelmsford Ave, Grimsby, DN34 5BA	Dr SN Keshri	April 2013 - present
Clee Medical Centre, 323 Grimsby Rd, Grimsby, DN35 7XE	Dr Kazim Sibtain	October 2014 - present
R Kumar, Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH	Dr R Kumar	April 2013 - present
Field House Medical Group, Freshney Green Primary Care Centre, Sorrel Rd, Grimsby, DN34 4GB	Dr D Hopper	April 2013 - present
Healing Health Centre, Wisteria Drive, Healing, DN41 7PU	Dr KS Koonar Dr Thomas Maliyil	April 2013 - February 2016 February 2016 - present
Dr Opie & Dr Spalding, Weelsby View Health Centre Ladysmith Rd, Grimsby, DN32 9EF	Dr Hasmuck Jethwa Dr Arun Nayyar	April 2013 - December 2015 December 2015 - present

Dr S Kumar and Partners, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE	Dr AP Kumar	April 2013 - present
Littlefield Surgery, Freshney Green Primary Care Centre, Sorrel Road, Grimsby, DN34 4GB	Dr Nathalie Dukes	April 2013 - present
Open Door, 13 Hainton Ave, Grimsby, DN32 9AS	Vicki Bowen Jane Miller	March 2015 - January 2016 January 2016 - present
Raj Medical Centre, 307 Laceby Road, Grimsby, DN34 5LP	Dr Rakesh Pathak	April 2013 - present
Pelham Medical Group, Church View Health Centre, Cartergate, DN31 1QZ	Dr David Elder	April 2013 - present
Humberview Surgery, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE	Dr David Elder	April 2013 - present
The Roxton Practice, Pilgrim Primary Care Centre, Pelham Road, Immingham, DN40 1JW	Dr Arun Nayyar	April 2013 - present
Dr A Sinha, Cromwell Primary Care Centre, Cromwell Road, Grimsby, DN31 2BH	Dr Anupam Sinha	August 2013 - present
Scartho Medical Centre, Springfield Road, Scartho, Grimsby, DN33 3JF	Dr Thomas Maliyil Dr Sudhakar Allamsetty** Dr Catherine Twomey**	February 2014 - February 2016 February 2016 - present February 2016 - present
Dr Dijoux and Partners, Taylors Avenue Medical Centre, Taylors Avenue, Cleethorpes, DN35 0LJ	Dr Sylvere Dijoux	April 2013 - present
Dr Singh & Dr Mathews, Stirling Medical Centre, Stirling Street, Grimsby, DN31 3AE	Dr Renju Mathews	April 2013 - present
Woodford Medical Centre, Freshney Green Medical Centre, Sorrel Road, Grimsby, DN34 4GB	Dr Peter S John	February 2015 - present
Dr O Z Qureshi Surgery Taylors Avenue Medical Centre, Taylors Avenue, Cleethorpes, DN35 0LJ	Dr Omar Qureshi	April 2013 - present
Quayside Open Access, 76B Cleethorpes Road, Grimsby, DN31 3EF	Caroline Day Nicola Glenn	March 2015 - present May 2015 - present
Greenland & New Waltham Surgery, New Waltham, Grimsby, N E Lincolnshire, DN36 4QG	Dr Narinder Bedi Dr Jeeten Raghwani	April 2013 - November 2015 November 2015 - present

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

2.1.1.3 Governing Body & Partnership Board members profiles

Our Governing Body is responsible for ensuring the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principals of good governance. It is made up of a membership that includes doctors and healthcare professionals, executive members and local authority and lay members:

Our Partnership Board is responsible for those matters delegated to it within the constitution; its principal functions are to, effectively manage the discharge of the CCG's statutory duties for the commissioning of health & adult social care services, and effective discharge of the Section 75 Partnership Agreement with North East Lincolnshire Council. It is made up of a membership of Governing Body membership with two additional members nominated by North East Lincolnshire Council.

Details on all committees and sub-committees can be found in the Annual Governance Statement.

Name and Biography	Position	Governing Body Sub- Committees	Declarations of Interest
 **Mark Webb **** Mark Webb spent a number of years in publishing and now owns a small local newspaper publishing company. He also runs a commercial property and business support company that is a social enterprise dedicated to assisting local business and entrepreneurs. Having spent many years in the commercial sector, Mark also has considerable experience in public/ private sector partnership and working with local communities. A former chair of the local strategic partnership and current chair of the Growth and Development Board, Mark brings this experience to the fore to provide challenge and support in equal measures to all sectors making up the CCG. Above all Mark is passionate about the real involvement of the community in the design and delivery of meaningful health and care to the population of North East Lincolnshire. He joined the Governing Body of the NELCCG at its commencement.	**CCG Chair** (1 April 2013 - present)	Remuneration Committee* (April 2013- present) Care Contracting Committee (March 2014 - present) Joint comittee for Primary Care Co-Commissioning* (April 2015 - present)	Managing Director:- E-Factor Ltd Cleethorpes Chronicle 50% Shareholder in Cleethorpes Chronicle Ltd Non exec Board Director Estuary TV (voluntary)

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

Name and Biography	Position	Governing Body Sub- Committees	Declarations of Interest
 **Peter Melton **** Dr Peter Melton was born and brought up in North East Lincolnshire. After studying medicine in London he returned to the area to complete his General Practice training. He became a partner in the Roxton Practice in Immingham in 1993 and remains there now. He joined the Governing Body of the CCG at its commencement.	**Clinical Chief Officer** (1 April 2013 - present)	Non member of sub committee	GP Principal • Roxton Practice • Roxton at Weelsby View, Grimsby • Dr Opie & Dr Spalding, Weelsby View, Grimsby Partners @ Practices • Dr Arun Nayyar • Dr Anne Spalding • Dr Sean Thrippleton • Dr Peter Opie Roxton Practice is a member of 360 Care limited & LINCS Wife is employed by 360 care Limited Director of Doc.Know Ltd Wife is Company Secretary of Doc. Know Ltd Shareholdings (more than 5%) - Local Care Provision Limited - Chair of NHS Commissioning Assembly
 **Cathy Kennedy **** Cathy has over twenty years' experience as an Executive Director of Finance in a variety of NHS organisations, including acute provider trusts and commissioning organisations. She has been working in the North East Lincolnshire area since 2000 and joined the Governing Body of the CCG at its commencement.	**Deputy Chief Executive/ Chief Financial Officer** (1 April 2013 - present)	Delivery Assurance Committee * (April 2013 - present) Care Contracting Committee (April 2013 - present) Joint Committee for Primary Care Co-commissioning (April 2015 - present)	Husband is IT Project Manager with Yorkshire and Humber Commissioning Support Healthcare Finance Managers Association (HfMA): President of Yorkshire branch Chair of National Commissioning Faculty

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

Name and Biography	Position	Governing Body Sub- Committees	Declarations of Interest
 **Dr Derek Hopper **** Dr Derek Hopper has been a GP in Grimsby for forty years. He also has a wide interest in medical politics and is an active member of both the Northern Lincolnshire Local Medical Committee and the National Association of Primary Care. He joined the Governing Body of the CCG at its commencement.	**Vice CCG Chair/ Chair of Council of Members** (1 April 2013 - present)	Council of Members * (April 2013 - present) Remuneration Committee (April 2013 - present) Joint Committee for Primary Care Co-Commissioning (April 2015 - present)	GP Partner Fieldhouse Medical Group Member of Council of National Association of Primary Care (NAPC) Son is Dental Surgeon at Freshney Green Primary Care Centre
 **Helen Kenyon **** Helen Kenyon has worked in the NHS for over 20 years, and has worked in North East Lincolnshire since 1999. She is a qualified accountant and has responsibility for both the commissioning and contracting of Adult Social Care on behalf of North East Lincolnshire Council and for the commissioning and contracting of Health services within the CCG. She joined the Governing Body of the CCG at its commencement.	**Deputy Chief Executive** (1 April 2013 - present)	Council of Members (March 2014 - present) Care Contracting Committee * (April 2013 - present) Delivery Assurance Committee (April 2013 - present)	SJW Solutions in Partnership. An independent consultancy has and does work within the locality and may work with NHS/Social Care including potentially working directly with the CCG in the future.

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

Name and Biography	Position	Governing Body Sub- Committees	Declarations of Interest
 **Philip Bond **** Philip worked for thirty years as a lawyer in the Courts Service before ill health caused retirement. Prior to becoming a Lay Member on the CCG Philip had been an elected Public Governor at an NHS Hospital Trust for seven years, serving as Lead Governor. He has many years of public sector voluntary service particularly in education. He is currently Chair of Directors of Tollbar Family of Academies, a chain of Academy schools. He joined the Shadow CCG Governing Body in June 2011 and was appointed to the substantive post in April 2013. As well as full CCG Board activities, Philip attends monthly Community Forum Meetings, he is also a member of the CCG Quality Committee. He has been heavily involved with the re-launch of Accord (the community membership of the CCG), acting as interim Chair of the Accord Steering Group and also instrumental in establishing regular meetings of the Chairs of Patient Participation Groups in North East Lincolnshire.	**Lay Member Community Engagement** (1 April 2013 - present)	Integrated Governance & Audit Committee (September 2013- May 2015) Quality Committee (31 July 2013 - present)	Member of PPG (Chair) Blundell Park Surgery Director of Tollbar Family of Academies (small academy chain) Cousin, is employed in a senior position within NLAG Trust
 **Dr Arun Nayyar **** 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 the governing body. He joined the CCG at commencement.	**GP Representative Clinical Lead for Planned Care** (1 April 2013 - present)	Council of Members (April 2013 - present)	GP Partner •Roxton Practice •Roxton at Weelsby View, Grimsby •Dr Opie & Dr Spalding Weelsby View, Grimsby Partners @ Practices •Dr Peter Melton •Dr Anne Spalding •Dr Sean Thrippleton •Dr Peter Opie Director of Core Care Links Ltd Core Care Links Co-Directors Dr Nathalie Dukes-Wiesenhaan Dr Thomas Maliyil Dr Martin Clausen Dr R Pathak Shareholdings (more than 5%) - •Local Care Provision Limited

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

Name and Biography	Position	Governing Body Sub- Committees	Declarations of Interest
 **Dr Rakesh Pathak **** Dr Rakesh Pathak is a full time GP. He was raised in the Grimsby area and is married to another GP. He has an interest in tackling health inequalities. He joined the CCG at commencement.	**GP Representative Clinical Lead for Unplanned Care** (1 April 2013 - present)	Council of Members (April 2013 - present)	GP Principal – Raj Medical Centre Laceby Road, Grimsby Wife is also a GP Principal at Raj Medical Centre Sister is a GP in London Director Core Care Links Ltd Co-Directors •Dr Arun Nayyar •Dr Nathalie Dukes-Wiesenhaan •Dr Thomas Maliyil •Dr Martin Clausen Director 360 Ltd •Other Directors •Dr Sean Thrippleton •Dr Annapurna Kumar Director M & R Medical Ltd Wife is Co-Director of M & R Ltd Brother-in-law is Chief Executive of the charity Mission Fish which deals with the charitable aspects of e-bay
 **Juliette Cosgrove **** Juliette Cosgrove is the Assistant Director for Quality at Calderdale and Huddersfield Foundation Trust where she leads on Quality Governance and Improvement. She joined the NELCCG Governing Body in April 2013 initially as the nurse on the Governing Body but now is a clinical lay member.	**Clinical Lay Member** (1 April 2013 - present)	Quality Committee * (29 September 2014 - present)	Calderdale & Huddersfield NHS Foundation Trust, Assistant Director to the Medical & Nurse Directors Husband is a Consultant Neurosurgeon at Lancashire Teaching Hospital NHS Trusts

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

Name and Biography	Position	Governing Body Sub- Committees	Declarations of Interest
 **Joe Warner **** Joe Warner qualified as a social worker in 1987 and is registered with the Health and Care Professional Council. Joe is the Chief Executive 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 joined the NELCCG Governing Body in September 2013.	**Chief Executive Focus Independent Adult Social Care work** (1 September 2013 - present)	Council of Members (March 2014 - present) Integrated Governance & Audit Committee (March 2015 - present)	Director - Praxis Social Care Solutions
 **Susan Whitehouse **** Susan is a member of the Chartered Institute of Internal Auditors and holds a MSC (Distinction) in Internal Audit and Management. She has spent most of her career in auditing in both the public and private sector including a number of years working internationally in a Head of Internal Audit role and as Head of Compliance at the Office of the National Lottery (now the Lotteries Commission). More recently she worked as an independent Lottery and Regulatory consultant both in the UK and overseas and currently works as a lottery compliance consultant for HealthCIC Services Ltd. From 2007 she was the Non-Executive Audit Chair for North East Lincolnshire Care Trust Plus before successfully being appointed to the CCG board as a lay member and Chair of the IG&A Committee. Susan brings a substantial amount of business experience and knowledge to the CCG Board gained both in the UK and overseas.	**Lay Member Governance and Audit** (1 April 2013 - present)	Integrated Governance & Audit Committee * (April 2013 - present) Remuneration Committee (April 2013 - present)	Compliance Manager - 51 community interest companies promoting society lotteries, for raising money for Health related good causes (non- NHS)

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

Name and Biography	Position	Governing Body Sub- Committees	Declarations of Interest
 **Dr Thomas Maliyil **** 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 fifteen years and is committed to developing and maintaining high quality services for the population of North East Lincolnshire. He joined the CCG in February 2014. He also works as a Specialist Doctor in palliative medicine with St Andrew's Hospice.	**Vice Chair Council of Members/GP representative** (1 February 2014 - present) **Primary Care Triangle Clinical Lead** (1 February 2014 - present)	Council of Members (February 2014 - present) Joint Committee for Primary Care Co-commissioning (April 2015 - present)	GP at Scartho Medical Centre Scartho Practice is a member of 360 Care Limited and LINCS My wife is practice manager at Blundell Park Surgery & Healing Health Centre Trainer - Foundation Year 2 HYMS Director of Core Care Links provider of Primary Care Services in NEL Director of Core Care Links Solutions **Other Directors** Core Care Links & Core Care links Solutions • Dr Arun Nayyar • Dr Nathalie Dukes-Wiesenhaan • Dr Martin Clausen • Dr R Pathak Director of Bethesda Ltd service supply medical cover & healthcare management **Other Director** of Bethesda Ltd (Wife) Specialist doctor in Palliative medicine at St Andrew's Hospice, Grimsby
 **Stephen Pintus **** Stephen has been Director of Public Health for a little over a year. Prior to joining the local authority, Stephen had been working in Derbyshire, jointly with local government and the NHS, leading a reconfiguration of lifestyle services producing a profile of the health needs of the population and leading a process of renewing the health and wellbeing strategy. Having worked at a senior level in public health for over 20 years, Stephen has built up a body of experience of work in a variety of settings: these have included regeneration work with communities, work with the voluntary sector, project management in health inequalities, running partnerships, as well as work in both local government and the NHS commissioning health and wellbeing services.	**Director of Public Health** (1 January 2015 - present)	Delivery Assurance Committee (February 2015 - present) Joint Committee for Primary Care Co-Commissioning (April 2015 - present)	Director of Public Health North East Lincolnshire Council Chair of Bridge Employment (Sheffield Based) Supported Employment Voluntary Organisation

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

Name and Biography	Position	Governing Body Sub- Committees	Declarations of Interest
 **Dr David James **** Having trained and worked as a junior doctor in several London hospitals, Dr David James was appointed in 1984 as Consultant Rheumatologist to the (now) Northern Lincolnshire & Goole NHS Foundation Trust, a post held until retirement 30 years later. As the first Rheumatologist to be appointed locally, he had the opportunity to develop and expand the work of the Rheumatology department, to undertake clinical research and to train junior doctors, several of whom have gone on to become Consultants in the specialty. He joined the CCG Board as a secondary care doctor in November 2015.	**Secondary Care Doctor** (Nov 2015 - present)	Non-Member of Sub-committees	Independent work - one day a week, outpatients consultations at St Hughes Hospital, Grimsby
 **Councillor Jane Hyldon-King ***** Cllr Jane Hyldon-King was born and brought up in Grimsby and has served in local politics for over 22 years initially as a member of the former Grimsby Borough Council starting in 1993 until the resurrection of NELC in 1996/7. Jane gained experience in health from serving on Grimsby's Social Service Committee before continuing through to the Health Scrutiny Panel and was also the chair of Environment served on several Scrutiny Panels from Health, Education & Environment. Jane was deputy Chair of the former CHC (Community Health Council) and then went on to spend several years as a Non-Executive member of the then newly formed NLAG under Andrew North. After a short break from the council Jane returned in 2012 and again served on the Health Scrutiny Panel becoming Chair of the Panel in 2013/14. In June this year Jane took over the role as Portfolio Holder for health with the added role of Chair of the Health & Wellbeing Board along with her new position as Deputy Leader. She joined NELCCG Partnership Board in May 2015.	**Deputy Leader and Portfolio Holder for Health Wellbeing and Adult Social Care (NELC)** (July 2015 - present)	Joint Committee for Primary Care Co-Commissioning (July 2015-present)	Councillor Deputy Leader NELC Accord, Hope Street, Friendship at Home, NAViGO

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

Name and Biography	Position	Governing Body Sub- Committees	Declarations of Interest
 **Councillor Matthew Patrick ***** Councillor Patrick was first elected in 2011, representing the Heneage ward and was successfully re-elected recently. Continuing from much success within his council duties where he has earned a reputation as a community champion, Matthew has since sought to further his activities to endeavour to deliver first class healthcare needs within tight budgets. Working within an ageing and vulnerable community has given Matthew key insights into the challenging demands that society has within Primary care, and a background in customer focused industries nurtured a passion to see that service is truly built around empowering the needs of the individual in a complex system. He joined NELCCG Partnership Board in May 2015.	**Portfolio Holder for Finance & Resources** (May 2015 - present)	Integrated Governance & Audit Committee (May 2015 - present) Remuneration Committee (December 2015 - present)	Portfolio Holder for Finance and Resources and Resources, North East Lincolnshire Council
 **Jan Haxby **** Jan is a Registered General Nurse (RGN), Registered Sick Children's Nurse (RSCN), Specialist Community Public Health Nurse (BSc Hons) she is currently completing a Master's degree in Leadership in Health & Social Care. Jan completed her nurse training in 1985 and worked for a number of years in adult services including surgical and renal specialties. She spent a number of years working in the fields of dialysis and renal transplant units across both Oxford and Hull, and at this point started working with young people aged 14+ with renal disease. She then worked for a number of years within children's acute paediatric & community public health services, including management and leadership roles. She moved into a strategy lead & commissioning role for children's health services in 2003 which was a joint post between the Primary Care Trust and the Council, and then became Head of Children's Health services in the Council in 2008, and finally Chief Nurse Commissioner in the Council in 2013, before taking up my current post of Director of Quality & Registered Strategic Nurse in in July 2015 with the CCG. Jan brings a range of values developed over my 30 years of experience working in the NHS; around quality of services, around the patient experience and around nursing as a caring profession.	**Director of Quality/ Registered Strategic Nurse** (14 July 2015 - present)	Quality Committee (July 2015 - present)	Nil Return

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

 **Nicky Hull ***** Nicky has been in the post for the past 2 years as practice manager at Beacon Medical Centre. This is her third position as Practice Manager in Primary Care previously working in Worcester & Hull, prior to moving to her current role within North East Lincolnshire. The majority of her experience has predominantly been gained in secondary care, where she managed both medical and surgical specialists within Hull & East Yorkshire Hospitals. She is passionate to deliver patient centered care for North East Lincolnshire. Having gained a broad insight into both primary & secondary care environments, her role as member of the CCG Partnership Board, will help to bring all primary care organisations together to work collaboratively, to deliver the aims & objectives of the CCG.	**NEL Primary Care (Non GP) Member** (April 2015 - present)	Non member of sub committee	Practice Manager at Beacon Medical Practice provides an enhanced service for substance misuse to own patients only, under a contract with NEL Council GP Partner in practice Dr Laura Bernal-Gilliver (council of members representative)

The following Governing Body & Partnership Board members have resigned from their position during 2015/16

Name	Position	Governing Body Sub- Committees	Declarations of Interest
Mr Perviz Iqbal **	**Secondary Care Specialist Doctor** (1 April 2013 - 31 March 2015)	Non Member of sub-committees	Consultant in Obstetrics & Gynecology. Doncaster & Bassetlaw NHS Trust
Councilor Michael Burnett***	**NELC Representative portfolio holder for Tourism & Leisure Culture** (1 April 2013 - 18 May 2015)	Integrated Governance and Audit Committee (April 2013 - 18 May 2015)	Councilor Leader North East Lincolnshire Council Director of Cleethorpes Events Director of Disability Active Director of Lincs Inspire

Governing Body & Partnership Board meetings are held regularly and members of the public are encouraged to attend any of our meetings that are held in public. Papers are available on our website

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

2.1.2. Additional Disclosures

Principals of 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 forms part of its complaints handling procedure for healthcare and adult social care. Those six principles are: **Getting it right; Being customer focused; Being open and accountable; Acting fairly and proportionately; Putting things right; and Seeking continuous improvement.**

The CCG has demonstrated its compliance with these principles through the complaints reporting process to the Quality Committee. An annual report on complaints is also received by the CCG's Partnership Board at a meeting held in public, and North East Lincolnshire Council Cabinet (consisting of elected members) for scrutiny. The CCG website also has a 'You said, We did' section specifically relating to PALS and complaints.

All complaints are investigated and responded to in line with the Principles for Remedy, any employee errors or maladministration are dealt with accordingly.

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

Disclosure of Data Loss Breaches

Details can be found in the Data Security Section of the Annual Governance Statement.

Emergency Preparedness

NHS England is responsible for emergency preparedness in the Yorkshire and Humber region including North East Lincolnshire. This regional management is administered through a Local Health Resilience Partnership (LHRP) attended by CCGs and NHS funded organisations. The basis of the LHRP is to seek assurance from NHS organisations that they meet the obligations of the national Emergency Preparedness, Resilience & Response & Framework (EPRR) which was revised and updated in 2015.

The purpose of the EPRR is to provide the framework for all NHS funded organisations in England to help with meeting the requirements of the Civil Contingencies Act 2004 (CCA 2004), the NHS Act 2006 as amended by the Health and Social Care Act 2012 (NHS Act 2006 (as amended)) and the NHS Standard Contract.

The CCG, though not a "Category 1" responder, has a key role in linking into NHS England in the event of a major incident and in a proportionate coordination role with local providers in the management of incidents depending on their nature.

The Humber Local Resilience Forum (LRF) also exists, consisting of Local Authorities, Emergency Services and the NHS funded organisations that are Category 1 NHS responders and this forum maintains an incident risk register which, for this region, is biased towards industrial accidents and flooding. In contrast the EPPR is biased towards health related emergencies e.g. pandemic flu and on major service failure (any cause) of NHS providers.

The CCG is active in the LHRP attending their meetings and scenario testing events. The CCG is developing plans to meet the EPRR assurance process which includes improving the NEL wide understanding of coordination roles through a local planning group, provider assurance on contract and statutory responsibilities and incident scenario testing.

The CCG Clinical Chief Officer and two Deputy Chief Executives provide out of hours (telephone) cover for emergency issues that require a local CCG commissioning response.

Health & Safety

North East Lincolnshire Clinical Commissioning Group recognises its responsibilities and duties under the Health & Safety at Work Act (1974) and is committed to ensuring so far as is reasonably practicable, the health, safety and welfare of its employees, visitors and other persons who may be affected by its activities.

North East Lincolnshire Clinical Commissioning Group will comply with legislation as a minimum and strive to improve performance on a continual basis by accepting best practice standards and the setting of performance targets in relation to the management of health & safety.

North East Lincolnshire Clinical Commissioning Group has commissioned Health & Safety service from North East Lincolnshire Council ensuring that there are robust arrangements in place for the management of health and safety across the organisation. Some of these arrangements consist of in-house first aiders and DSE assessors. We have also recently trained a selection of staff in defibrillator training.

Signature

Dr Peter Melton
Accountable Officer

Date

2.1.3 The 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 Clinical Chief Officer to be the Accountable Officer of North East Lincolnshire 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 North East Lincolnshire Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding North East Lincolnshire 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 North East Lincolnshire 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 North East Lincolnshire 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.

Signature

Dr Peter Melton
Accountable Officer

Date

2.1.4 Annual Governance Statement

Introduction & Context

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

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

Scope of responsibility

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

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

Compliance with the Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice. 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.

We have described through the narrative within this annual governance statement and our annual report and accounts how we have fulfilled four of the five main principles of the Code; specifically in relation to, leadership, effectiveness, accountability and remuneration. For the financial year ended 31 March 2016, and up to the date of signing this statement, we have applied those principles of the code that are directly relevant, and via this annual governance statement and our annual report and accounts demonstrate how we have discharged our responsibilities.

In line with best practice the CCG has completed a self-assessment to asses our compliance against the UK Corporate Governance Code. The self-assessment has been reviewed and signed off by sub-group of our Integrated Governance & Audit Committee, with no gaps identified.

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 has been achieved as follows:-

The CCG's Constitution

We have a constitution which has been agreed by our Member Practices and which sets out the arrangements we have made to meet our responsibilities for commissioning care for the people for whom we are responsible.
It describes the governing principles, rules and procedures that ensure probity and accountability in the day to day running of the CCG to ensure that decisions are taken in an open and transparent way and that the interests of patients and the public remain central to our goals.

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

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

b) The Good Governance Standard for Public Services;

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

d) the seven key principles of the NHS Constitution;

e) The Equality Act 2010.

Our constitution is a living document; and as such is refreshed bi-annually, changes made during 2015/16 are as follows:-

National guidance

- Updated conflict of interest guidance

Members Information

- The addition of member's code of conduct
- Reference to Vice Chair of Council of Members amended to read "Vice Chair (Chair Elect)"
- Changes to members practices.

Editorial changes

- Terms of Reference review to ensure consistent with the CCG Scheme of delegation.

In addition to the above, various minor formatting changes have been made. These changes have been approved by the Council of Members, Governing Body and subsequently NHS England.

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 from the Governing Body to the Partnership Board. The Partnership Board enables the local authority to be engaged in the governance of the CCG throughout the year which is essential as part of the Partnership working between NELC and the CCG.

The CCG had an internal audit review of committee effectiveness, which reported **significant assurance**. This was reported to Integrated Governance & Audit Committee and actions followed up by Internal Audit. The Integrated Governance & Audit Committee formally reports to the Governing Body annually.

All committees have at least one Governing Body member as part of their membership, and minutes of all committees are shared with all Governing Body members.

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 comprises a clinical lead, a service lead and a community lead.

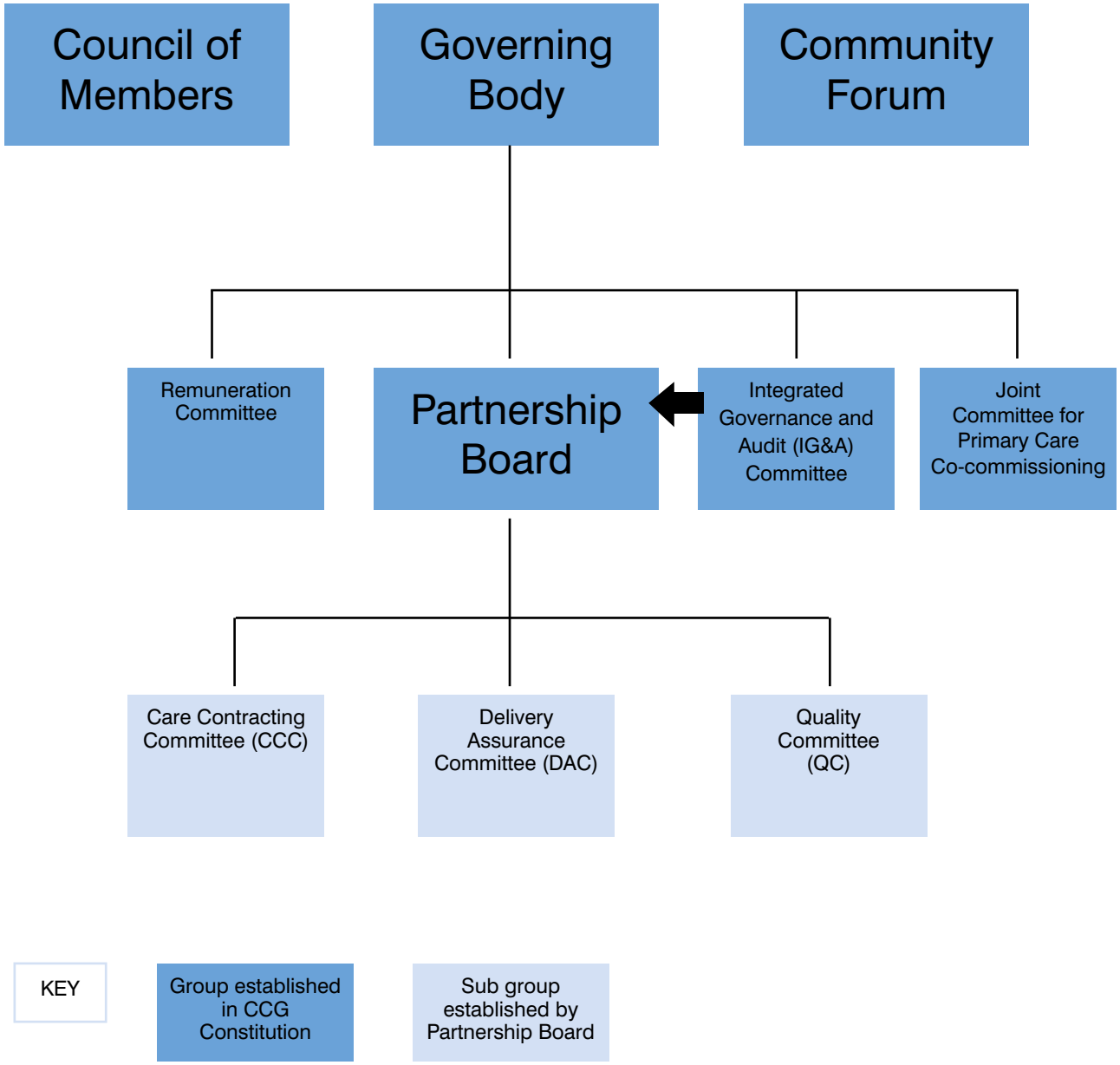
The CCG as part of its governance arrangements is required to "make arrangements for the public to be engaged. The CCG does via the Community Forum (please refer to Community Forum for full details). Community Contacts, who are drawn from the CCG's Accord membership scheme, have the opportunity to contribute to the CCG's governance arrangements through positions on Service Triangles, committees and working groups, where they sit as equal partners with health professionals to influence service improvements.

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

Figure 1: North East Lincolnshire CCG committee structure.

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

The performance dashboard within the performance report represents an overview of performance and risk for health and social care services across North East Lincolnshire. The dashboard consists of six performance and five 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 membership, attendance and activity Summary

The 2015-16 membership, attendance and activity summary of the Council of Members, Governing Body and the Governing Body committees are given below:-

Governing Body
Role and Performance Highlights 2015/16

The Governing Body has responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically.

The CCG constitution delegates many of the functions and responsibilities normally discharged by the Governing Body to the Partnership Board, and therefore the activities and assurances provided by each of these bodies need to be considered in tandem when gaining assurance about the overall governance of the organisation.

In addition to its core business the Governing Body has effectively overseen the following key areas of work (Please note: This list is not exhaustive).

Performance/highlights:

- Annual Reports & Annual Accounts (AGM)
- Ratification of its sub-committees Terms of Reference
- Annual review of the Integrated Governance & Audit Committee Assurance report
- CCG annual assurance review – Well Lead Organisation (WLO)
- Annual constitution reviews

The Governing Body met twice during 2015/16. Attendance records demonstrate that both the meetings were quorate

The Governing Body discharged its duties in full in 2015/16

Members Name	Role	Attendance (Max 2 public meetings)
Mark Webb (Chair)	CCG Chair	Attended all 2 meetings
Dr Peter Melton	Clinical Chief Officer	Attended all 2 meetings
Dr Derek Hopper	Vice CCG Chair/Chair of Council of Members	Attended all 2 meetings
Cathy Kennedy	Chief Financial Officer/Deputy Chief Executive	Attended 1 out of 2
Helen Kenyon	Deputy Chief Executive	Attended all 2 meetings
Philip Bond	Lay Member Community Engagement	Attended all 2 meetings
Dr Arun Nayyar	GP Representative	Attended 1 out of 2
Dr Rakesh Pathak	GP Representative	Attended all 2 meetings
Sue Whitehouse	Lay member for Governance & Audit	Attended all 2 meetings
Dr David James**	Secondary Care Doctor	Attended 0 out of 2
Juliette Cosgrove	Clinical Lay member	Attended 1 out of 2
Stephen Pintus	Public Health Consultant	Attended 0 out of 2
Joe Warner	Chief Executive of Focus Independent Adult Social Care Work	Attended all 2 meetings
Dr Thomas Maliyil	Vice Chair (Chair Elect) Council of Members/GP Representative	Attended all 2 meetings
Jan Haxby **	Director of Quality/Registered Strategic Nurse	Attended all 2 meetings

** denotes change in membership during this period (for details of changes, please refer to section 2.1.1.3)

Council of Members
Role and Performance Highlights 2015/16

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, throughout 2015/16 and were fully quorate at all meetings. Although all meetings where quorate there are still a small number of practices with limited engagement either by the named representative or deputy.

Performance/highlights include:

- Continual good representation by GP practices which enhances engagement between the CCG and member practices
- Review and approval of amendments to the CCG's constitution
- Members agreed the direction of travel for the Commissioning Intentions
- Members approved a number of schemes to manage rising service costs including the capping of some planned care out patient referrals to specific provider(s), and changes to the number of IVF cycles funded by the NHS in NEL
- Input into the evaluation of the following service (re)design proposals (Please note: This list is not exhaustive):
    - Children's Community Nursing Service
    - Community dermatology services
    - Ophthalmology services
    - Dermatology
    - Cardiology Outpatients
    - Support to care homes

Members Practice	Representative	Attendance (Max 12 meetings)
Dr E Amin, Weelsby View Health Centre	Dr E Amin	Attended 2 out of 12
Dr A Hussain, Weelsby View Health Centre	Dr A Hussain	Attended 1 out of 12
Roxton at Weelsby, **	Dr Reeta Singh	Attended 1 out of 12
	Dr Arun Nayyar	Attended 10 out of 12
Dr P Suresh–Babu, Weelsby View Health Centre	Dr P Suresh–Babu	Attended 0 out of 12
Beacon Medical, Primary Care Centre	Dr Laura Bernal-Gilliver	Attended 10 out of 12
Birkwood Medical Centre	Dr Karin Severin	Attended 10 out of 12
Dr B Biswas & Partner	Dr Biswas	Attended 0 out of 12
Dr Chalmers & Dr Meier	Dr Chalmers	Attended 1 out of 12
	Dr Meier	Attended 0 out of 12
Chantry Health Group	Dr A Bamgbala	Attended 2 out of 12
Chelmsford Medical Centre	Dr K N Keshri	Attended 0 out of 12
Clee Medical Centre	Dr K Sibtain	Attended 6 out of 12
R Kumar, Cromwell Primary Care Centre	Dr R Kumar	Attended 0 out of 12
Field House Medical Group	Dr D Hopper (Chair)	Attended all 12 meetings
Healing Health Centre **	Dr K Koonar	Attended 0 out of 12
	Dr T Maliyil (Vice Chair –Chair Elect)	Attended 8 out of 12
Dr Opie & Dr Spalding **	Dr H Jethwa	Attended 0 out of 12
	Dr Arun Nayyar	Attended 10 out of 12
Dr S Kumar and Partners	Dr A P Kumar	Attended 1 out of 12
Littlefield Surgery	Dr N Dukes	Attended 9 out of 12
Open Door **	Vicki Bowen	Attended 0 out of 12
	Jane Miller	Attended 1 out of 12
Raj Medical Centre	Dr R Pathak	Attended 6 out of 12

Members Practice	Representative	Attendance (Max 12 meetings)
Pelham Medical Group	Dr D Elder	Attended all 12 meetings
Humberview Surgery	Dr D Elder	Attended all 12 meetings
The Roxton Practice	Dr Arun Nayyar	Attended 10 out of 12
Cromwell Primary Care Centre	Dr A Sinha	Attended 8 out of 12
Scartho Medical Centre **	Dr T Maliyil	Attended 8 out of 12
	Dr S Allamesetty	Attended 9 out of 12
	Dr C Twomey	Attended 1 out of 12
Dr Dijoux and Partners	Dr S Dijoux	Attended 1 out of 12
Dr Singh & Dr Mathews	Dr R Mathews	Attended 1 out of 12
Woodford Medical Centre	Dr P John	Attended 2 out of 12
Dr O Z Qureshi Surgery	Dr O Qureshi	Attended 4 out of 12
Quayside Open Access **	Caroline Day	Attended 0 out of 12
	Nicole Glen	Attended 3 out of 12
Greenland Surgery & New Waltham Surgery **	Dr N Bedi	Attended 0 out of 12
	Dr J Raghwani	Attended 2 out of 12

** denotes change in membership during this period

Partnership Board
Role and Performance Highlights 2015/16

The Partnership Board is responsible for those matters delegated to it 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 2014/15. 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), the Partnership Board has effectively overseen the following key areas of work (Please note: This list is not exhaustive):

- An Update Report on Patient Experience - With the aim of continually driving improvements and the quality of services provided for the community, this update will provide information on the Patient Experience report and how it aims to collate intelligence about health and social care providers in North East Lincolnshire.
- 2015/16 Business Plan
- An outline of the objectives of the Service Triangles
- The transfer of services from the Commissioning Support Unit
- The Healthy Lives, Healthy Futures programme
- Update on Resilience Planning
- Annual Equality and Diversity Update
- Update on 16/17 Operational Plans and development of the Sustainability and Transformation Plan
- Quality of services, including standardised Hospital Mortality Index (SHMI) performance and CQC reports
- Healthy Lives, Healthy Futures programme updates and key decisions – this programme is focused on developing sustainable quality services, addressing the current significant financial and quality challenges that face the health and social care communities of NEL and NL.

Members Name	Role	Attendance (Max 6 public meetings)
Mark Webb (Chair)	CCG Chair	Attended all 6 meetings
Dr Peter Melton	Clinical Chief Officer	Attended all 6 meetings
Dr Derek Hopper	Vice CCG Chair/Chair of Council of Members	Attended 5 out of 6
Cathy Kennedy	Chief Financial Officer/Deputy Chief Executive	Attended 4 out of 6
Helen Kenyon	Deputy Chief Executive	Attended all 6 meetings
Philip Bond	Lay Member Community Engagement	Attended all 6 meetings
Dr Arun Nayyar	GP Representative	Attended 5 out of 6
Dr Rakesh Pathak	GP Representative	Attended 5 out of 6
Sue Whitehouse	Lay member for Governance & Audit	Attended all 6 meetings
Dr David James **	Secondary Care Doctor	Attended 3 out of 6
Juliette Cosgrove	Clinical Lay member	Attended 4 out of 6
Stephen Pintus	Public Health Consultant	Attended 2 out of 6
Joe Warner	Chief Executive of Focus Independent Adult Social Care Work	Attended 4 out of 6
Dr Thomas Maliyil	Vice Chair (Chair Elect) Council of Members/GP Representative	Attended 4 out of 6
Jan Haxby **	Director of Quality/Registered Strategic Nurse	Attended 4 out of 6
Nicky Hull **	NEL Primary Care (Non GP) Member	Attended 5 out of 6
Cllr Michael Burnett **	NELC Representative	Attended 0 out of 6
Cllr Jane Hyldon – King**	NELC Representative	Attended 3 out of 6
Cllr Matthew Patrick **	NELC Representative	Attended 3 out of 6

** denotes change in membership during this period (for details of changes, please refer to section 2.1.1.3)

Community Forum

Role and Performance Highlights 2015/16

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 2015/16. Meetings are always well-attended and minutes demonstrate that each meeting was quorate.

The strategic aims of the Forum continue to be:

- To work effectively as part of the CCG governance arrangements, supporting delivery of its business and priorities
- To actively support the implementation of the CCG's strategic aims for public engagement (Engagement Strategy)
- To work pro-actively with the Voluntary, Community and Social Enterprise (VCSE) sector and wider community to cascade and receive information
- To continue to develop the skills and knowledge of members to ensure quality and resilience

In January 2016 the meeting was dedicated to a 'So What?' session which sought to reflect upon and challenge progress against the Forum's Action Plan.

Collectively the Forum highlights for 2015/16 include:

- Collaborated with the Partnership Board and Council of Members in strategic workshops to develop priorities and sustainability plans
- Considered and commented on key commissioning plans and policies including the Adult Society Care, Primary Care and Engagement Strategies, Commissioning Intentions, Care Act, Gluten-free food prescriptions, Patient Transport Services, Social Prescribing and the development of Accountable Care organisation options for North East Lincolnshire
- Developed and delivered 'Healthy Conversations' a networking event to develop links and with the voluntary, community and social enterprise sector
- Reviewed Forum Terms of Reference to address succession planning

Individually through participation in service triangles, committees and working groups members highlights include:

- Participated in the planning and development of the Paediatric Community Nursing Service and the children's phlebotomy service in the community
- Development of plans to reduce use of antibiotic prescribing; reduce medicine waste and promote cost effective initiatives
- Procurement of Advocacy Services for vulnerable people
- Extra-care Housing Project including Allocation Panel
- Involvement in redesign of service in A & E to include GP triage availability
- Supporting engagement to inform the Dementia Vision and forward plan
- Recruitment and interview panels for key roles such as PPI Lay member candidates and Single Point of Access (SPA) manager
- Participation in multi-agency initiatives such as the Health and Wellbeing Board joint operational group, the SPA Steering Group and Alliance Board, the Preventative Board and Releasing Community Capacity board, North East Lincolnshire Mortality Steering Group, Good Neighbours Partnership, Cancer Collaborative, Systems Resilience Group
- Participation in cross-area planning such as the Area Prescribing Committee and Maternity Service review
- Contributing to the design and implementation of an Online Tool for Adults with Diabetes
- Mentoring of new Forum members
- Review, revision and monitoring of CCG equality impact assessments
- Recruitment event for the Care sector
- Development of easy read literature and review of CCG public-facing documents

Members Name	Role	Attendance (Max 12 Meetings)
Anne Hames (Chair)	Community Forum Chair	Attended all12 Meetings
Geoff Allen **	ACCORD Lay Member representative	Attended 6 out of 12 meetings
April Baker	Community Forum Representative	Attended 11 out of 12 meetings
Albert Bennett	Lay Community Lead Older People's Service Triangle	Attended 10 out of 12 meetings
Philip Bond	Lay Member Community Engagement	Attended all12 Meetings
Christine Foreman	Lay Community Lead Community Care Service Triangle	Attended 11 out of 12 meetings
Bernard Henry	Community Forum Member	Attended 9 out of 12 meetings
Margaret Henry	Lay Community Lead Prescribing Service Triangle	Attended 9 out of 12 meetings
Pam Taylor	Lay Community Lead Women & Children's Service Triangle	Attended 9 out of 12 meetings
Wendy Wood	Lay Community Lead Representative Council of Members	Attended 10 out of 12 meetings
Terrence Simco	Lay Community Lead Planned Care Triangle	Attended 11 out of 12 meetings
David McGuire **	Lay Community Lead Disability & Mental Health Service Triangle	Attended 6 out of 12 meetings
Barry Osborne **	Lay Community Lead Disability & Mental Health Service Triangle	Attended 6 out of 12 meetings
Christine Wallis **	Primary Care Community Member	Attended 8 out of 12 meetings
Cathy Kennedy	Chief Financial Officer/Deputy Chief Executive	Attended 6 out of 12 meetings
Sally Czabanuik	NELCCG Engagement Manager	Attended 11 out of 12 meetings
Diane Edmonds	Community Forum Member	Attended 10 out of 12 meetings
Roy Rufus-Isaacs	Community Forum Member	Attended all12 Meetings

** denotes change in membership during this period

Integrated Governance & Audit Committee
Role and Performance Highlights 2015/16

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 2015/16. Attendance records demonstrate that each meeting was quorate.

Performance/highlights include (Please note: This list is not exhaustive):

- 100% compliance with the Audit Committee handbooks best practice "must do's" & "should do's"
- Delivery of the Committees Annual work plan
- Assurance monitoring of the steps being taken to reduce the overall level of Adult Social Debt

Members Name	Role	Attendance (Max 12 Meetings)
Susan Whitehouse (Chair)	Lay member for Governance & Audit	Attended all 5 meetings
Joe Warner	Partnership board lay member	Attended all 5 meetings
Cllr Mathew Patrick **	Partnership board lay member	Attended 3 out of 5 meetings
Dr Karin Severin	GP Member	Attended 2 out of 5 meetings
Philip Bond **	Governing Body lay member	Attended 0 out of 5 meetings
Cllr Michael Burnett **	Partnership board lay member	Attended 0 out of 5 meetings

** denotes change in membership during this period (for details of changes, please refer to section 2.1.1.3)

Joint Committee for Primary Care Co-commissioning
Role and Performance Highlights 2015/16

The Joint Co-Commissioning Committee was established in 2015 with the primary purpose of jointly commissioning primary medical services (services provided by general practitioners) for the people of North East Lincolnshire. Its membership is drawn from North East Lincolnshire Clinical Commissioning Group (NEL CCG), NHS England (Yorkshire and Humber sub-region), and North East Lincolnshire Council (NELC), as all of these organisations are responsible for commissioning different elements of services from primary medical service providers within North East Lincolnshire.

The purpose of having these joint arrangements is so that each of the organisations that are responsible for commissioning such services can discuss and take decisions about those services together. The aim is to ensure that one organisation does not take a decision that adversely affects any of the others, and that the services are planned in a way that meets local need, fits with future service strategy and is affordable within the resources that are available.

Membership of the Committee includes lay representatives, GPs, Director of Public Health and Executive Officers of the CCG and NHS England. We also invite representatives from the local Healthwatch organisation and the Local Medical Committee (LMC, a representative committee of NHS GPs that represents their interests in their localities to the NHS health authorities) to sit in on our Committee, although they do not have voting rights when decisions are taken.

Five meetings of the Committee were held during 2015/16 and the attendance records demonstrate that each meeting was quorate. These meetings are also open for members of the public to observe, and the dates of the meetings are advertised on the CCG's website.

Performance/Highlights include

As this is a relatively new Committee, it is still in its early days. However, the Committee has overseen a number of pieces of work and has made a number of decisions over the past year in relation to local services. These include:

- Agreed funding to support recruitment of doctors to the local area
- Implemented new joint commissioning arrangements between the CCG and the local Council for local Substance Misuse Services
- Made decisions regarding amendments to individual GP's contracts (at their request) to allow them to take additional doctors on to their contract arrangements, to support the future viability of the practice
- Made plans to bring together previously separate contracts and commission the services as one in future
- Agreed investment for services within GP services in the coming year, e.g. Phlebotomy (blood taking) and supporting the most vulnerable and elderly patients more effectively
- Received update reports on the progress of local projects, such as the pilot being undertaken by 10 local Practices to test out new ways of accessing general practice services across 7 days. These pilots will help to shape future commissioning arrangements and the decisions that the Committee will make about future investment in these services.

The Committee has also had to take some difficult decisions, such as a small number of Practice requests to close their lists to new patients temporarily. The requests are usually made because the practice has a lot of vacancies or have had a large number of patients that have recently requested to register. It is not easy to take these kinds of decisions, because the Committee has to balance the needs of the local population against the need to protect the safety of services and the welfare of the staff. However, these requests have been very small in number, and the closure periods have all been 6 months or less.

The working arrangements for the Co-Commissioning Committee have recently been audited by our internal audit team and they have rated the Committee as green, which means there is significant assurance.

The Committee has an agreed workplan for the coming year and it will continue its work on supporting the development and improvement of local primary medical services.

Members Name	Role	Attendance (Max 5 meetings)
Mark Webb (Chair)	CCG Chair	Attended 4 out of 5 meetings
Cathy Kennedy	Chief Financial Officer/Deputy Chief Executive	Attended 3 out of 5 meetings
Dr Derek Hopper	Chair of Council of Members	Attended 4 out of 5 meetings
Dr Thomas Maliyil	GP Clinical Lead for Primary Care	Attended 5 out of 5 meetings
Zena Robertson **	NHS England Representative	Attended 3 out of 5 meetings
Geoff Day	NHS England Representative	Attended 3 out of 5 meetings
Stephen Pintus	Director of Public Health	Attended 4 out of 5 meetings
Cllr Jane Hyldon-King	NELC representative	Attended 4 out of 5 meetings
Christine Wallis **	Community Lay Member	Attended 3 out of 5 meetings

** denotes change in membership during this period (for details of changes, please refer to section 2.1.1.3)

Remuneration Committee
Role and Performance Highlights 2015/16

The Remuneration Committee, on behalf of the Governing Body, makes recommendations on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the CCG, and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme. They also agree the remuneration and terms of service of the Partnership Board Lay Members.

The Remuneration Committee met once throughout 2014/15. Attendance records demonstrate that each meeting was quorate.

Performance/highlights:

Review of remuneration and terms of service/reference for the following:

- Very Senior Managers
- Governing Body & Partnership Board Members
- Clinical leads
- Review of the Lease Car / Salary Sacrifice scheme for all CCG employees.

Members – Remuneration Committee
Please refer to section 2.2.1 for details of attendance

The Clinical Commissioning Group Risk Management Framework

The CCG's Risk Management Strategy sets out our risk management process on how to manage risks effectively, by practical means of identifying risk, asses and evaluate through control mechanisms to eliminate/reduce the risk. The strategy also sets out accountability arrangements for risk management, including roles & responsibilities. The Strategy was reviewed and updated in June 2015. Changes to the strategy include definitions for the Assurance Framework and Risk Register, describing the mechanism for reviewing static risks, annual reviews including training and closure of risks.

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

The CCG has a mechanism for monitoring static risks, for example if the risk rating of a risk hasn't changed for the last four quarters, this is reviewed to assist whether the risk remains relevant if so what actions will be taken.

To support the Partnership Board in carrying out its duties effectively the Integrated Governance & Audit Committee monitors the risk register and assurance framework at each of its meetings, which ensures robust and adequate progression of the risks are kept live and relevant. This is an on-going process and Integrated Governance & Audit Committee informs the Partnership Board of any developments/concerns.

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

- Review of the risk register and assurance framework at the monthly Service Leads meeting which ensures that the process is kept live and relevant.
- Openly encouraging staff to report any concerns through the incident reporting process and each incident is reviewed and investigated as applicable.
- The Senior Information Risk Owner (SIRO) to who supports our arrangements for managing and controlling risks relating to information/data security.
- Involvement of Public Stakeholders in managing risks, this is done, through lay membership of the CCG's Committee's (as per table above). These measures are in place to ensure that CCG decision making processes are transparent, to ensure that community engagement continues to be embedded in this process and, ultimately, to provide further assure the organisation.

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

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

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of North East Lincolnshire Clinical Commissioning Group
- Evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically.

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

1) Conflict of Interests

The CCG has the following systems & processes in place to ensure conflicts of interest are declared, mitigated, and proactively managed

- Maintaining and reviewing a Register of Declarations of Interest on an on-going basis
- Managing membership of formal committee and decision making bodies supporting the CCG
- Clear meeting and decision making procedures, for meeting chairs, members and the administration support
- Working within the Constitution, Standing Orders and Scheme of Reservations and Delegations

2) Counter fraud

The Integrated Governance and Audit Committee has assured itself that the organisation has adequate arrangements in place for countering fraud and regularly reviews the outcomes of counter fraud work. There is an approved risk based counter-fraud plan in place which is monitored at each IG&A committee meeting. In line with NHS Protect Commissioner Standards, which became effective 1st April 2015, the CCG completed an online survey in July 2015 to assess the work completed around anti-fraud, bribery and corruption. This self-assessment (SRT) - detailing our scoring was approved by Chief Finance Officer prior to submission.

3) Others

- Human Resources (HR) policies (refer to section 2.2.6 for further details)
- Service Proposal Management Tool (refer to page 65 for further details)
- Data Security Risks (refer to page 69 for further details)
- Performance dashboard (refer section 1.2 for further details)
- Emergency Preparedness (refer to section 2.1.2 for further details)

Each risk is reviewed at least quarterly (15+ monthly) by the risk assignee, and six monthly by the risk manager. Risks are forwarded to the individuals requesting review and update of their risks. The review/update should pay particular attention to any additional controls or assurance which could impact on the risk ratings and therefore must reconsider any changes to risk ratings, and a progress update. Risks which are deemed to have reached their target risk rating and are no longer a threat to the CCG are only closed, once approval has been agreed by the manager accountable for the risk.

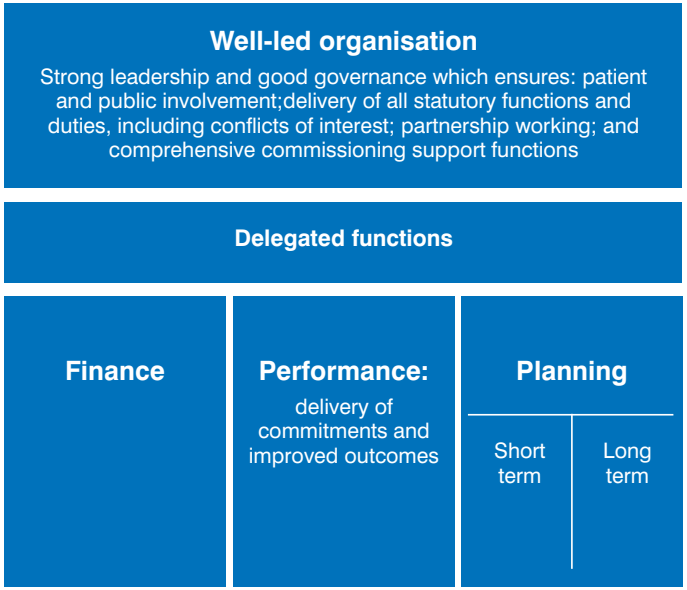
Regular risk reports are taken to the Integrated Governance and Audit Committee and the Delivery Assurance Committee to provide assurance that risks are being appropriately identified and managed.

Risk Assessment

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

The CCG Board Assurance Framework provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives.

All risks on both the CCG Board Assurance Framework and Risk Register have been allocated to the components of the NHS England new CCG assurance framework for 2015/16. It consists of the following components:



Component 1 - Well-led organisation	The CCG has strong leadership and good governance which ensures: patient and public involvement; delivery of all statutory functions and duties, including conflicts of interest; partnership working; and comprehensive commissioning support functions. or The CCG has strong and robust leadership; robust governance arrangements; involves and engages patients and the public actively; works in partnership with others, including other CCGs; secures the range of skills and capabilities it requires to deliver all of its commissioning functions, using support functions effectively, and getting the best value for money; and has effective systems in place to ensure compliance with its statutory functions.
Component 2 - Performance: delivery of commitments and improved outcomes	The CCG is delivering improved services, maintaining and improving quality, and ensuring better outcomes for patients. This includes progress in delivering key Mandate requirements and NHS Constitution standards plus safeguarding and digital record keeping and transfers of care.
Component 3 - Financial management	The CCG is delivering financial management capability and performance throughout the year, including an assessment of data quality and contractual enforcement.
Component 4 - Planning	Assurance of the CCG's plans including annual operational plans and related plans such as those relating to System Resilience Groups and the Better Care Fund, but also longer term strategic plans, including progress with the implementation of the Forward View. Progress towards moving secondary care providers from paper-based to digital processes and the extent to which the NHS Number and discharge summaries are being transferred digitally across care settings.
Component 5 - Delegated functions	Delegated functions including primary care. An annual review of the assurance for delegated functions will be required prior to the NHS England business planning process for 2016/17. This is in addition to the assurance needed for out of hours Primary Medical Services.

The CCG's board assurance framework includes details of gaps in control, gaps in assurance and the actions developed to reduce the gaps. The framework contains the organisation's strategic risks, and compliance with the CCG licence are captured in the Board Assurance Framework

The Delivery Assurance Committee and Integrated Governance & Audit Committee duties include ensuring that effective monitoring and review in relation to performance and risks are carried out; this is done by way of regular reporting to each committee. Any significant issues are escalated to the Partnership Board. The Partnership Board receives, on a bi-monthly basis, the CCG integrated assurance report, which provides assurance to the Board of how the CCG is performing against the domains developed for the dashboard with regard to its performance measures and risk.

The CCG will continue to develop its board assurance framework in 2016/17 in line with the latest guidance for CCG Assurance Framework 2016/17.

During the period 20 March 2015 to 20 March 2016, the risk register had nine risks which were closed and six new risks were identified. The board assurance framework had two new risk and two risks closed in the same period. The total number of risks on the risk register as at 20 March 2016 was 29 (March 2015 = 32). The total number of risks on the assurance framework as at 20 March 2016 was 12 (March 2015 = 12)

The tables opposite show the current residual risk ratings for the board assurance framework and risk register as at 20 March 2015 and 20 March 2016

March 2015

Board Assurance Framework

	20 Mar 15
Total number of risks	12
High level risks (rated at 15+)	2
Medium to high level risks (rated at 12+)	3
Low to medium level risks (rated at 9+),	3
Low level risks (rated at 3+)	4

Risk Register

	20 Mar 15
Total number of risks	32
High level risks (rated at 15+)	3
Medium to high level risks (rated at 12+)	9
Low to medium level risks (rated at 9+),	8
Low level risks (rated at 3+)	12

March 2016

Board Assurance Framework

	20 Mar 16
Total number of risks	12
High level risks (rated at 15+)	4
Medium to high level risks (rated at 12+)	2
Low to medium level risks (rated at 9+),	2
Low level risks (rated at 3+)	4

Risk Register

	20 Mar 16
Total number of risks	29
High level risks (rated at 15+)	5
Medium to high level risks (rated at 12+)	7
Low to medium level risks (rated at 9+),	6
Low level risks (rated at 3+)	11

The North East Lincolnshire CCG principal risks (that is a risk rating of 15 and above) identified in the board assurance framework and risk register as at 20 March 2016 are:

Board Assurance Framework

No.	Risk	Current risk rating	Actions taken to mitigate the risks
1	CCGAF2002 Summary Hospital Mortality Indicator (SHMI) Organisational Risk	16	Northern Lincolnshire Mortality Stakeholder Group continues to oversee the release of information into the public domain and to oversee the delivery of the Communication Protocol to support both organisations to communicate when SHMI data or other mortality data/information is published Progress monitored via the NL&G Contract management Board and NELCCG Quality Committee
2	CCGAF3001 Instability in partnership finances or services/costs leads to unaffordable consequences for members of the health care system	16	NELC flagging that their 3 year financial plan has an unresolved gap which may require additional savings in ASC to be identified - regular meetings for Executive Directors for CCG/LA in place to monitor position. Efficiency plans established for £9million savings, approved by CCG and NELC in principle. Delivery and risks being monitored jointly at Partnership Operational Group, reported to QiPP monitoring (and hence DAC) as and when required.
3	CCGAF3002 Financial challenges	20	The IG&A committee assures management of financial risk Regular meetings for Executive Directors for CCG/LA to monitor position. HLHF programme arrangements include Memorandum of Understanding including a collective risk management approach
4	CCGAF4001 Risk that Healthy Lives, Healthy Futures will not deliver the quality and financial sustainability outcomes in the requisite timeframe	16	PWC have provided assistance to the programme in assuring plans and identifying remaining gaps. They have also provided (March 2015) a modelling tool which will assist in planning future service redesign. HLHF Programme Board oversees the programme's activity, including a weekly operational group which ensures pace and accountability for programme work. Governance framework provided by HLHF programme board, engagement core group and assurance sub group in place. The Programme Board reviews the programme risk log on a monthly basis

Risk Register

No.	Risk	Current risk rating	Actions taken to mitigate the risks
1	CCG2001 Failure to achieve Accident and Emergency 4 hour targets	20	Commissioning weekly monitoring of performance. The System Resilience Group, with Commissioner & Provider membership, has a primary purpose in the monitoring and resilience of the A&E 4 hour performance. Action Plans focussing on all issues with potential impact on 4 hour A&E wait performance.
2	CCG2002 On-going failure to meet Clinical Handover time targets for EMAS patient delivery at DPoW A&E	20	Moving from monitoring only to action planning Performance is monitored by the Urgent Care Board.
3	CCG3005 Failure to meet residential and domiciliary care admission targets	20	Activity is monitored by the Delivery and Assurance Committee. Expenditure scrutiny and control through the risk and quality panel Internal controls within focus CIC are key however to creating the right culture and risk management approaches.
4	CCG3008 Adult ADHD Pathway breakdown and remodelling	16	Mitigations: multiagency ADHD workgroup generated, new model service proposed, Shared Care guidance being developed, regular reports to Council of Members (CoM)
5	CCG4006 The new Safeguarding Adults arrangements are unable to cope with the increasing number of referrals	20	Safeguarding Adults Operational Group, Safeguarding Adults Leadership Group and via formal contract monitoring arrangements between NELCCG and focus. The risks are monitored as part of the strategic plan and reviewed on a regular basis by the Chair and Deputy Chair of the Safeguarding Adults Board

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

The Clinical Commissioning Group Internal Control Framework

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

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

The system of internal control within the CCG is based on an on-going process designed to identify and prioritise the risks. It is frequently the case that whilst the impact of the risk may remain the same as the original raw assessment, successful mitigating actions/internal controls will reduce the likelihood of the risk occurring. The system has been in place in the CCG for the year ending 31 March 2016 and up to the date of approval of the Annual Report and Accounts.

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertakes annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. All our Information Governance suite of policies and procedures have been reviewed and are up to date, and staff have been made aware of these via a communications briefing. All our policies and procedures can be found on our CCG intranet.

There are processes in place for incident reporting and investigation of serious incidents. Data security incidents are reported via the CCG's incident reporting system and notified to the Information Governance Manager for investigation.

We are developing training programme for information asset owners and administers, together with records management training. This on-going work enables assurance to be provided that all such flows of data are fair, lawful and secure. It also ensures that adequate technical and operational measures are in place to secure any transfers of data.

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

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

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

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

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

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

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

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

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

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

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

The CCG publishes details of all contracts, including the value of the contract, as soon as contracts are agreed. Where the CCG decides to commission services through a provider framework, the type of services commissioned and the agreed price for each service will also be published. The information can be found on the **CCG website**

Feedback from delegated chains regarding business, use of resources and responses to risk

The CCG receives assurance regarding business, use of resources and responses to risk of delegated chains via a number of routes, namely:-

- External assurances via Service Auditor Reports (further details can be found in review of effectiveness section
- Internal Audit work
- Routine monitoring of the contracts we have in place throughout the year

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 Clinical Commissioning Group

Capacity to Handle Risk

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

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

The Integrated Governance and Audit Committee are responsible for:-

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

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

- Delivery Assurance Committee - responsible for overseeing the continuous development of the organisations internal performance and delivery assurance framework, encompassing balanced scorecard and exception reporting. The committee provides delivery assurance to the CCG Partnership Board that there are robust structures, processes and accountabilities in place for managing performance and delivery throughout the organisation.
- Quality Committee - responsible for overseeing and providing assurance on the clinical governance arrangements in commissioned services and ensuring that arrangements are in place to deliver governance and statutory requirements as identified by the Governing Body as being within the remit of the Committee.
- Service Leads Meeting - operational forum to raise awareness of and discuss matters relating to each service area. The meeting takes place every month and is attended by all Service Leads. Risk is a standing item at this meeting.

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

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

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

As part of our Corporate Governance Framework, the CCG has assessed the risks facing it and has ensured internal control/mitigation's are in place to manage those risks. A risk survey was circulated to staff band 4 and above, so that we can assess the level of risk awareness throughout the CCG. 28 out of 68 staff completed the survey, which equates to 41%. We are currently in the process of analysing the data, and we look to produce an action plan for development in 2016/17.

Review of Effectiveness

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

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

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

On carrying out my review I have drawn assurance from the following:-

- The assessment of the CCG undertaken by NHS England via the quarterly assurance meetings.
- NELCCG's self-assessment against the '**Well-led organisation**' domain of the CCG Assurance Framework 2015/16. This shows the organisations assurance against the key indicators within this component of the framework, with any gaps in assurance and any mitigating actions. NELCCG's overall assurance assessment for this element is '**good**' and based on the CCG Assurance Framework for this category it may be that some support may be required for specific issues but it is acknowledged that overall the CCG is well led and in good organisational health.
- The CCG Assurance Framework 2015/16 - Delegated Functions – Quarterly Self-certifications. This is to provide assurance of progress against the five key areas in the framework i.e. outcomes, governance and the management of potential conflicts of interest, procurement, and expiry of contracts and availability of services. The self-certification supports NHS England's assurance assessments of CCGs however its assessments will not be determined solely by it. This recognises there are a number of sources of additional primary care data and information that may be prioritised and considered locally (e.g. local plans, performance against GP High Level Indicators, OOH National Quality Requirements etc.)
- Internal Audit reviews of systems of internal control and progress reports to the Integrated Governance & Audit Committee.
- External Audit providing progress reports to the Integrated Governance and Audit Committee, the Annual Management Letter and their annual value for money conclusion
- Assurance received from the Integrated Governance & Audit Committee, on the CCG's governance, risk management and internal controls. Review of the board 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 board assurance framework and the Risk Register capturing key risks across the spectrum of corporate governance.
- A self-assessment undertaken by the Integrated Governance & Audit Committee to ensure adherence to the principles contained within the NHS Audit Committee Handbook.
- A self-assessment of Financial Governance & Control Environment. The initial assessment has scored the CCG as either Excellent or Good with the exception of two areas (Commissioning Support and In-year financial position) rated as Moderate.
- Annual reviews of Governing Body and Partnership Board committees/sub-committees.
- Performance management systems.
- Internal Committee structure with delegated responsibility for risk identification, evaluation, control, review and assurance.
- The CCG Strategy which captures clear clinical priorities, QIPP (Quality, Innovation, Productivity & Prevention) priorities and key risks.
- The results of staff and stakeholders surveys.

The integrated governance & audit annual report, was presented to the Governing Body on 10 March 2016, detailing the outcomes of the review of the effectiveness of the committee. The report assured the members of the effective governance arrangements of the organisation, and specifically that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the groups principals of good governance.

During 2015/16 the CCG contracted with a number of external organisations for the provision of support services; the largest of these arrangements was with Yorkshire and Humber Commissioning Support who provided a wide range of services to North East Lincolnshire CCG and to other NHS commissioning organisations.

However, Yorkshire and Humber Commissioning Support (YHCS) were unsuccessful in their bid to gain a place on the lead provider framework and as such cease to exist, as a provider of commissioning support service from April 2016. The CCG reviewed all the services that it acquired from YHCS, to determine whether going forward we would **do, share or buy** them.

With effect from 1 December 2015 the following services were either brought back in house or shared with other CCG's.

- Risk (brought back in house)
- Shared services with other CCG's - (FOI/Quality Team/ Communications & Engagement /Programme management office)

With effect from 1 March 2016, the following services were provided by North East Commissioning Support (NECS).

- Medicines Management
- Individual Funding Request (IFR)
- Non Contract Activity Support, and
- Data Services for Commissioning Regional Offices (DSCRO) support.

All other services previously provided by YHCS will transfer to eMBED.

The CCG has received a report on Internal Controls, North Yorkshire & Humber Finance and Payroll (Type II) from YHCS independent auditors (Deloittes) covering the period 1 October 2015 to 31 January 2016.

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

Assurances for other bought-in support services have either been attained via an annual Service Auditor Report, or the CCG's internal audit work programme.

I have been advised that adequate assurances have been provided for 2015/16 for the services bought by the CCG.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the Clinical Commissioning Group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the Clinical Commissioning Group's systems 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: in relation Quality Innovation Productivity and Prevention (QIPP).

During the year internal audit issued audit reports which identified governance, risk management and/or control issues which were significant to the organisation.

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

- **Quality Innovation Productivity and Prevention (QIPP)**

Limited assurance can be provided as a result of this review that adequate and effective procedures are in place; although a suitable framework is in place for the management of the QIPP programme and some areas of good practice were identified, the overall programme is not being achieved and there are several areas of weakness that have been identified where action is required to support and strengthen the arrangements currently in place, most notably:

- Not all projects had an adequate supporting business case.
- Not all project leads had provided the CCG with monitoring reports.
- One project lead stated that they had only recently become aware that their project was part of the QIPP, which had a savings target attached but had did not have any agreed KPIs.
- The lines of accountability for projects are not always clear.

Key actions agreed:-

- Business cases will be prepared for all new projects with effect from March 2016
- All project leads to provide regular updates to the QIPP group. Remedial action plans will be put in place as required and progress monitored and reported to the QIPP group, with effect from March 2016
- Clear KPI's to be agreed and communicated to project leads to monitor project performance. This will included clear details of the savings expectations with effect from March 2016.
- The processes for effectively measuring, extracting and analysing key activity data are to be developed and enhanced using funding recently awarded

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

Data Quality

The CCG has robust processes and governance arrangements in place to ensure that the quality of data used by Council of Members, Governing Body, Partnership Board and sub-committees is accurate and fit for purpose. Members are aware of the importance of maintaining high standards of information governance and securing confidentiality of patients.

The CCG, in line with its annual Information Governance toolkit requirements has produced and maintains an Information Asset Register which identifies business critical models and their asset owners in the organisation. The Senior Information Risk Owner (SIRO) has nominated Information Asset Owners covering all areas of the organisation. The SIRO and Caldicott Guardian have responsibility for data as part of the overall model including quality assurance. Data Flow mapping has also been conducted which enables an understanding of the flows of information related to these key business critical models to be identified, and Information Asset Owners are responsible for all quality checking of these processes which informs key decision making.

The CCG received support from Yorkshire & Humber Commissioning Support for specialist advice and training for information governance issues. Yorkshire & Humber Commissioning Support has in place internal procedures and controls in order to ensure data presented is of the best quality possible. Any data issues noted in source data is reviewed and identified with the source provider.

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

Our internal auditors independently assessed our compliance with the Information Governance Toolkit. The audit was conducting in two phases, initial audit in January 2016, with final audit February 2016. The objective was to review and assess valid evidence had been provided to support recommended level of compliance. Internal Audit was able to provide significant assurance that evidence uploaded to the CCG's Toolkit demonstrated that level 2, compliance had been achieved.

The CCG worked in partnership with the Yorkshire & Humber Commissioning Support to oversee management of personal and sensitive data; this was managed as part of the Information Governance Toolkit. The Information Governance Team within the Commissioning Support Service had completed a comprehensive data mapping exercise to collect and analyse information flows within the CCG. This work was conducted with the aim of identifying and recording information assets so that Information Asset Owners could be assigned and risks could be assessed. This work will continue to be developed for 2016/17 to ensure we capture any new or changes to Information Asset Owners.

One minor incident of data loss was reported during 2015/16. The incident involved the access management to folders containing staff employment data. A staff member was incorrectly added to a group that allowed access. The staff member reported this and the access was revoked. This was classed as a near miss given there was the potential for inappropriate access. The IMT provider has acknowledged the incident and has amended its operating processes accordingly.

The incident has now been closed with no external reporting required.

From 2016-17 the Information Governance Team will move to their new provider (eMBED) and the CCG will continue to work in partnership with the team to oversee the management of personal and sensitive data.

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, the CCG has reviewed and undertaken a self-assessment on all the statutory duties conferred on it by the National Health Service Act 2006 (as amended). The self-assessment noted evidence of compliance within each statutory duty. Compliance with statutory functions was monitored by the Integrated Governance & Audit Committee throughout the year. Work continues within the CCG to continue to monitor statutory duties, and where necessary address any gaps.

The CCG has established and maintained a range of information governance, human resources and other corporate policies in place to support the delivery of its statutory functions and underpin the requirements of the CCG Constitution. A programme is in place to review these policies and adapt them, as necessary, this piece of work will continue throughout 2016/17.

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.

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 2015/16, one area for improvement. Please refer to **Head of Internal Audit** section of this report for full details.

Signature

Dr Peter Melton
Accountable Officer

Date

2.2 Remuneration & Staff Report

2.2.1 Remuneration Committee Members

The Remuneration Committee is a formal sub-committee of the Governing Body whose members were appointed by the Governing Body. In 2015/16, members and attendees were:

Voting Members:		
Name	**Role**	**Attendance (Max 1 meeting)**
Mark Webb (Chair)	CCG Chair	Attended meeting
Sue Whitehouse	Lay member for Governance & Audit	Attendance (0 out of 1 meeting)
Dr Derek Hopper	Chair of Council of Members / Governing Body member	Attended meeting
Dr David Elder	Council of Members GP Representative	Attended meeting
Councilor Matthew Patrick (joined December 2015)	Portfolio Holder for Finance and Resources, North East Lincolnshire Council	Attendance (0 out of 1 meeting)
Other attendees:		
Cathy Kennedy, *	Chief Financial Officer/ Deputy Chief Executive	Attended meeting
Emma Kirkwood **	Human Resources Business Partner, Commissioning Support	Attended meeting

The remuneration committee met once cross the financial year to address agenda requirements, at all times the process followed good principles of governance with special reference to conflicts of interest and the requirements of the terms of reference. The meeting was quorate.

* attends to present papers from the CCG ** attends to advise the panel on HR implications

Senior managers' contracts and payments –

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

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

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

2.2.2 Salaries & Allowances

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

2015-16 Name and Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term Performance pay and bonuses (bands of £5,000)	(e) All pension related benefits (bands of £2,500)	(f) Total (a-e) (bands of £5,000)
	£'000	£'000	£'000	£'000	£'000	£'000
Dr Peter Melton, Clinical Chief Officer	85-90					85-90
Cathy Kennedy, Deputy Chief Executive / Chief Financial Officer	100-105		0.0-5.0		12.5-15.0	120-125
Helen Kenyon, Deputy Chief Executive	95-100				40.0-42.5	135-140
Jan Haxby, Director of Quality and Nursing (Started Jul15)	55-60				72.5-75.0	130-135
Mark Webb, CCG Chair	20-25					20-25
Dr Derek Hopper, Vice CCG Chair & Chair of Council of Members	5-10					5-10
Philip Bond, Lay Member Community Engagement	5-10					5-10
Dr Arun Nayyar, GP Representative	5-10				5.0-7.5	15-20
Dr Rakesh Pathek, GP Representative	5-10				2.5-5.0	10-15
Cllr Michael Burnett, Portfolio Holder for Tourism & Culture NELC (Deceased)	0-5					0-5
Susan Whitehouse, Lay Member Governance & Audit	10-15					10-15
Cllr Matthew Patrick, Portfolio Holder for Finance and Resources NELC (started May15)	5-10				0.0-2.5	5-10
Cllr Jane Hyldon-King, Portfolio Holder for Health, Wellbeing and Adult Social Care NELC (started July 15)	5-10				0.0-2.5	5-10
Dr Thomas Maliyil, GP Representative	10-15				52.5-55.0	65-70
Nicky Chatterton, (known as Nicky Hull) NEL Primary Care (non GP) Member (Started April 15)	0-5					0-5
Dr D James, Secondary Care Doctor (started Nov 15)	5-10					5-10
Juliette Cosgrove, Strategic Nurse	5-10					5-10
Jo Warner, Partnership Board Social Care Representative	0					0
Stephen Pintus, Director of Public Health	0					0

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

2.2.3 Pension Benefits

It is important to note that the pension benefit figures for the GPs relate to their non-practitioner employment only and the pensionable pay figure is grossed up to reflect a whole time equivalent post. The pension data used in these calculations has been provided by the Business Services Authority. Whilst this will include, 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.

The CCG hasn't made any payments in respect of compensation on early retirement, the loss of office, or payments to past directors.

Name and Title	(a) Real increase in pension at age 60 (bands of £2,500)	(b) Real increase in pension lump sum at aged 60 (bands of £2,500)	(c) Total accrued pension at age 60 at 31 march 2015 (bands of £5,000)	(d) Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2014	(f) Real increase in cash Equvalent transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2015	(h) Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cathy Kennedy, Deputy Chief Executive / Chief Financial Officer	0.0-2.5	2.5-5.0	35-40	115-120	675	29	712	
Helen Kenyon, Deputy Chief Executive	2.5-5.0	0.0-2.5	30-35	90-95	441	32	479	
Jan Haxby, Director of Quality and Nursing	2.5-5.0	12.5-15.0	25-30	85-90	436	106	517	
Dr Arun Nayyar, GP Representative	0.0-2.5	0.0-2.5	10-15	30-35	173	20	195	
Dr Rakesh Pathak, GP Representative	0.0-2.5	0.0-2.5	05-10	25-30	119	2	123	
Dr Thomas Maliyil, GP Representative	2.5-5.0	0.0-2.5	10-15	30-35	156	26	184	
Jane Hyldon-King	0.0-2.5	0	0-5	0	0	0	0	
Matthew Patrick	0.0-2.5	0	0-5	0	0	0	0	

2.2.4 Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

2.2.4.1 Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the state and end of the period.

2.2.5 Pay Multiples

Year	2015/16	2014/15
Band of highest paid directors' total remuneration (£'000)	120-125	120-125
Median total	26,698	26,677
Ratio	4.6	4.6

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 an full time equivalent basis (FTE) in North East Lincolnshire Clinical Commissioning Group in the financial year 2015-16 was £120,000 - £125,000. The mid-point of the banded remuneration of the highest paid director would usually be the same as the band reflected in the directors' remuneration table. However as the highest remuneration for this ratio has been based on an annualised FTE basis these are different. This was 4.6 times the median remuneration of the workforce, which was £26,638.

In 2015-16, no employees received remuneration in excess of the highest-paid director as per the remuneration table. Remuneration ranged from £2,786 to £106,229.

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.

2.2.6 Staff Report

a) Number of directors senior civil servants (or equivalent)

Directors are remunerated with the national guidance entitled "Clinical Commissioning Groups Remuneration Guidance for Chief Officers' detailed in section 2.2.1. Please refer to section c below for numbers.

b) Staff numbers

Refer to note 4 of annual accounts for full details

c) Staff composition

The CCG has a staffing establishment of 79.03 whole time equivalents, in its headquarters functions, and also has formal arrangements in place to buy in a range of support services from a number of different providers at a cost of £2.2 million in 2015-16.

The sickness rate at the CCG headquarters was regularly below 1.5% with occasions where the percentage is below 1%, the majority of these absences were short term. Turnover rate of employees in 2015/16 has reduced to 6.84 FTE compared to that of 9.76 FTE in 2014/15.

The number of persons of each sex who were directors senior civil servants (or equivalent)	Male 1	Female 3
The number of persons of each sex who were employees of the CCG	Male 18	Female 66

d) Sickness absence data

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

The sickness data provided are calendar year figures (January – December 2015).

Figures converted by DH to best estimates of required Data Items		Statistics Published by HSCIC from ESR Data Warehouse		
Average FTE 2015	Adjusted FTE sick days	FTE-Days Available	FTE-Days recorded Sickness Absence	Average Annual Sick Days per FTE
69	155	25,309	251	2.2

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

e) Staff policies applied during the financial year

As an employer we actively work to remove any discriminatory practices, eliminate all forms of harassment and promote equality of opportunity in our recruitment, training, performance management and development practices. The CCG has a number of policies and processes in place to support this including:

- Managing Work Performance
- Disciplinary / Conduct
- Grievance
- Bullying and Harassment
- Flexible working
- Annual appraisals with staff

We actively encourage people with disabilities to apply for positions in our organisation. We have a commitment to interviewing job applicants with disabilities where they meet the minimum criteria for the job as well as making 'reasonable adjustments' to avoid any disabled employee being put at a disadvantage compared to non-disabled people in the workplace. Should circumstances change with an employee's disability status during their employment then the framework within the Absence Management Policy would be used. Occupational Health and where applicable other specialist advice is taken and reasonable adjustments would be made to support the employee to continue in employment as far as possible.

f) Expenditure on consultancy

Further details in relation to expenditure on consultancy can be found in note 5 in the Financial Statements.

2.2.7 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 2016, for more than £220 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2016	37
Of Which, the number that have existed:	
• For less than 1 year at the time of reporting	12
• For between 1 and 2 years at the time of reporting	17
• For between 2 and 3 years at the time of reporting	8
• For between 3 and 4 years at the time of reporting	0
• For 4 or more years at the time of reporting	0

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	12
Number of new engagements which include contractual clauses giving the Clinical Commissioning Group the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	12
Of which:	
assurance has been received	12
assurance has not been received	0
engagements terminated as a result of assurance not being received *If no assurance is received from individuals they may face the risk of their contract being terminated*	0

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	25

2.2.8 Exit Packages & Severance Payments

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

2.2.9 External Audit

Our external auditor is KPMG who is appointed by the Audit Commission. Auditors' remuneration in relation to April 2015 to March 2016 totalled £46,500.00 (excluding VAT). This covered audit services required under the Audit Commission's Code of Audit Practice (giving opinion on the Annual Accounts and Value for Money.

Our Integrated Governance & Audit Committee receives our external auditor's Annual Audit Letter and other external audit reports. The external auditor is required to comply with the Audit Commission's standard in respect of independence and objectivity and with International Auditing Standard 260 for UK & Ireland (Standard 260: The auditor's communication with those charged with governance).

Work undertaken by the external auditor during financial year 2015/16 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).

Signature

Dr Peter Melton
Accountable Officer

Date

THE FINANCIAL STATEMENTS

3.0

3.0 Financial Statements

3.1 FOREWORD TO THE ACCOUNTS

NHS NORTH EAST LINCOLNSHIRE CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2016 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

Peter Melton
Accountable Officer
26 May 2016

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

We have audited the financial statements of NHS North East Lincolnshire CCG for the year ended 31 March 2016, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows and related notes, under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Members of the Governing Body of NHS North East Lincolnshire CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body 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 Governing Body 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, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer, and the overall presentation of the financial statements.

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Opinion on 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 2016 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

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 other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We have nothing to report in respect of the above responsibilities.

Certificate

We certify that we have completed the audit of the accounts of NHS North East Lincolnshire CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

John Graham Prentice FCCA MBA
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

Date: 26 May 2016

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	5	**3,485**	3,174
Operating Expenses	5	**267,285**	267,533
Other operating revenue	2	**(48,480)**	(56,933)
Net operating expenditure before interest		**222,290**	**213,774**
Investment Revenue	8	**0**	0
Other (gains)/losses	9	**0**	0
Finance costs	10	**0**	0
Net operating expenditure for the financial year		**222,290**	**213,774**
Net (gain)/loss on transfers by absorption	11	**0**	0
Total Net Expenditure for the year		**222,290**	**213,774**
Of which:			
Administration Income and Expenditure			
Employee benefits	5	**2,994**	2,637
Operating Expenses	5	**2,022**	2,899
Other operating revenue	2	**(1,445)**	(1,942)
Net administration costs before interest		**3,571**	**3,594**
Programme Income and Expenditure			
Employee benefits	5	**491**	537
Operating Expenses	5	**265,263**	264,634
Other operating revenue	2	**(47,035)**	(54,991)
Net programme expenditure before interest		**218,719**	**210,180**

Other Comprehensive Net Expenditure		2015-16 £000	2014-15 £000
Impairments and reversals	22	**0**	0
Net (gain)/loss on revaluation of property, plant & equipment		**0**	0
Net (gain)/loss on revaluation of intangibles		**0**	0
Net (gain)/loss on revaluation of financial assets		**0**	0
Movements in other reserves		**0**	0
Net (gain)/loss on available for sale financial assets		**0**	0
Net (gain)/loss on assets held for sale		**0**	0
Net actuarial (gain)/loss on pension schemes		**(3,533)**	2,281
Share of (profit)/loss of associates and joint ventures		**0**	0
Reclassification Adjustments		**0**	0
On disposal of available for sale financial assets		**0**	0
Total comprehensive net expenditure for the year		**218,757**	**216,055**

The notes on pages 88 to 123 form part of this statement

Statement of Financial Position as at 31 March 2016

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets:			
Property, plant and equipment	13	**0**	0
Intangible assets	14	**0**	0
Investment property	15	**0**	0
Trade and other receivables	17	**0**	0
Other financial assets	18	**0**	0
Total non-current assets		**0**	0
Current assets:			
Inventories	16	**0**	0
Trade and other receivables	17	**6,452**	6,968
Other financial assets	18	**0**	0
Other current assets	19	**0**	0
Cash and cash equivalents	20	**13**	46
Total current assets		**6,465**	7,014
Non-current assets held for sale	21	**0**	0
Total current assets		**6,465**	7,014
Total assets		**6,465**	7,014
Current liabilities			
Trade and other payables	23	**(15,577)**	(16,711)
Other financial liabilities	24	**0**	0
Other liabilities	25	**0**	0
Borrowings	26	**0**	0
Provisions	30	**(486)**	(408)
Total current liabilities		**(16,063)**	(17,119)
Total Assets less Current Liabilities		**(9,598)**	(10,105)
Non-current liabilities			
Trade and other payables	23	**(2,111)**	(5,479)
Other financial liabilities	24	**0**	0
Other liabilities	25	**0**	0
Borrowings	26	**0**	0
Provisions	30	**(8)**	(8)
Total non-current liabilities		**(2,119)**	(5,487)
Assets less Liabilities		**(11,717)**	(15,592)
Financed by Taxpayers' Equity			
General fund		**(7,199)**	(7,540)
Revaluation reserve		**0**	0
Other reserves		**(4,518)**	(8,052)
Charitable Reserves		**0**	0
Total taxpayers' equity:		**(11,717)**	(15,592)

The notes on pages 88 to 123 form part of this statement

The financial statements on pages 84 to 87 were approved by the Integrated Governance & Audit Committee on 26 May 2016 and signed on its behalf by:

Peter Melton
Accountable Officer
26 May 2016

Statement of Changes In Taxpayers Equity for the Year Ended 31 March 2016

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in Taxpayers' Equity for 2015-16				
Balance at 1 April 2015	(7,540)	0	(8,052)	**(15,592)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted Balance at 1 April 2015	**(7,540)**	**0**	**(8,052)**	**(15,592)**
Changes in Taxpayers' Equity for 2014-15				
Net operating expenditure for the financial year	(222,290)			(222,290)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain/(loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain/(loss) on pensions	0	0	3,533	3,533
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised Expenditure for the Financial Year	**(222,290)**	**0**	**3,533**	**(218,757)**
Net funding	222,631	0	0	222,631
Balance at 31 March 2016	**(7,199)**	**0**	**(4,518)**	**(11,717)**

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

Statement of Cash Flows for the Year Ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year (see note 46)		**(222,462)**	(213,205)
Depreciation and amortisation	5	**0**	0
Impairments and reversals	5	**0**	0
Movement due to transfer by Modified Absorption		**0**	0
Other gains (losses) on foreign exchange		**0**	0
Donated assets received credited to revenue but non-cash		**0**	0
Government granted assets received credited to revenue but non-cash		**0**	0
Interest paid		**0**	0
Release of PFI deferred credit		**0**	0
Other Gains & Losses		**0**	0
Finance Costs		**0**	0
Unwinding of Discounts		**0**	0
Increase/(decrease) in inventories		**0**	0
Increase/(decrease) in trade & other receivables	17	**853**	(2,509)
Increase/(decrease) in other current assets		**0**	0
Increase/(decrease) in trade & other payables	23	**(1,134)**	2,546
Increase/(decrease) in other current liabilities		**0**	0
Provisions utilised	30	**(257)**	(297)
Increase/(decrease) in provisions	30	**336**	377
Net Cash Inflow (Outflow) from Operating Activities		**(222,664)**	(213,088)
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		**(222,664)**	(213,088)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		**222,631**	213,067
Other loans received		**0**	0
Net modified absorption accounting transfer through reserves		**0**	0
Other loans repaid		**0**	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		**0**	0
Capital grants and other capital receipts		**0**	0
Capital receipts surrendered		**0**	0
Net Cash Inflow (Outflow) from Financing Activities		**222,631**	213,067
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(33)**	(21)
Cash & Cash Equivalents at the Beginning of the Financial Year		**46**	67
Effect of exchange rate changes on balance of cash and cash equivalents held in foreign currencies		**0**	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**13**	46

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of CCGs shall meet the accounting requirements of the Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 Charitable Funds

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

1.6 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the CCG is in a "jointly controlled operation", the CCG recognises:

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

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

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the CCG"s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.7.1 Critical Judgements in Applying Accounting Policies

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

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

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:

- 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.
- Prescribing - The full year figure is estimated on the spend for the first 10 months of the year
- Continuing Care - This is based upon the client data base of occupancy at the financial year end.

1.8 Revenue

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

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

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

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

1.9.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the CCG of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the CCG commits itself to the retirement, regardless of the method of payment.

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

1.10 Other Expenses

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

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

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- 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 valuation.

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

- 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 current value in existing use.

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

1.11.3 Subsequent Expenditure

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

1.12 Intangible Assets

1.12.1 Recognition

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

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

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

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

1.12.2 Measurement

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 Depreciation, Amortisation & Impairments

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

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

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

1.13 Depreciation, Amortisation & Impairments

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

1.14 Donated Assets

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

1.15 Government Grants

The value of assets received by means of a government grant 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.

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

1.17.2 The CCG as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the CCG"s net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the CCG"s net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 Private Finance Initiative Transactions

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

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

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

1.18.1 Services Received

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

1.18.2 PFI Asset

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

1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to „finance costs" within the Statement of Comprehensive Net Expenditure. The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

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

1.18.4 Lifecycle Replacement

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

1.18.4 Lifecycle Replacement (Continued)

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

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

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

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

1.18.6 Other Assets Contributed by the CCG to the Operator

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

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present valueof the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS17

1.19 Inventories

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

1.20 Cash & Cash Equivalents

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

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

1.21 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

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

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

1.22 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which the CCG pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the CCG.

1.23 Non-clinical Risk Pooling

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.24 **Continuing healthcare risk pooling**

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

1.25 Carbon Reduction Commitment Scheme

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

1.26 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.27 Financial Assets

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

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

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

1.27.1 Financial Assets at Fair Value Through Profit and Loss

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

1.27.2 Held to Maturity Assets

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

1.27.3 Available For Sale Financial Assets

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

1.27.4 Loans & Receivables

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

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

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the CCG assesses whether any financial assets, other than those held at „fair value through profit and loss" are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset"s carrying amount and the present value of the revised future cash flows discounted at the asset"s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 Financial Liabilities

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

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

1.28.1 Financial Guarantee Contract Liabilities

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

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

1.28.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.28.3 Other Financial Liabilities

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

1.29 Value Added Tax

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

1.30 Foreign Currencies

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

1.31 Third Party Assets

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

1.32 Losses & Special Payments

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

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

1.33 Subsidiaries

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

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

1.34 Associates

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

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

1.35 Joint Ventures

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

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

1.36 Joint Operations

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

1.37 Research & Development

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

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

The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year.

2 Other Operating Revenue

	2015-16 Admin £000	2015-16 Programme £000	2015-16 Total £000	2014-15 Total £000
Recoveries in respect of employee benefits	**21**	**0**	**21**	22
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**	**4**	**4**	56
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 *	**2**	**473**	**475**	598
Continuing Health Care Risk Pool Contributions	**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 **	**1,422**	**46,558**	**47,980**	56,257
Total other operating revenue	**1,445**	**47,035**	**48,480**	**56,933**

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

*** This includes £38.5m in relation to the adult social care partnership agreement and £8m in relation to adult social care private client revenue. In 2014/15 these figures were £47.9m & £7m respectively. The Partnership Agreement has reduced by £3.5m in 15/16 as Better Care Funding previously received by NELC is now funded directly from the health allocation. Further analysis can be found at note 35.*

*** This includes £24,150 from the Big Lottery Fund Grant in respect of a Development grant for Social Prescribing.*

3 Revenue

	2015-16 Admin £000	2015-16 Programme £000	2015-16 Total £000	2014-15 Total £000
From rendering of services	1,445	47,035	48,480	56,933
From sale of goods	0	0	0	0
Total	**1,445**	**47,035**	**48,480**	**56,933**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2015-16	Admin			Programme			Total		
	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000
Employee Benefits									
Salaries and wages	2,350	55	**2,405**	324	112	**436**	2,674	167	**2,841**
Social security costs	201	1	**202**	23	0	**23**	224	1	**225**
Employer Contributions to NHS Pension scheme	343	1	**344**	32	0	**32**	375	1	**376**
Other pension costs	0	0	**0**	0	0	**0**	0	0	**0**
Other post-employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Other employment benefits	0	0	**0**	0	0	**0**	0	0	**0**
Termination benefits	43	0	**43**	0	0	**0**	43	0	**43**
Gross employee benefits expenditure	**2,937**	**57**	**2,994**	**379**	**112**	**491**	**3,316**	**169**	**3,485**
Less recoveries in respect of employee benefits (note 4.1.2)	(21)	0	**(21)**	0	0	**0**	(21)	0	**(21)**
Total - Net admin employee benefits including capitalised costs	**2,916**	**57**	**2,973**	**379**	**112**	**491**	**3,295**	**169**	**3,464**
Less: Employee costs capitalised		0	**0**	0	0	**0**	0	0	**0**
Net employee benefits excluding capitalised costs	**2,916**	**57**	**2,973**	**379**	**112**	**491**	**3,295**	**169**	**3,464**

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

4.1.2 Recoveries in respect of employee benefits

	2015-16			2014-15		
	Permanent Employees £000	**Other £000**	**Total £000**	**Permanent Employees £000**	**Other £000**	**Total £000**
Employee Benefits - Revenue						
Salaries and wages	**(17)**	**0**	**(17)**	(19)	0	(19)
Social security costs	**(2)**	**0**	**(2)**	(1)	0	(1)
Employer contributions to the NHS Pension Scheme	**(2)**	**0**	**(2)**	(2)	0	(2)
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	**(21)**	**0**	**(21)**	(22)	0	(22)

4.2 Average number of people employed

	2015-16			2014-15		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**73**	**3**	**76**	65	3	68
Of the above:						
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0	0	0

On 1st Dec 2015, 7 staff transferred to the CCG, which related to services previously purchased from Yorkshire & Humber CS.

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	**155**	129
Total Staff Years	**69**	63
Average working Days Lost	**2**	**2**

The sickness data provided are calendar year figures

4.4 Exit packages agreed in the financial year

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	1	42,802	1	42,802
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	0	0	1	42,802	1	42,802

There were no exit packages agreed in 2014/15

Analysis of Other Agreed Departures

	2015-16 Other agreed departures		2014-15 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	1	42,802	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	1	42,802	0	0

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 NHS Body 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 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2015-16, employers" contributions of £341k were payable to the NHS Pensions Scheme (2014-15: £287k) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme"s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9th June 2014. The change in employer contribution took effect from April 2015 and the employer contribution rate will move from 14% to 14.3%. These costs are included in the NHS pension line of note 4.

4.5.2 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 34.8% of gross salary with effect from 1st April 14.

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

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

4.5.4 Local Government Pension Scheme (Continued)

	31 March 2016 % p.a.	31 March 2015 % p.a.
Pension Increase rate	**2.2%**	2.4%
Salary Increase rate	**3.7%**	3.8%
Discount Rate	**3.5%**	3.2%

	31st March 2016		31st March 2015	
Mortality Assumptions	**Males Years**	**Females Years**	Males Years	Females Years
Current Pensioners	**21.9**	**24.1**	21.9	24.1
Future Pensioners**	**24.2**	**26.7**	24.2	26.7

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

Sensitivity Analysis	**31st March 2016**		31st March 2015	
Change in assumptions at year ended 31 March 2016	**Approximate % increase to Employer liability**	**Approximate monetary amount £'000**	Approximate % increase to Employer liability	Approximate monetary amount £'000
0.5% decrease in Real Discount Rate	**11%**	**3,326**	11%	3,733
1 year increase in member life expectancy	**3%**	**916**	3%	1,028
0.5% increase in the Salary Increase Rate	**0%**	**89**	0%	103
0.5% increase in the Pension Increase Rate	**11%**	**3,258**	11%	3,634

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 the Employers Contributions payable in the year to 31 March 2017 will be approximately £50,000.

The above information relates to the LGPS annualised calculation used for the actuarial pension valuation.

Employer Membership Statistics	**31 Dec 2014 Number**
Actives	**4**
Deferred pensioners	**305**
Pensioners	**146**
Total	**455**

Deferred pensioners include undecided leavers & frozen refunds.

The membership numbers shown do not affect any of the calculations and are provided purely for information purposes

5. Operating Expenses	2015-16 Admin £000	2015-16 Programme £000	2015-16 Total £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	**2,573**	**491**	**3,064**	2,835
Executive governing body members	**421**	**0**	**421**	339
Total gross employee benefits	**2,994**	**491**	**3,485**	3,174
Other costs				
Services from other CCGs and NHS England	**1,059**	**849**	**1,908**	2,238
Services from foundation trusts	**0**	**101,146**	**101,146**	102,996
Services from other NHS trusts	**0**	**14,880**	**14,880**	14,989
Services from other NHS bodies	**0**	**0**	**0**	0
Purchase of healthcare from non-NHS bodies	**0**	**66,693**	**66,693**	61,978
Social Care from Independent Providers	**0**	**49,483**	**49,483**	53,270
Chair and Non Executive Members	**128**	**0**	**128**	129
Supplies and services – clinical	**0**	**0**	**0**	0
Supplies and services – general	**76**	**1,321**	**1,397**	920
Consultancy services	**1**	**102**	**103**	1,066
Establishment	**151**	**250**	**401**	663
Transport	**9**	**0**	**9**	9
Premises	**150**	**383**	**533**	413
Impairments and reversals of receivables	**0**	**381**	**381**	630
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	**56**	**0**	**56**	74
Other non statutory audit expenditure				
· Internal audit services	**75**	**0**	**75**	75
· Other services	**0**	**0**	**0**	0
General dental services and personal dental services	**0**	**0**	**0**	0
Prescribing costs	**0**	**27,716**	**27,716**	26,223
Pharmaceutical services	**0**	**0**	**0**	0
General ophthalmic services	**0**	**0**	**0**	0
GPMS/APMS and PCTMS	**0**	**393**	**393**	476
Other professional fees excl. audit	**291**	**142**	**433**	371
Grants to other public bodies	**0**	**108**	**108**	119
Clinical negligence	**0**	**0**	**0**	0
Research and development (excluding staff costs)	**0**	**0**	**0**	0
Education and training	**24**	**5**	**29**	77
Change in discount rate	**0**	**0**	**0**	0
Provisions	**1**	**335**	**336**	377
Funding to Group Bodies	**0**	**0**	**0**	0
CHC Risk Pool contributions	**0**	**901**	**901**	308
Interest (Local Government Pension Scheme)	**0**	**1,085**	**1,085**	1,255
Expected Return on Assets (Local Governement Pension Scheme)	**0**	**(910)**	**(910)**	(1,123)
Other expenditure	**1**	**0**	**1**	0
Total other costs	**2,022**	**265,263**	**267,285**	267,533
Total operating expenses	**5,016**	**265,754**	**270,770**	270,707

6. Better Payment Practice Code

6.1 Measure of compliance

	2015-16 Number	2015-16 £000	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**38,486**	**122,571**	35,660	116,357
Total Non-NHS Trade Invoices paid within target	**36,283**	**118,421**	33,545	113,274
Percentage of Non-NHS Trade invoices paid within target	**94.28%**	**96.61%**	94.07%	97.35%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,059**	**117,446**	1,968	121,043
Total NHS Trade Invoices Paid within target	**2,027**	**117,413**	1,955	121,005
Percentage of NHS Trade Invoices paid within target	**98.45%**	**99.97%**	99.34%	99.97%

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

The CCG had no late payment of commerical debts as at 31 March 2016 (31 March 2015: £NIL).

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 2016 (31 March 2015: £NIL).

9. Other Gains & Losses

The CCG had no other gains and losses as at 31 March 2016 (31 March 2015: £NIL).

10. Finance Costs

The CCG had no finance costs as at 31 March 2016 (31 March 2015: £NIL).

11. Net Gain (Loss) on Transfer by Absorption

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

12. Operating Leases

12.1 As lessee

The CCG makes payments to NHS Property Services Ltd under an operating lease arrangement to occupy Athena building (main headquarters) and other buildings. There are no contingent rental obligations. The lease was signed in September 2015 and will run for 5 years, with a review in 2018. There are no purchase options or escalation clauses. The lease restrict that the properties can be used as office accomodation only.

12.1.1 Payments recognised as an Expense

	Land £000	**Buildings £000**	**Other £000**	**2015-16 Total £000**	2014-15 Total £000
Payments recognised as an expense					
Minimum lease payments	0	60	8	**68**	106
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**60**	**8**	**68**	**106**

Minimum lease payments reduction specifically relates to Olympia House being vacated in 2014/15

12.1.2 Future minimum lease payments

	Land £000	**Buildings £000**	**Other £000**	**2015-16 Total £000**	2014-15 Total £000
Payable:					
No later than one year	0	60	5	**65**	6
Between one and five years	0	212	15	**227**	1
After five years	0	0	2	**2**	0
Total	**0**	**272**	**22**	**294**	**7**

Our arrangements with NHS Property Services Ltd fall within the definition of operating leases. The rental charge for future years has now been agreed & the note includes future minimum lease payments.

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 2016 (31 March 2015: £NIL).

13. Property, Plant & Equipment

The CCG had no property, plant & equipment as at 31 March 2016 (31 March 2015: £NIL).

14. Intangible Assets

The CCG had no intangible Assets as at 31 March 2016 (31 March 2015: £NIL).

15. Investment Property

The CCG had no investment property as at 31 March 2016 (31 March 2015: £NIL).

16. Inventories

The CCG had no inventories as at 31 March 2016 (31 March 2015: £NIL).

17. Trade & Other Receivables

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	250	0	188	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	725	0	708	0
NHS accrued income	25	0	90	0
Non-NHS receivables: Revenue	3,521	0	3,056	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	698	0	763	0
Non-NHS accrued income	2,332	0	2,988	0
Provision for the impairment of receivables	(2,789)	0	(3,126)	0
VAT	2	0	7	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	1,688	0	2,294	0
Total Trade & other receivables	**6,452**	**0**	**6,968**	**0**
Total current and non current	**6,452**		**6,968**	
Included in the CCG NHS Receivables are pre-paid pensions contributions	0		0	

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

Other receivables include £1,604k in relation to the adult social care partnership agreement (14/15: £2,294k)

17.1 Receivables past their due date but not impaired

	2015-16 £000	2014-15 £000
By up to three months	(208)	(178)
By three to six months	(390)	(354)
By more than six months	0	0
Total	**(598)**	**(532)**

17.2 Provision for impairment of receivables

	2015-16 £000	2014-15 £000
Balance at 1 April 2015	(3,126)	(2,672)
Amounts written off during the year	718	176
Amounts recovered during the year	592	364
(Increase) decrease in receivables impaired	(973)	(994)
Transfer (to) from other public sector body	0	0
Balance at 31 March 2016	**(2,789)**	**(3,126)**

The provision relates to two main areas:

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

Receivables are provided against at the following rates:	**2015-16 %**	2014-15 %
NHS & Adult Social Care debt	**0%**	0%
7 to 9 months	**25%**	25%
10 to 12 months	**50%**	50%
1 to 2 years	**75%**	75%
over 2 years	**100%**	100%

It should be noted that where a sales invoice raised relates to backdated care costs , the provision has been calculated based on the period of care that the debt relates to not the date the invoice was raised.

18. Other financial assets

The CCG had no other financial assets as at 31 March 2016 (31 March 2015: £NIL).

19. Other current assets

The CCG had no other current assets as at 31 March 2016 (31 March 2015: £NIL).

20. Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 1 April 2015	46	67
Net change in year	(33)	(21)
Balance at 31 March 2016	**13**	**46**
Made up of:		
Cash with the Government Banking Service	13	46
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	**13**	**46**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2016	**13**	**46**
Patients" money held by the clinical commissioning group, not included above	0	0

21. Non-current Assets Held for Sale

The CCG had no non-current assets held for sale as at 31 March 2016 (31 March 2015: £NIL).

22. Analysis of Impairments & Reversals

The CCG had no impairments or reversals recognised in expenditure during 2015-16 (2014-15: £NIL).

23. Trade and other payables

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	1,243	0	309	0
NHS payables: capital	0	0	0	0
NHS accruals	1,650	0	2,293	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	826	0	1,809	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals	11,622	0	12,099	0
Non-NHS deferred income	23	0	47	0
Social security costs	36	0	31	0
VAT	0	0	0	0
Tax	39	0	32	0
Payments received on account	0	0	0	0
Other payables	138	2,111	91	5,479
Total Trade & Other Payables	**15,577**	**2,111**	**16,711**	**5,479**
Total current and non-current	**17,688**		**22,190**	

Other payables include £56k outstanding pension contributions at 31 March 2016 (31 March 2015: £47k).

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

24. Other Financial Liabilities

The CCG had no other financial liabilities as at 31 March 2016 (31 March 2015: £NIL).

25. Other Liabilities

The CCG had no other liabilities as at 31 March 2016 (31 March 2015: £NIL).

26. Borrowings

The CCG had no borrowings as at 31 March 2016 (31 March 2015: £NIL).

27. Private Finance Initiative, LIFT & Other Service Concession

The CCG had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2016 (31 March 2015: None).

28. Finance Lease Obligations

The CCG had no finance lease obligations as at 31 March 2016 (31 March 2015: None).

29. Finance Lease Receivables

The CCG had no finance lease receivables as at 31 March 2016 (31 March 2015: None).

30. Provisions

	Current 2015-16 £000	Current 2014-15 £000	**Non-current 2015-16 £000**	Non-current 2014-15 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	8	7
Continuing care	212	139	0	0
Other	274	269	0	0
Total	**486**	**408**	**8**	**7**

Total current and non-current	**494**	**415**

30. Provisions (continued)

	Pensions Relating to Former Directors	Pensions Relating to Other Staff	Restructuring	Redundancy	Agenda for Change	Equal Pay	Legal Claims	Continuing Care	Other	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	**0**	**0**	**0**	**0**	**0**	**0**	**7**	**139**	**269**	**415**
Arising during the year	0	0	0	0	0	0	1	209	136	**346**
Utilised during the year	0	0	0	0	0	0	0	(136)	(121)	**(257)**
Reversed unused	0	0	0	0	0	0	0	0	(10)	**(10)**
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 2016	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**212**	**274**	**494**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	212	274	**486**
Between one and five years	0	0	0	0	0	0	8	0	0	**8**
After five years	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**212**	**274**	**494**

Other provisions relate to three adult social care provisions created within 2015/16.

- Section 117 reimbursement of client contributions
- sustainability funding to support planned closure of Learning Disability Provider
- Supported Living

It is anticipated these provisions will be utilised in full during 2016/17

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 2016 is £1,374k (31 March 2015 is £1,524k).

The deadline for completing all of this work is 31 March 2017

31. Contingencies

The CCG had no borrowings as at 31 March 2016 (31 March 2015: £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 2016 (31 March 2015: £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 2016 (31 March 2015: £NIL).

33. Financial instruments

33.1 Financial risk management

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

Because the CCG is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The CCG has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the CCG in undertaking its activities.

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

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

33.1.3 Credit risk

Because the majority of the CCG and revenue comes 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, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

33. Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	Loans and Receivables 2015-16 £000	Available for Sale 2015-16 £000	Total 2015-16 £000
Embedded derivatives	0	0	0	**0**
Receivables:				
· NHS	0	275	0	**275**
· Non-NHS	0	5,854	0	**5,854**
Cash at bank and in hand	0	13	0	**13**
Other financial assets	0	1,688	0	**1,688**
Total at 31 March 2016	**0**	**7,830**	**0**	**7,830**

	2014-15 £000	2014-15 £000	2014-15 £000	2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	188	0	188
· Non-NHS	0	3,056	0	3,056
Cash at bank and in hand	0	46	0	46
Other financial assets	0	2,294	0	2,294
Total at 31 March 2015	**0**	**5,584**	**0**	**5,584**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	Other 2015-16 £000	Total 2015-16 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,892	2,892
· Non-NHS	0	14,697	14,697
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 2016	**0**	**17,589**	**17,589**

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

34. Operating Segments

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

2015-16	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Health	224,001	(1,711)	**222,290**	2,465	(12,094)	**(9,629)**
Adult Social Care	50,782	(50,782)	**0**	4,000	(6,088)	**(2,088)**
Total	**274,783**	**(52,493)**	**222,290**	**6,465**	**(18,182)**	**(11,717)**

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

The Adult Social Care figures reflect the Partnership Agreement as detailed in note 35.

35. Pooled Budgets

The CCG has a pooled budget with North East Lincolnshire Council . The pool is hosted by NHS North East Lincolnshire CCG and forms part of the overall integrated health & social care budget that the CCG has responsibility for.

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

The tables below provides a summary of the income and expenditure in the financial year.

Adult Social Care Partnership Agreement	**2015-16 £000**	2014-15 £000
NELC Allocation	**38,491**	47,869
Other Contributions*	**12,291**	7,203
Adult social care expenditure	**(50,782)**	(55,072)
Total	0	0

*Other Contributions, includes £4.0m funding from the Health Better Care Fund Allocation. This is an internal recharge between the Health & Adult Social Care Operating Segments and as such is not reflected as Income & Expenditure on the SOCNE.

Better Care Fund	**2015-16 £000**	2014-15 £000
Allocation (Health)	**11,246**	0
Allocation (North East Lincolnshire Council)	**1,582**	0
Health Expenditure	**(7,672)**	0
Adult Social Care expenditure	**(5,010)**	0
Total	**146**	0

The £146k underspend relates to slippage on capital schemes funded from North East Lincolnshire Council allocation. The council will make the funding available for use in 2016/17

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

The main change for 2015/16 is that £3.6m funding, previously received directly by North East Lincolnshire Council and then transferred in full to NEL CCG (as part of the Partnership Agreement) came directly to the CCG.

36. NHS LIFT Investments

The CCG had no NHS LIFT investments as at 31 March 2016 (31 March 2015: £NIL).

37. Intra-government and other balances

	Current Receivables 2015-16 £000	Non-current Receivables 2015-16 £000	Current Payables 2015-16 £000	Non-current Payables 2015-16 £000
Balances with:				
· Other Central Government bodies	46	0	1,620	0
· Local Authorities	1,614	0	293	0
· NHS bodies outside the Departmental Group	0	0	0	0
· NHS bodies within the NHS England Group	26	0	610	0
· NHS Trusts and Foundation Trusts	974	0	2,282	0
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	3,792	0	10,771	2,111
Total balances at 31 March 2016	**6,452**	**0**	**15,576**	**2,111**

	2014-15 £000	2014-15 £000	2014-15 £000	2013-14 £000
Balances with:				
· Other Central Government bodies	57	0	1,420	0
· Local Authorities	2,374	0	142	0
· NHS bodies outside the Departmental Group	93	0	0	0
· NHS bodies within the NHS England Group	90	0	226	0
· NHS Trusts and Foundation Trusts	803	0	2,376	0
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	3,551	0	12,547	5,479
Total balances at 31 March 2015	**6,968**	**0**	**16,711**	**5,479**

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 (greater than £1 million) with entities for which the Department is regarded as the parent Department. This Includes:

- **NHS England (including commissioning support units);**
- **NHS Foundation Trusts;**
  Northern Lincolnshire & Goole Hospitals NHS Foundation Trust
- **NHS Trusts;**
  East Midlands Ambulance Service NHS Trust
  Hull & East Yorkshire Hospitals NHS Trust
- **NHS Litigation Authority; and,**
- **NHS Business Services Authority.**

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with North East Lincolnshire Council in respect of the provision of adult social care.

38. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Phillip Bond				
Partnership Board Lay member Community Engagement/ Integrated Governance & Audit				
Member of PPG (Chair) Blundell Park Surgery	10	-	10	-
Chair of Blundell Park Surgery	25	-	-	-
My cousin is employed in a senior position at NLAG Trust	98,167	(5)	190	(766)
Cllr Michael Burnett				
Partnership Board member				
Was a Councillor for North East Lincolnshire Council	4,482	(10,743)	269	(1,614)
Juliette Cosgrove				
Partnership board registered nurse				
Calderdale & Huddersfield NHS Foundation Trust, Assistant Director to the Medical & Nurse Dire	2	-	1	-
Husband is a Consultant Neurosurgeon at Lancashire Teaching Hospital NHS Trusts	21	-	-	-
Dr D Elder				
Committee member for Remuneration Committee/Council of Members				
Partner in Humberview Surgery	21	(4)	4	-
Partner in Pelham Medical Group	337	-	28	-
Practice provides an enhanced service for substance misuse to our own patients only, under a contract with NE Lincs Council	4,482	(10,743)	269	(1,614)
Engaged with Birkwood in joint delivery of drug services	256	-	28	-
Engaged with Chantry in joint delivery of drug services	143	-	14	-
Engaged with Woodford in joint delivery of drug services	235	-	36	-
Dr D Hopper				
Partnership Board Vice Chair/Remuneration committee member/ Chair of Council of Members				
Partner at Fieldhouse Medical Group	490	-	58	-
Nicky Hull				
NEL Primary Care (Non-GP) Member				
Practice Manager at Beacon Medical	426	-	43	-
Practice provides an enhanced service for substance misuse to own patients only, under a contract with NE Lincs Council	4,482	(10,743)	269	(1,614)

38. Related party transactions (Continued)

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Cllr Jane Hyldon-King				
NELC Representative				
Councillor Deputy Leader NELC	4,482	(10,743)	269	(1,614)
Friendship at Home	15	-	-	-
NAViGO	23,607	-	375	-
Dr D James				
Secondary Care Doctor				
Independent work –one day a week. Outpatients consultations at St Hughes Hospital, Grimsby	6,843	-	33	-
Cathy Kennedy				
Deputy Chief Executive				
Husband is IT Project Manager with Yorkshire and Humber Commissioning Support	1,885	-	166	-
HFMA -President of Yorkshire branch & Chair of National Commissioning Faculty	7	-	1	-
Helen Kenyon				
Deputy Chief Executive				
Personal friend is a director of an independent consultancy company SJW Solutions in Partnership.	18	-	14	-
Dr R T Maliyil				
Vice Chair Council Of Members/ Partnership Board GP Representative				
GP at Scartho Medical Centre	378	-	62	-
Scartho Practice is a member of 360 care limited	538	-	49	-
Scartho Practice is a member of LINCS	73	-	6	-
Wife is practice manager at Blundell Park Surgery	10	-	10	-
Wife is practice manager at Healing Health Centre	31	-	7	-
Specialist doctor in Palliative medicine at St Andrew"s Hospice,	450		11	
Director of Core Care Links	2,236	-	65	-
Dr P Melton				
Clinical Chief Officer				
GP Principal at Roxton Practice	1,358	(5)	163	-
GP Principal at Roxton at Weelsby View , Grimsby	1	-	15	-
GP Principal at Dr Opie & Dr Spalding, Weelsby View, Grimsby	8	-	10	-
Wife is employed by 360 care Ltd	538	-	49	-
Roxton Practice is a member of LINCS	73	-	6	-
More than 5% Shareholding in Local Care Provision Limited	95	-	-	-

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 A Nayyar				
Partnership Board GP representative				
More than 5% Shareholding in Local Care Provision Limited	95	-	-	-
GP Partner Roxton Practice	1,358	(5)	163	-
GP Partner Roxton at Weelsby View , Grimsby	1	-	15	-
GP Partner Dr Opie & Dr Spalding, Weelsby View, Grimsby	8	-	10	-
Director Core Care Links Ltd	2,236	-	65	-
Dr R Pathak				
Partnership Board GP representative				
GP Principal at Raj Medical Centre	147	(2)	17	-
Director of Core Care Links Ltd	2,236	-	65	-
Director of 360 Ltd	538	-	49	-
Cllr Matthew Patrick				
NELC Representative				
Councillor for North East Lincolnshire Council	4,482	(10,743)	269	(1,614)
Stephen Pintus				
Partnership Board NELC Officer member				
Director of Public Health at North East Lincolnshire Council	4,482	(10,743)	269	(1,614)
Dr K Severin				
Council of Members/ Integrated Governance & Audit Committee				
GP Partner at Birkwood Medical Centre	256	-	28	-
North Yorkshire & Humber Appraiser (NHS England)	201	(1,243)	197	(1,235)
Joe Warner				
Partnership Board Social Care Representative				
Director of Focus	6,061	(2)	115	-
Mark Webb				
CCG chair/Partnership board member/Remuneration committee member				
Director of E-Factor Ltd	2	-	0	-

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

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

39. Events after the end of the reporting period

There were no events after the end of the reporting period

40. Losses and special payments

40.1 Losses

	Total Number of Cases	**Total Value of Cases**	Total Number of Cases	Total Value of Cases
	2015-16	**2015-16**	2014-15	2014-15
	Number	**£'000**	Number	£'000
Administrative write-offs	4	1	0	0
Total	**4**	**1**	**0**	**0**

The losses relates to 4 items of minor equipment damage / loss.
Please see note 17.2 for details of the provison for impairment of receivables

40.2 Special payments

The CCG had no special payments cases during 2015-16 (2014-15: None)

41. Third party assets

The CCG held no third party assets as at 31 March 2016 (31 March 2015: None)

42. Financial performance targets

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

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

National Health Service Act Section	Duty	2015-16 Target £'000	2015-16 Performance £'000	2014-15 Target £'000	2014-15 Performance £'000
223H(1)	Expenditure not to exceed income (reported surplus £4,531k)	**228,532**	**224,001**	222,168	215,635
223I(2)	Capital resource use does not exceed the amount specified in Directions	**0**	**0**	65	0
223I(3)	Revenue resource use does not exceed the amount specified in Directions	**226,821**	**222,290**	220,307	213,774
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	0	0
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	0	0
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	**3,923**	**3,571**	4,297	3,594

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 £38m 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 2015-16 financial year.

44. Analysis of Charitable Reserves

The CCG held no charitable reserves as at 31 March 2016 (31 March 2015: None).

45. FRS Accounting Information - Pensions

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

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

The actuaries report states that the market value of the assets of the Pension fund as at 31 March 2016 was £28.4 million (31 March 2015 was £28.8 million).

Assets	Value at 31 March 2016 £000	Value at 31 March 2015 £000
Equity Securities	12,426	11,381
Debt Securities	2,833	2,890
Private Equity	1,434	1,544
Real Estate	3,352	2,453
Investment Funds & Unit Trusts	7,583	9,576
Cash & Cash Equivalents	798	930
Total	28,426	28,774

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 2016 £000	31 March 2015 £000
Fair Value of Employer Assets	28,426	28,774
Present Value of Funded Obligations	(30,537)	(34,253)
Net Asset/(Liability)	(2,111)	(5,479)

Recognition in the profit or loss	31 March 2016 £000	31 March 2015 £000
Current service cost	41	27
Interest Cost	1,085	1,255
Expected Return on Employer Assets	(910)	(1,123)
Past Service Cost / (Gain)	0	0
Losses / (Gains) on Curtailments and Settlements	0	0
Total	216	159

Reconciliation of defined benefit obligation	31 March 2016 £000	31 March 2015 £000
Opening Defined Benefit Obligation	34,253	29,493
Current Service Cost	41	27
Interest Cost	1,085	1,255
Contribution by Members	10	10
Actuarial Losses/(Gains)	(4,120)	4,092
Past Service Costs / (Gains)	0	0
Losses / (Gains) on Curtailments	0	0
Estimated Benefits Paid	(732)	(624)
Closing Defined Benefit Obligation	30,537	34,253

45. FRS Accounting Information - Pensions (Continued)

Reconciliation of fair value of employer assets	31 March 2016 £000	31 March 2015 £000
Opening Fair Value of Employer Assets	**28,774**	**26,410**
Expected Return on Assets	**910**	**1,123**
Contributions by Members	**10**	**10**
Contributions by the Employer	**51**	**43**
Actuarial Gains/(Losses)	**(587)**	**1,812**
Estimated Benefits Paid	**(732)**	**(624)**
Total actuarial gain (loss)	**28,426**	**28,774**

Amounts for the current and previous accounting periods	31 March 2016 £000	31 March 2015 £000
Fair Value of Employer Assets	**28,426**	**28,774**
Present Value of Defined Benefit Obligation	**(30,537)**	**(34,253)**
Surplus / (deficit)	**(2,111)**	**(5,479)**
Experience Gains/(Losses) on Assets	**(587)**	**1,812**
Experience Gains/(Losses) on Liabilities	**(786)**	**(457)**

Cumulative Statement of Recognised Gains / Losses	31 March 2016 £000	31 March 2015 £000
Actuarial Gains and Losses	**(587)**	**1,812**
Effect of Surplus Recovery Through Reduced Contributions	**4,120**	**(4,092)**
Actuarial Gains / (Losses) recognised in STRGL	**3,533**	**(2,281)**
Cumulative Actuarial Gains and Losses	**(2,371)**	**(5,904)**

46. Cash Flow Workings

	£'000
Net operating costs for the financial year (per SOCNE)	**(222,290)**
Impairment of receivables	**(337)**
Pension charge	**165**
Net operating costs for the financial year per cash flow	**(222,462)**

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