NHS
North Lincolnshire
Clinical Commissioning Group

NHS North Lincolnshire Clinical Commissioning Group

2014-15

Annual Report




your community, *your* health

Contents

6. Remuneration Report

1. Introduction

Welcome to the Annual Report and Accounts of NHS North Lincolnshire Clinical Commissioning Group (CCG) for 2014-15. All NHS organisations are required to publish an annual report and financial accounts at the end of each financial year.

This report provides an overview of the work of NHS North Lincolnshire CCG between 1 April 2014 and 31 March 2015. The report is made up of two parts: a summary of the CCG's business, performance and projects over the past year, as well as commentary on wider events which have shaped its work and priorities as an organisation; and the financial accounts for the year 2014-15.

As a publicly accountable body, the CCG is committed to being transparent with its staff, partners, patients and the public. The CCG holds six Governing Body meetings and an Annual General Meeting each year, all of which are open to the public. For dates, times and venues of all public meetings, please contact the CCG via the details below or visit the CCG's website: http://www.northlincolnshireccg.nhs.uk/theboard/our-meetings

Information contained in this report can also be provided in other languages and alternative formats, including audio, large print and Braille. An electronic copy of this report is also available on the CCG's web site www.northlincolnshireccg.nhs.uk

For further information, assistance or to request copies of this report in your preferred format, contact:

NHS North Lincolnshire Clinical Commissioning Group
Health Place
Wrawby Road
Brigg North
Lincolnshire
DN20 8GS

Tel: 01652 251000
E-mail: NLCCG.ContactUs@nhs.net
Twitter: @northlincsccg
Web: www.northlincolnshireccg.nhs.net

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ئەگەر دەخوازیت ئەم زانیارییەت بە زمانی خۆت بۆ بڕوونبکرێتەوە، ئەوا تکایە نیشانە لە خانەی گونجاو بدە و بیگەڕێنەرەوە بۆ:

Arabic ☐

لك بلغتك، فالرجاء التأشير في المربع المناسب ثم إرساله إلى
إذا كنت ترغب في توضيح هذه المعلومة

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NHS North Lincolnshire Clinical Commissioning Group
Health Place, Wrawby Road, Brigg, North Lincolnshire DN20 8GS

2. Welcome from the CCG Chair and Chief Officer

We are delighted to share with you NHS North Lincolnshire Clinical Commissioning Group's Annual Report for 2014-15.

The report summarises our progress and performance against key local and national priorities over the last 12 months, highlighting our significant achievements to date. The report also provides an insight into our future plans for commissioning high quality, safe and sustainable health and care services for the people of North Lincolnshire.

We are very proud of what we have achieved in only our second year as a fully authorised organisation. We feel that we are already making a significant impact in many areas of our community.

As part of the latest phase of the Healthy Lives Healthy Futures review of health and care services across North and North East Lincolnshire, hyper-acute stroke services were permanently centralised at Scunthorpe General Hospital. This means that specialised stroke care is now available to patients 24/7 – and it's already saving lives. Our annual mortality rate for stroke has dropped from 14% to 11%, putting our region amongst one of the best for stroke survival in the country. In context, that means that 22 more stroke patients are alive today than would have been under the previous service arrangements.

Our Better Care Fund plan is targeted at ensuring the needs of the Frail and Frail Elderly in North Lincolnshire are better managed and supported. It builds on the model of community based care and extends it further by bringing a range of health and social care services together to provide a joined-up, holistic experience of care to patients. We had a taste of the improved outcomes the Plan will bring during 'The Perfect Week', when four services were trialled to assess their sustainability and impact. Early indications showed that, with appropriate levels of planning and phased implementation, our Better Care Fund plan has the potential to provide increased levels of care and support to patients in their own home or community and ultimately reduce unnecessary admissions to hospital.

Patients are at the heart of everything we do and their views and feedback has been fundamental to the development of our commissioning plans and implementation of service change. We continue to use Experience Led Commissioning (ELC) to inform our commissioning plans around dementia, long term conditions and end of life care. Notable outputs included the launch of the Dementia Directory, http://www.ddnl.org.uk/ , the first virtual resource in the North Lincolnshire area specifically focused on providing high quality and responsive information for people affected by dementia. We also launched the Advance Care Plan, in partnership with Northern Lincolnshire and Goole NHS Foundation Trust. The plan has been designed by patients, carers and health care staff to help people to start having those difficult conversations about the type of care they may wish to receive in their final days and their wishes for after they pass on. Designed primarily for end of life patients, the plan is also a helpful, supportive resource for anyone to document their wishes.

Embrace, our public membership engagement network, launched in June 2014 and membership is growing (117 members as at end of March 2015). Members have been involved in our recent business planning event, 'Health Matters', where they had the opportunity to share their views on our commissioning plans for 2015-16, particularly around how they can continue to be involved in shaping services as they develop. We are looking forward to developing further opportunities for Embrace members to get involved in our work over the coming year.

Our Governing Body and Council of Members have become well-established and continue to provide valuable clinical input into our work. The membership of our Governing Body has seen a few changes during this year. Sadly, Dr Jagrit Shah, our Secondary Care Doctor, tendered his resignation in February 2014 due to his increasing work load in secondary care which meant he did not have enough time to commit to the Governing Body. However, he returned on a voluntary basis in his own time for the Governing Body workshop in May to agree the CCG's accounts. Recruitment for his successor began in April 2014, and Professor John Mayberry, a professor of gastroenterology at University Hospitals of Leicester NHS Trust, accepted his position on 21 October 2014. Professor Mayberry was able to take up the position from 1 April 2015.

We were also sorry to see Dr Fergus MacMillan retire at the end of March 2015. Dr MacMillan has been the champion for unplanned care on behalf of both the former North Lincolnshire Primary Care Trust and the CCG since its inauguration, playing a fundamental role in the development and implementation of the Urgent Care Model and NHS 111. He has been a committed and conscientious member of the CCG's Governing Body and his honest, passionate and practical approach to improving patient care will be greatly missed. We welcome Dr Faisel Baig, from The Birches Practice in Scunthorpe, as Dr MacMillan's successor on our Governing Body and as lead for unplanned care from 1 April 2014.

The last 12 months have been challenging. We have striven to commission the best healthcare services we can for residents of North Lincolnshire in spite of increasing demand pressures on our available funding resources. Looking forward we will have to continue to make some tough decisions about the services we commission. Some services might have to change or be delivered differently if we are going to be able to ensure a high quality, safe and sustainable standard of care to our population in the coming years. However, we know that we can depend on the commitment, expertise and professionalism of our staff, member practices, partners and our colleagues in our Commissioning Support Service to pull together to meet these challenges. To you all we give our deepest thanks for all your hard work over the past year and we look forward to building on what we have already achieved in the year ahead.

Allison Cooke

Chief Officer

Dr Margaret Sanderson

Chair

3. Member Practices Introduction

During the past 12 months, the Members have seen our CCG grow in strength and confidence as the lead commissioners for health care services for the people of North Lincolnshire.

Our first year was largely spent getting to grips with the transition from a Primary Care Trust to a clinically-led CCG, including embedding a new model of governance. We also developed our strategic vision and commissioning intentions for commissioning services and models of care that are safe, sustainable and of high quality, closer to patients homes, with an emphasis on facilitating independence and self-care as much as possible.

During 2014-15, we have increasingly got into our stride, seeing a real sense of progress, commitment and leadership from the CCG membership in moving ahead with our vision and plans. Our refreshed two-year operating plan for 2015-16 has recently been agreed and submitted to NHS England. Our five-year strategy, which defines the principle actions we need to take in order to deliver our vision, was published in June 2014.

The CCG continues to work to address the challenges of complex local health needs: an ageing population with co-morbidities, an increase in the number of people living with disabilities and long term conditions and higher than average smoking and obesity rates. People are also living longer which means an increased likelihood of developing age-related conditions. Much of our work over the past year has been around planning for and managing these challenges within the resources available to the CCG by improving service quality and performance, improving efficiency and securing more integrated ways of working.

Primary care has led the way on our ambition to ensure that patients who are presenting signs of dementia receive a timely diagnosis through their direct input into the development of the local dementia toolkit. The toolkit is designed to help clinicians identify early onset dementia patients so that these patients can then be signposted to vital treatment and support as soon as possible. Our GPs have also shown continuing commitment to develop their professional knowledge and understanding of dementia, as demonstrated by the success of our dementia Protected Time for Learning event in October 2014.

16 of our 19 practices have signed up to the 'Productive General Practice' initiative designed to help practices make small but significant changes to their procedures and processes. These in turn have been proven to improve the quality of patient care and staff morale.

The CCG has worked with service providers to develop and enhance a range of community services to support people with long term conditions and bring care closer to people's homes. These include the appointment of a dedicated Parkinson's nurse and provision of a larger, more accessible community nursing team for children and young people with acute, complex and chronic conditions. Access to a pain clinic is now much quicker as we have commissioned a community based service as well as the existing hospital based service. And our Expert Patient Programme, delivered in partnership with North Lincolnshire

Council, continues to provide practical help and advice to people living with a long term condition on how to manage their health issues and get the most out of life.

Patient insight continues to be fundamental to the services that the CCG commission. During 2014-15, we have continued with our Experience Led Commissioning (ELC) programme, working closely with service users, carers and frontline professionals from across the health, social care and voluntary sectors to co-design adult mental health services. We have also seen the fruits of previous years' ELC work around dementia, long term conditions and end of life care in the form of the establishment of the Dementia Action Alliance, the launch of the Dementia Directory and the development of the Advance Care Plan for end of life care. The outcomes of our ELC work have been instrumental in shaping the latest iteration of the CCG's two-year operational plan.

The Friends and Family Test (FFT) has been progressively rolled out across NHS services in England since 2013. In February 2014, the CCG was one of a select number of pathfinder sites chosen by NHS England to test and review the application of FFT in different healthcare settings. We opted to trial the FFT across the complete care pathway for stroke. The trial proved multi-beneficial in that it not only improved working relationships and communication between the CCG, service providers, service users and the voluntary sector, but also produced real and co-ordinated improvements to the stroke care pathway. A notable example is the development of the referral template for GPs to refer discharged stroke patients to the Stroke Association for rehabilitative support in the community. Our innovative approach was put forward for the 2014 Medipex NHS Innovation Awards, where we were successful finalists.

The CCG has continued to work with a range of partners to develop multi-agency, integrated approaches to health and social care service delivery. Our Better Care Fund plan, which was approved by NHS England in February 2015, has been developed with our partners across health and social care. The plan takes forward changes to services for the frail and frail elderly in order to provide people with a more joined-up experience of care along with better support at home, treatment in the community to avoid the need for urgent hospital treatment or early admission into care or nursing homes, and a reduction in the time they spend in hospital if they do have to be admitted.

In November 2014, some of these changes were trialled during 'The Perfect Week', when four schemes in the Better Care Fund plan were implemented to assess their sustainability and impact. The results were encouraging, suggesting that with the right amount of planning and phased approach to improvement, the changes will improve outcomes for frail and elderly patients. We are looking forward to seeing this on a larger scale over the coming months.

The latest phase of the Healthy Lives, Healthy Futures review of health and social care services across North and North East Lincolnshire saw 24/7 hyper-acute stroke services centralised at Scunthorpe General Hospital and agreement that specialist ear, nose and throat in-patient surgery will be centralised at Diana, Princess of Wales Hospital in Grimsby.

The arrangements for hyper-acute stroke services had temporarily been in place since November 2013 and have already produced improved outcomes for stroke patients, most notably a significant reduction in our annual mortality rates for stroke from 14% to 11%. As a result, our region is now one of the best for outcomes on stroke in the country.

Our Governing Body has continued to meet on a bi-monthly basis throughout the year, to lead on the implementation of the CCG's vision and strategy. It has discharged its duties to provide risk assurance, monitor performance, approve commissioning plans and make decisions on commissioned services on behalf of the wider CCG as duly delegated. The Governing Body has also played a key co-ordination and development role, with our Lay Member for Public and Patient Involvement working with Patient Participation Groups (PPGs) in association with Healthwatch North Lincolnshire to develop induction training and a supporting resource pack and organising regular update meetings between the PPG chairs.

Our Council of Members (CoM) has met monthly during the year in order to provide clinical insight and advice on the CCG's strategic direction, key objectives, clinical governance and service standards. In November 2014, the CoM opted to jointly commission primary care services with NHS England, for which we received approval from NHS England in March 2015. This step will be crucial to the achievement of our long-term vision and plans as it will allow us to redesign, enhance and extend what primary care is able to do at practice and locality level in a more co-ordinated, cost-effective and managed way. The CoM also confirmed they wished to retain a clinical Chair of the Governing Body and a non-clinical Accountable Officer in anticipation of the retirement of the current Chief Officer of the CCG.

Complementing the co-commissioning decision is the formation of the GP Federation, which will enable GPs to be part of a provider organisation. The Federation is still in its early stages and the CCG is playing a supporting role to practices in its development. We look forward to seeing how both of these key developments will help drive forward our commissioning agenda during the next 12 months.

Both the Governing Body and Council of Members have pro-actively evaluated their own and the CCG's effectiveness. Following the 360 Stakeholder Survey in March 2014 a joint review meeting of the CoM and the Governing body was held, facilitated by an independent chair. The meeting reflected on the Survey feedback and considered a number of elements, including a general review of how the CCG was operating, the role and responsibilities of the CoM, and the structure and timing of CoM meetings. The Council of Members and Governing Body have the same clinical Chair and it was concluded that this arrangement should continue. Changes were agreed regarding CoM meetings to alternate between business and development meetings each month with the aim of allowing sufficient time for clinical discussion regarding change and improvement. Further details on how the Governing Body and the CoM have reviewed their effectiveness can be found in the Annual Governance Statement.

The Members are satisfied that the CCG has met all of its statutory and mandatory obligations, including delivery of all financial targets, during the period 2014-15. We look forward to another successful year of working together to commission the best healthcare services we can for the people of North Lincolnshire.

Dr Margaret Sanderson, Chair, CCG Governing Body and Council of Members

Signed: Allison Cooke, Chief & Accountable Officer
Date: 27 May 2015

4. Strategic Report

4.1. About the CCG and its community

NHS North Lincolnshire Clinical Commissioning Group (CCG) is the NHS organisation responsible for designing, developing and buying (commissioning) local health services in the North Lincolnshire area.

CCGs were introduced nationally in 2013 as part of the Government's restructuring of the NHS with the aim of putting local clinicians, such as GPs and nurses, in a position where they can develop the services their patients and local residents need. NHS North Lincolnshire CCG was established and licensed, without conditions, on 1 April 2013. The CCG central team operates from offices at Health Place, Wrawby Road, Brigg, which are leased from NHS Property Services. The organisation is led by GP representatives from the 19 practices within North Lincolnshire supported by a small team of non-clinical staff who carry out the day-to-day business of the CCG. The CCG is accountable to its members, patients and the public and is overseen by the executive, non-departmental public body for the Department of Health, NHS England.

The primary role of the CCG is to assess the health needs of the North Lincolnshire population and make sure that safe, sustainable and high quality healthcare services are in place. This has to be achieved within the financial budget set by the Government. The CCG has an annual commissioning budget of approximately £210 million and a budget for running costs of approximately £4m. This budget is based on a complex funding formula which takes into account the overall health and wellbeing of people living in the area.

The CCG shares in large parts the same administrative boundary as North Lincolnshire Council, covering an area of approximately 328 square miles (850 square kilometres). North Lincolnshire has a distinct settlement pattern. The large urban area of Scunthorpe and Bottesford is the main population settlement for employment and retail, and is home to just under half (48%) of North Lincolnshire residents. The remaining 52% live in the 6 market towns of Barton, Brigg, Crowle, Epworth, Winterton and Kirton Lindsey and in the 80 surrounding villages.

The latest mid-year population estimates for 2013 from the Office for National Statistics (ONS) suggest that 168,760 people live in North Lincolnshire; this represents an 8% growth since 2003 and an average annual growth of around 1200 more people a year. This is a faster rate of population growth than experienced by both our regional neighbours and nationally (6.2% and 7.9% respectively). The local population is projected to grow by a further 9.4% to reach 184,136 between now and 2037.

North Lincolnshire not only has an increasing population but also an ageing one. 2013 mid-year population estimates suggest that 19.3% of the North Lincolnshire population was aged 65 and over, higher than regional and national figures. Currently there are 32,522 people aged 65+ resident in North Lincolnshire. This represents a 22.6% increase since 2003. The most significant growth in the retirement age population has been amongst those aged 90+ and amongst older men in particular. In the 10 year period between 2003 and 2013, the number of residents aged 85+ grew by more than 46%.

The CCG has faced a number of challenges during 2014-15. In part these are due to the changing demographic profile described above. As our population becomes older, the number of people living with multiple, and often complex, conditions increases. This has placed additional demand on our health services and has affected waiting times and costs. To tackle these challenges, the CCG will continue to work closely with partners in North East Lincolnshire CCG and Northern Lincolnshire and Goole Foundation Trust on the Healthy Lives, Healthy Futures joint review of services to understand the funding gap over the coming years and work collectively to find sustainable models of care which can be delivered within the funding available. Complementing this will be the implementation of the Better Care Fund plan which sets out new models of care, particularly for the frail and elderly community. The plan will put in place new or enhanced services that will enable more people to be cared for in their own home, or a home like environment, with support to return to independence. These services will build on those already available and will include support for people with mental health needs, including dementia, rapid access to home-based care during illness, and support for care homes. Public engagement has played an important role in the shaping and development of both Healthy Lives Healthy Futures and Better Care Fund plans so far, and this engagement will continue throughout 2015-16.

Following the publication of the Francis Inquiry report, which examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009, the CCG has implemented a detailed plan to ensure that the organisation learns from the lessons of this report. This includes adjustments to the business and assurance processes within the CCG's commissioning functions to ensure that the CCG is assured on the quality of local service provision. This work will continue in 2015-16.

4.2. The CCG business model

The CCG commissions hospital and community services from Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and specialist services from Hull and East Yorkshire Hospitals NHS Trust (HEYHT). Mental health services are commissioned from Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH). Where appropriate, the CCG will jointly commission services with partners, such as neighbouring North East Lincolnshire CCG for health care and North Lincolnshire Council for social care services.

Examples of the range of NHS services commissioned by the CCG include:

- Acute secondary care (hospital) services including emergency and urgent care (including the out-of-hours GP service).
- Routine and planned hospital treatment on an outpatient, day case and inpatient basis, across a range of medical and surgical specialities
- Maternity care
- Mental health services, including community and inpatient care
- Community nursing
- Learning disability services
- Community services, including district nursing, therapy services and Emergency Care Practitioners

Up to now, CCGs have not been responsible for directly commissioning primary care (GP) health services – these have been commissioned by NHS England. However, during 2014-15, CCGs were able to apply for co-commissioning status. The CCG requested and was approved as a joint commissioner of primary care from 1 April 2015 and has now commenced that responsibility in conjunction with NHS England. The newly formed Joint Commissioning Committee held its inaugural meeting in April 2015.

A number of established committees, together with the appointment of key officers and feedback from external assurance ensure that robust governance arrangements are in place to support delivery of the CCG's vision and commissioning plans.

Governing Body

The CCG's Governing Body has responsibility for ensuring that the CCG operates effectively, efficiently and economically and in accordance with the CCG's principles of good governance. It is also responsible for the clear commitment and direction for risk management within the CCG, delegating responsibility for risk and non-clinical risk to the Audit Group and operational and clinical risk management to the Quality Group.

In 2014-15, there were 12 voting members on the Governing Body - a clinical chair (GP), five GP members, three executive officers of the CCG, a secondary care doctor and two lay members (one with responsibility for governance and the other with responsibility for public and patient involvement). There are also two non-voting members – an executive director of the CCG and the Director of Public Health.

Audit Group

The Audit Group is responsible for providing an independent overview of risk management arrangements with specific responsibility for financial risk management.

Quality Group

The Quality Group has overarching responsibility for clinical risk management, providing assurance to the Governing Body that appropriate clinical risk management arrangements are in place across the organisation.

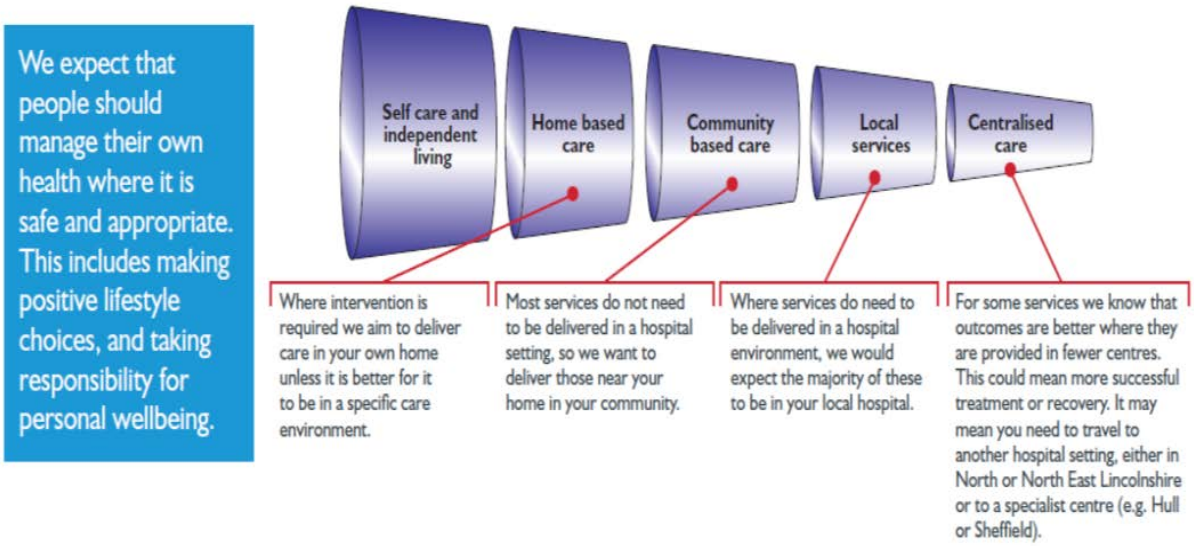
The CCG works closely with the NHS England Area Team to comply with the national CCG assurance process. Throughout 2014-15, all reviews have been positive, strengthening the co-commissioning relationship with NHS England. All reviews have covered authorisation domains and the national CCG assurance framework.

4.3. The CCG strategy

The CCG has recently submitted its operational plan for 2015-16 to NHS England. This refreshes year two of the five year strategic plan submitted in 2014-15.

The strategic vision for the CCG remains relatively unchanged from 2014-15. The CCG aims to commission services which empower and support people to manage their own health and care, and maintain their independence for as long as possible. People will receive care in the home or community setting wherever it is safe to do so, only being admitted to hospital for clear clinical reasons, and supported to return to independence through access to reablement and rehabilitation. The strategy has been informed by engagement with the public, patients, carers and front line staff through our Experience Led Commissioning programme and is based on enabling people to manage their own health and accept responsibility for their lifestyle choices.

The strategy is described pictorially below:



The CCG's strategy is reflected in its Commissioning Plan for 2014/15 – 2018/19 and also the Better Care Fund plan. The implementation of these plans will see a significant change in the future provision of services, including the development of support services to help people keep well and maintain independence, as well as have more of their care needs met within primary care and the community. The operational plan for 2015-16 includes the full implementation of the Better Care Fund plan and sets ambitious targets for reductions in hospital admissions through delivery of community based care and prevention.

National policy change and guidance released during 2014-15 offers the CCG some additional opportunities during 2015-16.

The Five Year Forward View (NHS England, October 2014) sets out a range of new models of care which will enable providers to work together in different ways to deliver the outcomes commissioners require. The CCG registered its interest in joining the 'Vanguard' new models of care programme but was unsuccessful. However, despite not being part of this national programme, the CCG maintains that the use of new models of care have significant potential to support delivery of a sustainable health and care system across North and North East Lincolnshire. The CCG will therefore continue to assess how it takes these models forward in the absence of support and national funding.

As previously referenced, the CCG has been successful in its application to NHS England to jointly commission primary care (GP) services. The CCG sees this as an opportunity to deliver increased benefits to patients through co-commissioning services to support the shift in care from hospital based to primary and community based care. This will include commissioning alternative services in both GP practices and the community using new models of care.

The CCG strategy is also an essential component of the Healthy Lives Healthy Futures joint programme for transformational change across North and North East Lincolnshire. This programme aims to secure high quality, safe and sustainable services for the local populations of North and North East Lincolnshire now and for the next 10 years.

Within its plan for 2015-16, the CCG has set an expectation for delivery against all the NHS Constitution measures, and whilst some of these remain challenging locally, the CCG continues to work with providers to ensure delivery.

Our strategic and operational plans, and our Better Care Fund plan, can be read in full on the CCG web site www.northlincolnshireccg.nhs.uk

4.4. Achievements this year

The CCG has made significant progress towards the vision and ambitions it set out when it was first established back in 2013 and it is performing well against key local and national priorities. 2014-15 saw a number of achievements that have contributed towards the CCG's planned step changes to delivery of care which aim to reduce the need for in-hospital care by bringing care services into or closer to people's homes, providing people with the knowledge and confidence to self-care and developing pro-active services that support people to remain independent for as long as possible.

- *New model of care for diabetes*

The CCG has started a pilot service of a new model of care for diabetes which sees patients from four practices initially receive more of their care in their GP surgery thus reducing un-necessary hospital visits. This model will be expanded to all practices in 2015-16.

- *Care closer to home and independent living for people with learning disabilities*

In response to the Winterbourne review, the CCG has made great steps towards ensuring that people with learning disabilities who require care receive this close to home. The CCG has worked closely with North Lincolnshire Council to develop a Market Position Statement which supports provider organisations to understand the needs of the people of North Lincolnshire and to respond to this when they develop services. This means that providers are starting to develop care solutions that meet the needs of our residents, resulting in fewer people being cared for outside of North Lincolnshire. 2014-15 saw the opening of purpose-built housing for people with learning difficulties in Scunthorpe, enabling people to live independently in suitable accommodation, closer to family and friends. In addition to this, the CCG has clear plans in place for the small number of people who are still living in residential settings outside of North Lincolnshire, to move them back to local services where these can meet their needs.

- *Paediatric Assessment Unit and Children's Community Nursing*

The last year also saw further development in services for acutely ill children. Children who attend the Emergency Department and need further assessment now receive this in a children's assessment unit at Scunthorpe General Hospital. This allows medical and nursing staff to assess them over a number of hours without the child having to be admitted. The Children's Community Nursing Team has also been expanded to increase the number of children the team can care for in the community, reducing the need for parents to take their child to hospital for tests and monitoring.

- *Advance Care Plan for end of life patients and single point of care for people with long term conditions*

The CCG has continued to work with its partners to utilise Experience Led Commissioning (ELC) as a way of engaging with patients, carers and staff about a range of health needs in order to help them co-design care models for the future. During 2014-15, the CCG's ELC work focused on end of life care, keeping well – living independently, long term conditions and dementia.

Following the completion of this ELC engagement work, the CCG worked with patients at end of life, their carers and staff to co-design an Advance Care Plan. The plan, which was launched in May 2014, is designed to support people approaching end of life to discuss and describe their preferences and plans with family and health and care professionals. The plan can then be used by health and care professionals to deliver care in line with these preferences.

The CCG has also taken the learning from work around people with long term conditions and the 'keeping well-living independently' work to plan a holistic care model for people with long term conditions. This approach will result in patients having a single named clinician – the GP co-ordinating care for all their long term conditions, pulling in consultant advice and support where required. This model will be further developed during 2015-16.

- *Improvements to the stroke care pathway*

During April and May 2014, the CCG concluded its work with partners and local organisations, including GP practices, NLaG and the Stroke Association, to help NHS England pilot the Friends and Family Test (FFT) for the stroke services pathway. The Friends and Family Test has been introduced to the NHS as a way to assess how well services are performing by asking patients to say how likely they are to recommend a service they have accessed to friends or family.

The CCG pilot focused on the stroke services pathway, the journey taken through different parts of the health service by a stroke patient on the road to recovery and the transfer between the different parts of the service. Patients involved in the pilot were asked the following question: "How likely are you to recommend our stroke services to a friend or family member if they needed similar care or treatment?"

The CCG involved partners, the Stroke Association and stroke survivors in developing the surveys and approach to implementing the pilot, which ran from March 2014 to May 2014. The outcome of the pilot was improved working relationships and communication between the CCG, service providers, service users and the voluntary sector. It also resulted in the development of a referral template for GPs to refer discharged stroke patients to the Stroke Association for rehabilitative support in the community. This means that stroke patients now receive a more joined-up experience of care whilst they need acute or specialist interventions, followed by longer-term support at home to aid their on-going recovery and reduce their risk of relapsing and requiring further hospital treatment.

This work was positively evaluated by NHS England and was also put forward for the 2014 Medipex NHS Innovation Awards where it reached the finals. More information about the Friends and Family Test can be found on the national website at www.nhs.uk/friendsandfamily

- *Increased dementia diagnosis and access to treatment and support*

During 2014-15 there was a national drive to improve the proportion of people with dementia who had a diagnosis. Across the country the number of people diagnosed with dementia falls significantly short of the expected prevalence level. This means that people who may be experiencing symptoms are not being diagnosed and therefore not offered appropriate treatment or support. The Government set a challenging target for CCGs to ensure a diagnosis rate of 67% of the expected prevalence. Throughout 2014-15, local GP practices have pro-actively reviewed patients at risk of dementia to identify those who have the disease, and progress towards the national target is being made. In April 2014, 1117 people had presented to a GP and been diagnosed with dementia in North Lincolnshire – this translated as 49.6% of the expected prevalence. In March 2015, 1356 people had been diagnosed – an increase to 59.8% of the expected prevalence. This positive progress means that increasing numbers of people with dementia are now able to consider and access treatment, care and support options.

- *Better public and patient engagement through 'Embrace'*

Embrace, the CCG's public membership engagement network, launched in June 2014 and membership is growing (117 members as at end of March 2015). Members were involved in the CCG's recent business planning event, 'Health Matters', where they had the opportunity to share their views on the CCG's commissioning plans for 2015-16, particularly around how they can continue to be involved in shaping services as they develop. The CCG will be developing further opportunities for Embrace members to get involved in its work over the coming year.

- *Development of Patient Participation Groups*

Working with Healthwatch North Lincolnshire, the CCG has held a number of engagement events with GP practice Patient Participation Groups (PPGs) and their chairs, establishing training and providing support for groups to develop.

- *Improving services for lesbian, gay and bi-sexual patients*

The CCG has continued its work with Stonewall to improve services for lesbian, gay and bisexual patients, families and carers who use GP and other health services in North Lincolnshire. This work included an engagement event to understand their experiences followed by training for staff to increase awareness and understanding to support service developments. The CCG will continue this work to improve services for all diverse groups throughout the coming year.

4.5. Risks facing the CCG

The revenue resources available to the CCG at the start of the year were set out in the CCG's financial plan for 2014-15 as part the overall operational plan. Throughout the year the CCG has reported publicly through its Governing body against these budgets. The CCG has had to manage a number of financial risks in the year, especially the growth, cost and acuity of continuing health care cases and activity levels within our local acute trusts.

The Better Care Fund is a national policy which supports transformation and integration of the health and social care system. This plan sets an ambitious target for reducing non-elective hospital admissions. The implementation of this policy and its consequences, should this not reduce demand on hospital services, is the principle financial risk for the CCG over the next 2-5 years.

Delivery of the Healthy Lives Healthy Futures programme is essential if the CCG and its programme partners are to secure high quality, safe and sustainable services for the population of North and North East Lincolnshire over the next 10 years. The North and North East Lincolnshire health economy is predicting a funding gap of over £100m by 2019, therefore the development and implementation of the Healthy Lives Healthy Futures plan over the next five years and beyond is one of the main priorities for the CCG. Key to the success of the programme will be ensuring that the public and affected health and care services staff understand the case for change and feel able to participate in the change process through engagement and consultation.

The CCG has adopted a risk management process where logical steps are taken to manage risks effectively. More detail on our approach to risk management is within the Annual Governance Statement.

4.6. CCG performance

The CCG's performance against the rights and pledges set out in the NHS Constitution is reported to its Governing Body at each meeting through a set of defined key indicators and associated targets. We are meeting most of the targets; however there remain a number of challenges.

Ambulance response times

The current provider is East Midlands Ambulance Service (EMAS) and, whilst local performance against the targets is reasonable, the CCG is judged on overall EMAS Trust performance which continues to fail to meet the required target. The CCG is currently part of a collaborative commissioning arrangement across all EMAS commissioners, with Erewash CCG as the lead commissioner. The CCG continues to work with the collaborative and pursue recovery actions to secure continuing improvements in response times in North Lincolnshire.

A&E 4 hour wait

This target has been challenging during 2014-15, with a year-end position of 92.4% against a target of 95% within 4 hours. Actions are being taken as set out in the CCG's System Resilience Plan and there is significant focus via the Urgent Care Working Group, which brings together representation from the acute and community services including EMAS, North Lincolnshire Council, NHS East Riding of Yorkshire CCG and the NHS England Area Team, to understand and address the issues impacting on performance against this target. The implementation of the new, integrated urgent care model and embedding this whole system change will contribute towards sustained improvement in performance during 2015-16 and beyond.

Breast cancer 2 week waits

The CCG has experienced difficulties with achieving consistent delivery of this standard with breaches occurring at a range of providers. Reasons for these breaches are varied and include trust capacity and patient choice. Breaches and performance levels are monitored and discussed at regular monthly contract review meetings and tracking against recovery plans in place is made available to the CCG and its Governing Body.

NHS Outcomes Framework Domains

Performance against the 5 domains in the NHS Outcomes Framework highlights a number of challenges for the CCG:

- Preventing people dying prematurely – local challenges remain regarding cardiovascular disease and alcohol related liver disease
- Recover quickly and successfully – issues regarding the number of non-elective admissions for ambulatory care sensitive conditions and conditions that should not usually require admission, both of which are a fundamental part of the emergency care revised pathways contracted in 2015-16
- Great experience of care – local challenges regarding experience of hospital and out-of-hours care
- Kept safe from avoidable harm - there have been 3 cases of MRSA attributed to patients in 2014-15 (against a target of zero). The target for C Difficile has been achieved – 35 actual cases against a target of 37

4.7. The wider context in which the CCG operates

The two North and North East Lincolnshire CCGs are served by a single, main acute provider – Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). The majority of acute services are provided at Scunthorpe General Hospital and Diana, Princess of Wales Hospital in Grimsby, with a lesser range of services provided at Goole Hospital. NLaG also provide community services. Mental health services are provided by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH), with only a low number of small additional service providers locally. Hull and East Yorkshire Hospitals NHS Trust provide some specialist services for patients in North and North East Lincolnshire.

Hospital trusts nationally have faced a challenging financial position in 2014-15. Local trusts are working with their commissioners to design services in a way that achieves financial stability going forward. With no projected growth in financial allocation, plus an ageing population with multiple and complex long term conditions, continuation of current health service models will result in a funding gap of circa £30bn nationally by 2020-21. For North and North East Lincolnshire, this represents a funding gap of over £100m by 2018-19.

Healthy Lives, Healthy Futures is the on-going, joint programme of service review and transformation which aims to achieve an affordable and sustainable health model for the future in North and North East Lincolnshire. The programme, which the CCG is delivering in partnership with North East Lincolnshire CCG and NLaG, has made significant progress during 2014-15 to ensure robust, clinically led proposals are developed. These proposals have been informed by engagement with the local population. During 2015-16, the proposals will be publicly shared and further engagement will take place, including formal consultation as required.

During 2014/15 the CCG was supported by North Yorkshire and Humber Commissioning Support which from 1 October 2014 merged to become part of Yorkshire and Humber Commissioning Support.

There was also a change in relationships with NHS England in year following the realignment of Area Teams. Our relationship has therefore moved in year from working with the North Yorkshire and Humber Area Team to working with the Yorkshire and Humber Area Team.

4.8. The CCG's year-end financial position

The CCG has had no capital allocations this year.

The revenue resources available to the CCG at the start of the year were set out in the CCG's 2014-15 financial plan as part the overall operational plan. Throughout the year the CCG has reported publicly through its Governing Body against these budgets. The CCG has had to manage a number of financial risks in the year especially the growth, cost and acuity of continuing health care (CHC) cases and mental health placements, increases in the price and usage of drugs and additional activity across a number of healthcare contracts. In addition, there were changes as a continued consequence of the Health and Social Care Act, for example, additional resources transferred to NHS England for specialist commissioning, primary care and the CHC Legacy Pool. These have been covered by underspends in other areas and the use of contingency and reserves.

There have been no significant changes to accounting policies that have affected the accounts in 2014-15.

4.9. Going concern

The 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:

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

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

4.10. Assurance Framework

The NHS England CCG Assurance Framework requires clinical commissioning groups to report on their delivery of the duties laid down in the National Health Service Act 2006 (as amended). The report for how we have delivered on the duties in the Act can be found in the Annual Governance Statement. Additional information regarding our compliance with the requirements of the Act, specifically regarding inequalities and public involvement, is also detailed below.

The Risk Register and Board Assurance Framework are the Clinical Commissioning Group's tools for managing risks to the organisation and our objectives. More detail on the Risk Register and Board Assurance Framework can be found in the Annual Governance Statement.

Reducing inequalities

The CCG is committed to reducing health inequalities through commissioning services that meet the needs of the local population. The CCG's strategic commissioning plans are underpinned by the findings of the Joint Strategic Needs Assessment (JSNA) which identifies local health need, gaps and inequalities. The CCG is a member of the JSNA working group and consequently the CCG ensures that commissioning priorities are informed by the latest updates from public health population profiles and the JSNA. In addition, through its commitment to the Experience Led Commissioning approach, the CCG actively seeks the views of service users, carers and partners to ensure that health care services locally are shaped by the views of local people.

Equality Impact Assessments (EIAs) are undertaken on the development of all new commissioned services and routinely as part of service reviews / re-design. They are also embedded as part of the policy development process to ensure that no service is commissioned or policy implemented without a full consideration of the impact it may have on equity of access and health inequalities.

The CCG is a statutory member of the Health and Wellbeing Board and, as such, plays a full and active part in the work of the partnership. The CCG has aligned its plans to support the delivery of the Joint Health and Wellbeing Strategy. The purpose of the Health and Wellbeing Board is to improve the health and wellbeing outcomes of the people of North Lincolnshire and to reduce inequalities.

An Integrated Impact Assessment has been undertaken alongside the development of the Joint Health and Wellbeing Strategy suite of documents. As part of this, consideration has been given to a range of factors, including environmental, community safety, health, geographical, economic and social inclusion, diversity and human rights, statutory legal processes, risk, procurement and child poverty, all of which take account of the wider determinants of health and inequalities and deliver improved outcomes.

The CCG is a member of the Integrated Working Partnership (IWP). The partnership champions the development and delivery of whole system integration and integrated ways of working on behalf of the organisations represented on the Health and Wellbeing Board in order to serve the best interests of service users.

Public Involvement

Working alongside other NHS trusts, partners and members of the public, the CCG is working to shape and define the NHS in North Lincolnshire. The CCG's clinical leaders believe the only way it can succeed in delivering high quality services for the community and improving the health of the local population is by involving members of the public, partner organisations and its member GP practices in the development of services. Therefore it is vital that the public and the health and care community are not only informed of the process, but also engaged in it and offered the opportunity to be involved. In order to be trusted and valued, it is vital that the CCG is transparent and open in its approach, and effective communications and engagement form the cornerstone of this.

This year the CCG refreshed its Communications and Engagement Strategy to reflect the updated national policy drivers and to establish a model for how it will engage with local stakeholders and the public to ensure that the right local services are provided in the right place, at the right time for local people.

The Communications and Engagement Strategy sets out that the CCG will:

- Engage with, and listen to, patients, carers, diverse groups and other stakeholders
- Take patients' experiences into account when developing services to respond to local needs and priorities
- Communicate with stakeholders to ensure that people are kept informed of developments and have access to information they need, when they need it
- Ensure engagement and communication processes are open and accessible to all communities

How the CCG engages

North Lincolnshire Public and Patient Engagement Network (Embrace)

The CCG launched Embrace, its public membership engagement network, to capture the contact details and particular interests of patients and the public within the North Lincolnshire area.

The purpose behind Embrace is to establish a strong network of local people, patients, carers, voluntary sector representatives and other partners who have an interest in service developments, learning more about the NHS and being more closely involved in shaping local services.

The CCG has seen a steady increase in numbers of people signing up to Embrace over the year. Embrace members receive regular communications from the CCG including:

- Electronic or hard copy of the CCG's quarterly, public facing newsletter, Health Linc
- Information about national and local engagement opportunities in their areas of interest
- Information about CCG Governing Body and committee meetings and events

To join Embrace, please contact us or visit the CCG's website: www.northlincolnshireccg.nhs.uk/Embrace

Stakeholder list

The CCG has a well-established, wide ranging 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.

Healthwatch North Lincolnshire

The CCG has worked with Healthwatch North Lincolnshire to develop links with local Patient Participation Groups (PPGs), jointly hosting quarterly PPG chairs meetings and co-facilitating training sessions for newly formed PPGs. The CCG is working with North East Lincolnshire CCG and both of North and North East Lincolnshire's Healthwatch groups to scope and plan future engagement on patient transport services.

An overview of engagement and consultation in North Lincolnshire 2014-15

Healthy Lives, Healthy Futures

During 2014-15, phase 3 of the Healthy Lives Healthy Futures on-going review of health and care services across North and North East Lincolnshire took place. This took the form of an engagement and formal consultation programme on proposals for changes to hyper acute stroke services and ear, nose and throat inpatient services.

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

• Public events (11)

• Road shows (523)

• GP practice visits (241)

• Living Well events (93)

• Mela festival (North East Lincolnshire) (77)

• NLaG staff event (29)

• Public meetings (17)

• Stakeholder and community groups (350)

In total, 298 formal consultation responses were received, comprising of 257 questionnaires (26 of which were Easy Read), 29 comment cards, 6 e-mails, 5 letters, and 1 Facebook query.

In November 2014, the Governing Bodies of both North and North East Lincolnshire CCGs formally agreed to implement the preferred service change options.

The CCG will continue to involve local people in the next phase of the Healthy Lives Healthy Futures review throughout 2015-16. More information, including details of the service changes agreed in phase 3 and the full feedback report, is available on the review's dedicated website at:

www.healthyliveshealthyfutures.nhs.uk

Business Planning

In February 2015, the CCG held its second annual business planning event – 'Health Matters' - inviting members of the public and stakeholders to come along to hear about the CCG's plans and priorities for local healthcare services in 2015-16. Approximately 50 people attended and highlights from the meeting were tweeted live via the CCG's Twitter account. The event gave people the opportunity to share their views on the CCG's plans and have their say about how the public and stakeholders can continue to be involved in shaping services as they develop.

Participants were then invited to look in more depth at plans for either long term conditions, frail and elderly or mental health services with service leads. The event rounded off with a Q&A panel where the audience could pose questions to CCG and Healthwatch representatives.

Experience Led Commissioning

The CCG's Experience Led Commissioning (ELC) activity in 2013-14 was used to provide a foundation for its work around commissioning services for end of life care, keeping well, long term conditions; and dementia.

In 2014-15 the ELC approach was used to look at mental health in-patient services and asked the commissioning question: ***''How can we deliver services that support people during mental health crisis and support recovery and sustained health and in the process recognise the need for 'parity of esteem'?'***

During the first stage of the process, the CCG visited organisations and community venues to meet with 75 patients, carers and front line professionals to understand their current and desired experiences of mental health services. All participants were then invited to a PATH event in December 2014 to jointly design a visual representation of the care that they thought North Lincolnshire people need and the steps that needed to be taken to achieve this.

The findings from the mental health ELC programme have informed the CCG's Mental Health Strategy and future commissioning plans.

GP Practices

GP practices actively engage with their patients using online surveys, paper surveys and electronic equipment which captures patient views on the service they receive in order to identify areas for improvement. Patient surveys were carried out in Ashby Turn, Trent View and South Axholme practices as part of

the Patient Participation Directed Enhanced Service (DES) to explore patients' views of access to primary care services.

Stonewall Healthcare Equality Index

In 2014, the CCG has been working with Stonewall to develop and improve its links and relationships with lesbian, gay, bi-sexual and transgender (LGBT) people. The CCG held a workshop in October 2014 with members of the LGBT community, and attended a local "Yes group" (LGBT forum for young people) in November 2014 to discuss health issues.

The CCG once again took part in the Stonewall Healthcare Equality Index which is a tool for health organisations to benchmark and track their progress on equality for their lesbian, gay and bisexual patients and communities.

Focus / Special Interest Groups

The CCG have met with a number of community and special interest groups over the course of the year to inform its engagement across the commissioning cycle, including the Carers Advisory Group, Scunthorpe & District Mind, the Lindsey Blind Society and Breathe Easy group.

4.11. Sustainability Report

NHS North Lincolnshire Clinical Commissioning Group is committed to shaping and commissioning health services that are environmentally appropriate, meet the health needs of the local population, and are financially sustainable. To underpin achievement of these goals, the CCG introduced its first Sustainability Development Management Plan in 2014.The following report provides commentary on the CCG's key achievements to date.

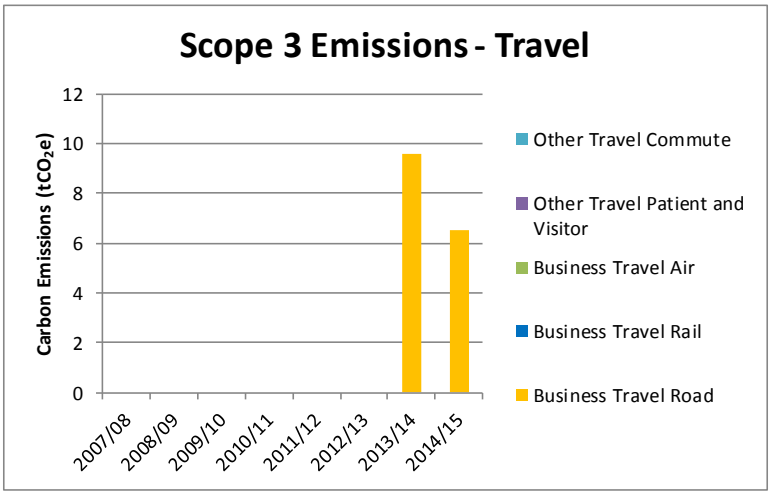
Governance

The CCG has designed, developed and implemented a Sustainability Impact Assessment (SIA) template to help us to anticipate the likely sustainability implications of a policy, strategy or service design or redesign. During 2014, the template was embedded within the CCG's corporate templates and decision making functions.

Travel

To support the CCG's ambition to reduce its carbon footprint, the CCG have introduced unified communications tools as an alternative to face to face meetings. These include video-conferencing and teleconferencing. In addition to this, the CCG has developed and introduced a number of policies to support and further encourage its staff to consider new ways of working, including a 'Remote Access & Home Working Policy'. The CCG have continued to build upon legacy policies from when it was a Primary Care Trust, for example, in areas such as green travel.

Table 1: Travel Emissions 2014-15

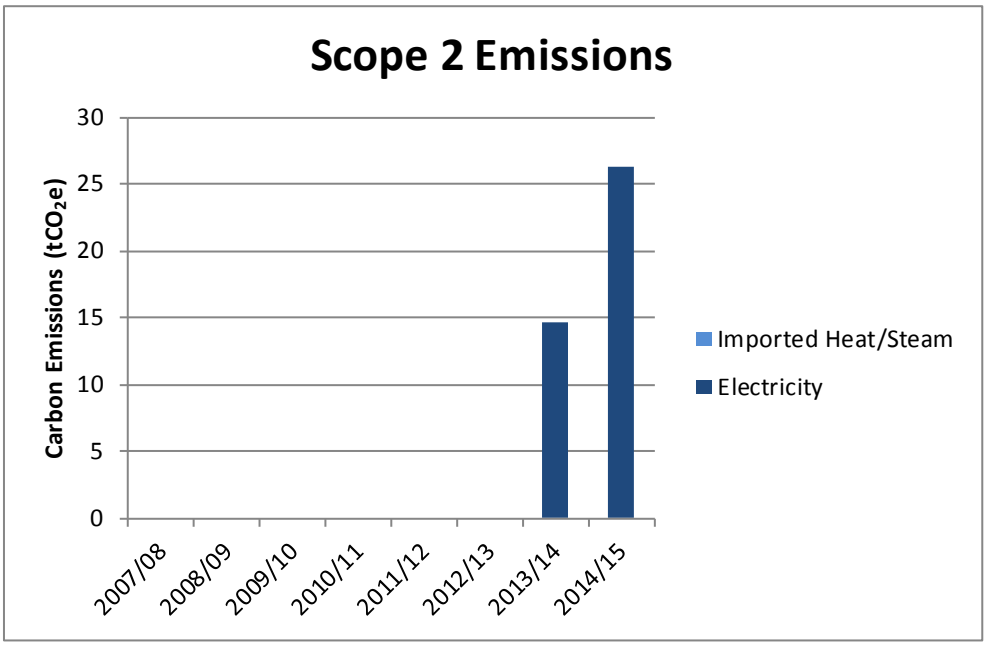


Facilities Management

NHS Property Services (NHS PS) manage the building from which the CCG operates. The CCG has a lease/rental agreement with NHS PS and all utility bills go directly to them as 'landlord'. The CCG has been working with NHS PS to obtain its baseline position for electricity, gas, waste and water. The following tables highlight the CCG's carbon footprint for travel, gas, electricity, water and waste.

Energy

Table 2: Electricity Usage Kwh 2014-15



Electricity usage has increased by 20,352 kWh. This variation is being investigated in co-operation between the CCG and NHS PS.

Water

Table 3: Water/Waste Water 2014-15

Water		2013-14	2014-15
Mains	m^3	398	259
	tCO_2e	0	0
Water & Sewage Spend		£1,100	£491*

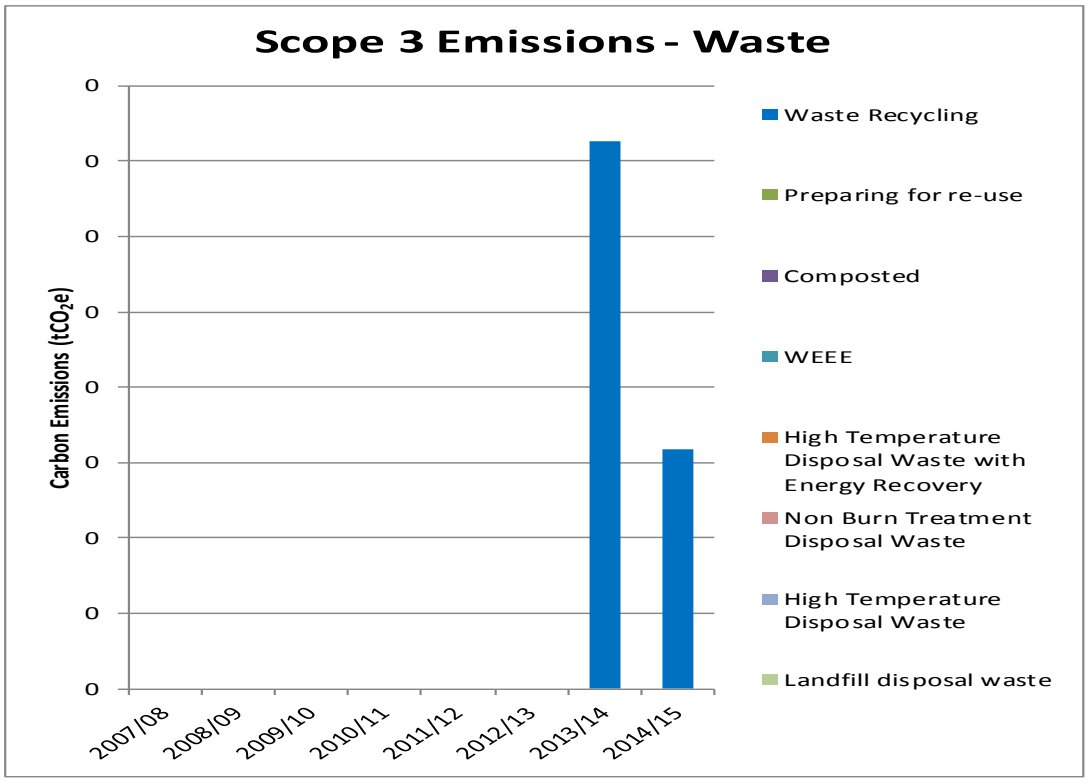
* Estimate based on invoicing information up to November 2014

Waste

Figures for waste management are shown in Table 4 below.

Table 4: Waste Recycling Emissions 2014-15

Procurement



As a commissioner of services, the CCG aims to assure the sustainability of the organisation and the services it commissions. The CCG continues to work collaboratively with its procurement and commissioning colleagues to identify and maximise opportunities to integrate sustainability considerations within its commissioning processes and functions. This has resulted in the development and implementation of the CCG's Ethical Procurement Policy.

Table 5: The CCG Carbon Footprint

During 2014-15 the CCG engaged with its workforce to generate ideas for reducing its carbon footprint and reducing waste. This resulted in the implementation of green initiatives which include the collection of tin cans for recycling, a review of the use of photocopying and printing facilities and setting CCG printers to double-sided, grey-scale printing by default. Other initiatives include a 'switch off' campaign for lights and computers. Office consumables, such as printer cartridges and paper waste, are routinely collected for the purpose of recycling.

Workforce

Raising the profile of sustainability in the workplace is key to maintaining a sustainable workforce and commissioning environmentally appropriate services to meet the health needs of our local population now and in the coming years. During 2014, the CCG introduced policies which promote wellbeing whilst at the same time reducing its carbon footprint. These include policies on remote access and home working, absence management, flexible working. Staff are also encouraged to suggest new ways and approaches of raising the sustainability profile of the CCG.

Adapting to climate change

Climate change brings new challenges to the CCG, not only through the direct effects to the healthcare estates, but also to patient health. Examples in recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The CCG's Governing Body approved plans to address the potential need to adapt the delivery of the organisation's activities and infrastructure in response to climate change and adverse weather events. The CCG has identified the need for the development of a Governing Body approved plan for future climate change risks affecting the North Lincolnshire area.

In collaboration with its strategic partners, the CCG has developed policies to take account of the health needs of its local population caused by climate, environmental and social changes. These include an emergency preparedness, resilience and response policy and a business continuity policy. Through its strategic partners, such as the Integrated Commissioning Partnership, the CCG will continue to ensure that it is better able to plan, prepare and respond to any occurrence.

Models of Care

Through the models of care approach, the CCG continues to work in partnership with social care and other commissioning partners and providers to promote health and wellbeing and to continue to influence the use of SIAs in order to develop sustainable service plans. The strategic direction of travel and priorities of the CCG reflect the recognition that services need to be sustainable and meet the needs of local people. The CCG's future model of care is reflected in the Healthy Lives Healthy Futures model which aims to support people to self-care where possible, access care closer to home through community based services, and receive hospital or specialist care when appropriate for the best outcome.

Next steps

- Develop energy, water and waste reduction targets
- Complete the Good Corporate Citizen Tool
- Reduce business miles expended by CCG employees
- Work with providers to ensure there are plans in place to reduce carbon emissions
- Work with strategic partners and local stakeholders to support sustainable development preparing and adapting to the predicted effects of a future changing climate.

4.12. Equality and Diversity Report

Promoting Equality

NHS North Lincolnshire Clinical Commissioning Group fully believes in fairness and equity, and above all value diversity in all matters as a commissioner of health services, and as an employer.

As a commissioner of the majority of health services in the area, the CCG is committed to eliminating any form of discrimination and aims to commission services that are accessible and delivered in a way that respects the needs of each individual, whilst being inclusive to everyone.

To achieve this, the CCG works with other health care providers and contractors to ensure that valuing diversity and promoting fair access to services are core elements of care. Full consideration is given to all equalities issues when planning or redesigning services and when assessing the health needs of the local population. In partnership with local communities and other local organisations in the health and social care sector, the CCG aims to reduce inequalities in health.

The CCG's Equality and Diversity Plan 2013-2015, which was approved in August 2013, reinforces these commitments and is the first step in outlining the CCG's approach to equality and diversity, whilst ensuring compliance with the Equality Act 2010 and the Human Rights Act 1998.

The CCG published the plan and objectives in October 2013, in line with the requirements of the Public Sector Equality Duty, using the NHS Equality Delivery System (EDS) tool:

Objective 1
Increasing input from representatives of the protected groups in the commissioning process and ensuring systems are in place to embed equality in all our commissioning decisions.

Objective 2
Ensuring that appropriate Equality and Diversity initiatives are taken forward in current year's work plan

The CCG made progress on these objectives in its first year and built on this in 2014-15. A summary is as follows:

Leadership and Commitment

The Governing Body accountability for Equality and Diversity sits with the Chief Officer of the CCG who is supported by a Clinical Lead for equality and diversity. In addition, the CCG's Lay Member for Public and Patient Involvement is an active Equality Champion.

The Governing Body reviewed the progress made against the Equality Plan Objectives in April 2014; and the Equality and Diversity Committee met throughout the year to monitor delivery of the CCG's Equality Objectives and action plan.

Staff Awareness and Training

All CCG staff have access to a computer based training package which includes Equality and Diversity training. This is mandatory for all staff and, by the end of March 2015, 89% of staff had completed this training. Equality impact analysis training and enhanced training appropriate to individual staff roles is also available. A training and awareness workshop for staff was delivered by Stonewall focusing on the health needs of lesbian, gay and bi-sexual patients and their families, and how this can inform commissioning and service redesign.

Provider Compliance

Systems are in place to monitor healthcare provider compliance with the Equality Act. This starts at the service specification development stage, is checked as part of procurement and monitored through regular and robust contract monitoring arrangements.

Complaints/Incidents

Systems are in place to monitor complaints and incidents that occur both at CCG and at service provider level. These are specifically monitored in relation to equality and diversity issues. In 2013-14, there have not been any complaints or incidents reported relating to accessibility issues.

Stonewall Assessment

Once again this year, the CCG is proud to have taken part in Stonewall's Healthcare Equality Index 2014. The Stonewall Assessment helps healthcare organisations benchmark and track their progress on equality for lesbian, gay, bi-sexual (LGB) patients and communities. Last year the CCG scored well in comparison to other CCGs, especially in relation to policy and practice, staff training and communications and engagement. This year the CCG has been working with Stonewall to develop and improve its links and relationships with LGB people. These specific actions included engagement, dedicated training and patient information for the CCG website.

Publishing Information

One of the ways to help the CCG demonstrate its commitment to embedding a culture of inclusiveness has been to establish an area on its website that is dedicated to promoting Equality and Diversity:
http://www.northlincolnshireccg.nhs.uk/publications/equality-and-diversity/
These pages include a section on health information and resources providing a wide range of information and links to support and inform staff. The CCG intends to continue to build up this resource and add in links to local support groups as these become known through the course of its work.

The CCG's policies and associated EIAs are published on its website, as is the EIA template and guidelines for staff.

As an employer, the CCG recognises and values people as individuals and accommodate differences wherever possible by making adjustments to working arrangements or practices. The CCG actively works to remove any discriminatory practices, eliminate all forms of harassment and promote equality of opportunity in its recruitment, training, performance management and development practices. All its policies, including Workforce policies, are subject to a robust EIA.

This year the CCG conducted a staff survey in which 100% of respondents said they had not in the previous six months personally experienced discrimination at work by their manager, work colleagues or both.

For more information, and to see the CCG's full year-end equality report, visit: http://www.northlincolnshireccg.nhs.uk/publications/equality-and-diversity/

Communications and Engagement

This year the CCG launched its Health Linc public newsletter which is distributed to member practices, partners and wider community stakeholders. The CCG has made arrangements with the local Talking News community organisation to supply an audio version of Health Linc for visually impaired people. This can be accessed on the CCG's web site or can be supplied on CD upon request. Audio copies of Health Linc are sent out to members of the CCG's public engagement membership network, Embrace, who have indicated that this is their preferred format for receiving CCG communications.

In April 2014, the CCG approved its Communications and Engagement Strategy, which includes a section setting out its commitment and approach to ensuring that engagement and communication methods take into account the access needs of people with a protected characteristic so that they are able to fully participate in the CCG's activities.

Table 6: Organisational Gender Analysis 2014-15

	Male	Female	Transgender
CCG Governing Body members	7	4	0
CCG Council of Members representatives	16	4	0
CCG senior managers	0	4	0
All CCG staff	5	14	0

4.13. Key performance indicators

Financial

Note 42 to the accounts outlines the CCG's achievement of the statutory financial duties.

In summary, the CCG has achieved its target surplus and has lived within its Running Cost Allowance. The CCG did not have any capital allocation or expenditure this year.

4.14. 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).

Allison Cooke
Accountable Officer
27th May 2015

5. The Members' Report

5.1. The Governing Body

The CCG's Governing Body combines a wide range of experience and expertise. It comprises of the following voting members, as shown in the Table below:

Table 7: Governing Body Members 2014-15

NAME	APPOINTMENT
Dr Margaret Sanderson	Chair
Allison Cooke	Accountable (Chief) Officer
Catherine Wylie	Nurse Member
Therese Paskell	Chief Finance Officer & Business Support
Dr Robert Jaggs-Fowler	Medical Director/GP Member
Dr Jagrit Shah	Secondary Care Doctor up to 31 May 2014 – new appointment, Professor John Mayberry, to take up position on 1 April 2015.
Dr Andrew Lee	GP Member
Dr Nick Stewart	GP Member
Dr James Mbugua	GP Member
Dr Fergus MacMillan	GP Member
Paul Evans	Lay Member, Governance
Ian Reekie	Lay Member, Public and Patient Involvement

In addition, there are two non-voting members on the Governing Body – Caroline Briggs, Director of Commissioning and Frances Cunning, Director of Public Health.

5.2. Member practices of the CCG

At year end, there are a total of 19 member practices in the North Lincolnshire CCG area, each with a representative on the CCG's Council of Members. At the start of the current financial the year, there were 22 practices. However, on 31 October 2014, The Cauvery Medical Practice closed and on 2 February 2015, Ashby Clinic and Children's Centre in Scunthorpe merged with West Common Lane Teaching Practice. West Common Lane is the main practice and Ashby Clinic is the branch practice.

A full list of the CCG's member practices is below.

- Ancora Medical Practice, Scunthorpe
- Ashby Turn Primary Care Partners, Scunthorpe
- Bridge Street Surgery, Brigg
- Cambridge Avenue Medical Centre, Bottesford
- Cedar Medical Practice, Scunthorpe
- Central Surgery Barton, Barton upon Humber
- Church Lane Medical Centre, Scunthorpe
- Dr Balasanthiran's Practice, Ashby, Scunthorpe (now a branch practice of West Common Lane Teaching Practice)
- Kirton Lindsey Surgery, Kirton Lindsey
- Market Hill Medical Practice, Scunthorpe
- Riverside Surgery, Brigg
- South Axholme Practice, Epworth
- The Birches Medical Practice, Scunthorpe
- The Killingholme Surgery, South Killingholme
- The Medical Centre, Barnetby
- The Oswald Road Medical Centre, Scunthorpe
- Trent View Medical Practice, Keadby
- West Common Lane Teaching Practice, Scunthorpe
- West Town Surgery, Barton on Humber
- Winterton Medical Practice, Winterton

Representatives from the practices who were members of the CCG's Council of Members during 2014-15 are detailed in the table overleaf:

Table 8: The CCG's Council of Members 2014-15

NAME	APPOINTMENT
Dr G Armstrong	Representative for South Axholme Practice and The Birches Practice
Dr J Gallagher	Deputy Representative for South Axholme Practice and The Birches Medical Practice
Dr S Balasanthiran	Representative for Ashby Clinic ***resigned 2nd February 2015 due to practice merger***
Dr T Blumenthal	Representative for Central Surgery Barton
Dr D Wellings	Deputy Representative Central Surgery Barton
Dr N Samuel	Representative for Winterton Surgery
Dr A Clark	Deputy Representative for Winterton Surgery
Dr A Muraleedharan	Representative for West Town Surgery
Dr U Khan	Deputy Representative for West Town Surgery
Dr A Lee	Representative for West Common Lane Teaching Practice
Dr C Hall	Deputy Representative for West Common Lane Teaching Practice
Dr M Nasim	Representative for Ashby Turn Primary Care Partners
K Terreros	Deputy Representative for Ashby Turn Primary Care Partners
Dr BT Elango	Representative for Cambridge Avenue Medical Centre
Dr TJ Tarigopula	Deputy Representative for Cambridge Avenue Medical Centre
Dr S ul Ahmed	Representative for Barnetby Medical Centre
Dr S Rajkumar	Representative for Oswald Road Surgery
Dr S Kurien-George	Deputy Representative for Oswald Road Surgery
Dr J Taylor	Representative for Ancora Medical Practice
Dr E Ryan	Deputy Representative for Ancora Medical Practice

NAME	APPOINTMENT
Dr J Ojidu	Representative for Trent View Medical Practice
Dr R Chisabingo	Deputy Representative for Trent View Medical Practice
DR H Gandhi	Representative for Cedar Medical Practice
Dr P Tandon	Deputy Representative for Cedar Medical Practice
Dr G Bhorchi	Representative for South Killingholme Practice
A Elsom	Deputy Representative for South Killingholme Practice
Dr S Shekhawat	Representative for Kirton Lindsey Surgery
Dr T Turner	Deputy Representative for Kirton Lindsey Surgery
D Oplopoiadis	Representative for Market Hill Medical Practice
Dr E Okeke	Deputy Representative for Market Hill Medical Practice
Dr A Pillai	Representative for Riverside Surgery
Dr S Modan	Deputy Representative for Riverside Surgery
Dr N Stewart	Representative for Church Lane Medical Centre
J Steers	Deputy Representative for Church Lane Medical Centre
Dr C Chambers	Representative for Bridge Street Surgery
Dr A Whitaker	Deputy Representative for Bridge Street Surgery
Dr R Ugargol	Representative for Cauvery Medical Centre ***resigned 31 October 2014 due to practice closure***

5.3. Audit Group

Members of the CCG's Audit Group up to the signing of the 2014-15 Accounts were as follows:

Table 9: Audit Group Members 2014-15

NAME	APPOINTMENT
Paul Evans	Chair
Ian Reekie	Lay Member
Dr Satpal Shekhawat	GP
Dr Tehmina Mubarika	GP

Therese Paskell, Chief Finance Officer & Business Support, attends meetings to advise the group as required.

Catherine Wylie, Director of Quality and Risk Assurance and John Pougher, Assistant Senior Officer Quality and Assurance, attend meetings to advise the group on matters of corporate governance and are the link to the Quality Group for integrated governance.

The following non-CCG staff attend meetings to provide support as required:

Table 10: Non CCG Staff Audit Group Attendees 2014-15

NAME	ORGANISATION REPRESENTED
Benita Jones	East Coast Audit Consortium
Robert Bassham	East Coast Audit Consortium
Chris Wallace	Information Governance and Information Management and Technology, Yorkshire & Humber Commissioning Support
Jackie Rae	KPMG
John Prentice	KPMG
John Doherty	Deputy Finance Officer, Yorkshire & Humber Commissioning Support

5.4. Committee and Sub-committee membership and Declarations of Interest

Full details of the membership of the Remuneration Committee can be found in the Remuneration Committee Report. For details and membership of all other Committees and Sub-committees of the Governing Body, please refer to the Annual Governance Statement.

Details of Members' declared interests can be accessed on the CCG's web site here: http://www.northlincolnshireccg.nhs.uk/publications/?subdir=declarations-of-interest

5.5. Future developments

Future developments for the CCG will be those local plans which, in conjunction with North East Lincolnshire CCG, will deliver the Healthy Lives, Healthy Futures programme of service review and change (see the Strategic Report). Locally this will mean an increased focus on prevention and early intervention to reduce the number of people who subsequently require hospital care through better patient education, self-management and community based services.

Planned initiatives for 2015-16 include:

- Improved support to care homes through the development of multi-disciplinary support teams to:
    - increase the number of patients who have had comprehensive and holistic assessments of their needs and have a written personalised care plan with an identified named professional responsible for their care
    - increase the number of patients who have experienced an evidenced based dementia and memory assessment and who have received on-going referral and support if they are identified to be at risk of memory deterioration
    - reduce referrals to the Emergency Department, ambulance journeys and overall hospital admissions for preventable conditions
    - provide focussed and targeted training and development to individual homes who have repeated patterns of the cause for referral
- Full implementation of the Urgent Care Model, including the use of Ambulatory Emergency Care models, to manage people within their own home with appropriate care and support wherever clinically safe to do so.

- Development of a time limited support service to provide a rapid and enhanced short term support service to named patients who are at risk of deteriorating and requiring unplanned admission. This will be an integrated health and social care response aimed at avoiding hospital admission and returning the person to their previous level of independence where possible.

- Continued investment in support to carers to keep them well. The investment in carers will be reviewed to ensure we are in a position to implement the changes as a result of the Care Act 2014.

- Implementation of Ambulatory Emergency Care models - delivered through a dedicated team who rapidly assess and manage acutely ill patients - enabling them to be discharged home the same day, with community based support if required. These models of care are evidence-based and becoming established across the country.

- Further enhancement of Integrated Locality Teams to deliver a multi-disciplinary approach to care for those people with the most complex needs, including input from nursing, therapies, general practice and social care to improve care co-ordination and outcomes for people.

- Continued increase in the diagnosis rate for people with dementia and improvements to their experience through the implementation of the Action Plan from the Experience Led Commissioning Programme.

Research and innovation

To support the NHS innovation agenda, the CCG will promote innovative practice within local provider organisations through Commissioning for Quality and Innovation (CQUIN) schemes, monitoring NICE compliance and participation in forums to share innovation.

The CCG has a research strategy, underpinned by an implementation plan, which sets clear goals to promote research activity and adopt and promote innovative practice.

The CCG will continue to participate in, and support, the local clinical research networks through our primary care research lead and seek to increase infrastructure capacity.

5.6. Better Payments Practice Code

The Better Payments 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. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

The CCG has achieved 2 out of 4 of the Better Payment Practice Code target of 95% as shown in Note 6.1 to the accounts, the same as in 2013-14.

5.7. Prompt Payments Code

The CCG is an approved signatory to the Prompt Payments Code.

5.8. Pension liabilities

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. As a consequence, it is not possible for the CCG to identify its share of the underlying scheme assets and liabilities. Therefore the Scheme is accounted for as a defined contribution scheme and the cost of the Scheme is equal to the contributions payable to the Scheme for the accounting period.

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

Further details on pension liabilities can be found at Note 4.5 to the accounts and also in the Remuneration Report at section 6.2.5.

5.9. Fraud

Information regarding the CCG's policies and procedures relating to countering fraud and corruption can be found in the Annual Governance Statement. The CCG is also required to produce an annual report on fraud which goes to the CCG's Audit Group. This report contains full details of work undertaken throughout the year.

5.10. External audit

External audit services in 2013-14 were provided by KPMG, who do not provide any other non-audit services to the CCG. The cost of work performed by the auditor in the reporting period was £72,000 for audit services. There was no further assurance services provided not related to the CCGs financial statements.

5.11. Sickness absence data

The sickness absence data for the CCG between 1 April 2014 and 31 March 2015 is below:

The average number of days taken as sickness absence by employees of the CCG in 2014-15 year was 9.9 days per full time equivalent post. This is below the average for the NHS workforce as a whole.

Table 11: Sickness Absence Information 2014-15

	2014-15	2013-14*
	CCG Number	CCG Number
Total days lost	184	55
Total staff years	19	18
Average working days lost	9.68	3.06

**based on 9 months of payroll data*

We regularly review reasons for absence and all sickness is managed in line with our Absence Management Policy which can be found at www.northlincolnshireccg.nhs.uk

Sickness absence data can be found in Note 4.3 to the accounts.

5.12. Disclosure of "serious incidents" / personal data related incidents

During 2014-15, the CCG has had no incidents or serious incidents relating to any loss of data.

More information on Information Governance can be found in the Annual Governance Statement.

5.13. Access to information

Table 12: Access to Information Requests 2014-15

Description	2014/2015
Number of FOI requests processed	248
Percentage of requests responded to within 20 working days	99.2%
Average time taken to respond to an FOI request	14.3

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

- In 234 cases, all the requested information was **provided in full**.
- Two requests took longer than the statutory 20 days to completer, due to the complexity of the request.
- In 5 cases **no information was provided**, and in 9 cases only **part of the information was provided** because an exemption was applied. Exemptions applied included those where the requested information was either accessible by other means, intended for future publication or was personal information..

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The CCG's publication scheme contains documents that are routinely published; this is available on the CCG's website:

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

5.14. Cost allocation and setting of charges for information

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

5.15. Principles for Remedy

The CCG fully endorses the values set out in the Parliamentary and Health Service Ombudsman's 'Principles of Remedy' guidance and undertakes to comply with these standards consistently when considering all complaints.

This guidance has been developed to ensure public bodies seek to resolve situations in which groups or individuals have suffered harm or injustice, and is based upon six core principles. These principles underpin the services and work commissioned by the CCG and will be demonstrated in how complaints are handled and how the CCG demonstrates learning and improvement.

The CCG works to meet the 6 principles as follows:

1. **Getting it right** – the CCG will quickly acknowledge and aim to put right cases of maladministration and poor service that have led to any injustice and hardship by considering all the relevant factors. The CCG will ensure fairness to the complainant and any others who have suffered from the same maladministration or poor service.

2. Being customer focused – the CCG will deal with patient complaints professionally and sensitively, and where appropriate provide an apology and explanation of any poor service or maladministration.

3. **Being open and accountable** – the CCG will explain clearly, in its response to any complainant, its findings and the reasons for upholding or not upholding the complaint and any associated remedy.

4. Acting fairly and proportionately – the CCG will treat all complaints without bias, unlawful discrimination or prejudice.

5. Putting things right – where a complaint is upheld, the CCG aims to offer an appropriate remedy including an apology, an explanation and details of any remedial action to be undertaken. The CCG will consider any remedy that returns the complainant to the position they would have been in and where that is not possible, compensation will be considered.

6. Seeking continuous improvement – the CCG is keen to learn from complaints and ensures that, where identified, changes are made to policies, procedures and systems and any associated staff training is carried out. An explanation will be provided of changes that are made to prevent any recurrence of poor services or maladministration.

Table 13: Complaint Information 2014-15

Number of complaints received	Not upheld	Upheld	On-going
8	8	0	0

Complaints received by the CCG are handled in accordance with Statutory Instrument 2009 / 309 - Local Authority Social Services and NHS Complaints [England] regulations 2009. This is applied through the CCG's policy for managing complaints, and also incorporates the NHS England guidance for 'Good Handling of Complaints for CCGs 2013'. The CCG policy also incorporates the relevant recommendations from the Department of Health report, 'Hard Truths: The Journey to Putting Patients First', by Robert Francis, QC.

The CCG is cognisant of recent national guidance for example, 'My expectations for raising concerns and complaints', by the Parliamentary and Health Service Ombudsman (PHSO), the Local Government Ombudsman (LGO) and Healthwatch England, and is committed to developing a user-led 'vision' of the complaints process.

An annual detailed report of CCG related complaints will be published each year and will be presented to the Governing Body.

5.16. Employee consultation

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

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

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

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

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

- Disciplinary Policy
- Managing Work Performance Policy
- Annual Leave Policy
- Working Time Directive Policy
- Change Management Policy
- Pay Protection Policy
- Travel and Expenses Policy
- Starting Salaries Policy

There have been no major organisational changes that have taken effect in the financial year.

5.17. Equality disclosures

As an organisation, the CCG is committed to equality and valuing diversity within its existing and potential workforce. The CCG actively encourages people with disabilities to apply for positions in the organisation. Applicants applying for roles within the CCG, who declare a disability, are guaranteed an interview providing they meet the minimum criteria within the person specification for the particular vacancy. The CCG achieves its requirements to make reasonable adjustments to the workplace environment to support staff who either consider themselves to be disabled or may develop a disability or long term condition during their employment. Professional occupational health advice is also available in this regard.

All opportunities for promotion and progression within the CCG are freely and equally accessible to all employees.

All CCG staff are required to complete mandatory equality and diversity training. Equality impact analysis training and enhanced training appropriate to individual staff roles is also available. Learning and development opportunities are accessible to all employees, including those who may consider themselves to have a disability. The CCG's blended approach to learning and development ensures that these opportunities address the varied learning needs of all staff.

Policies, procedures and publications that are developed for the CCG include advice on how to obtain them in different formats to meet the needs of anyone who wishes to access them, for example, audio, Braille or alternative languages.

Further information regarding the CCG's approach to Equality and Diversity, including our policies for equal opportunities and disabled employees, can be found in the Equality and Diversity Report.

5.18. Emergency preparedness, resilience and response

Under the Health and Social Care Act 2012, the Civil Contingencies Act 2004 (CCA 2004) and the 'NHS Commissioning Board Emergency Preparedness Framework 2013', the CCG is required to develop and maintain sufficient plans to ensure that the organisation and all commissioned services are well prepared to respond effectively to major incidents/emergencies. These plans serve to mitigate the risk to public and patients and ensure that critical functions can be maintained in the event of unforeseen disruption to services. The CCG is a designated Category 2 responder under the CCA 2004 and its key responsibilities include:

- Ensuring contracts with provider organisations contain relevant emergency preparedness, resilience and response (EPRR) elements (including business continuity)

- Support NHS England (NHSE) in discharging its EPRR functions and duties locally;
- Fulfil the responsibilities as a Category 2 responder under the Civil Contingencies Act 2004 (CCA 2004) including maintaining business continuity plans for its own organisation;
- Seek assurance provider organisations are delivering their contractual obligation.

In line with its responsibilities as a Category 2 responder, the CCG has both a Business Continuity Plan and an EPRR policy, both of which are regularly reviewed. Taken together, these two policies provide an overview of key functions, roles and responsibilities of the EPRR system and the CCG's arrangements for EPRR response and Business Continuity; the two policies should be read in conjunction and provide assurance that the CCG has robust processes in place to meet its statutory duties.

During 2014 the CCG was involved in the NHS England 'North Yorkshire & Humber EPRR Assurance Process'. The assurance process involved the CCG undertaking self-assessment against 37 minimum core standards for EPRR. Following the self-assessment the CCG declared substantial compliance. An action plan has been developed to address any areas that require further development and current plans mitigate any impact to the organisation. As a result of the assurance process the CCG now has a 24/7 on-call rota in place and is currently reviewing the Pandemic Influenza Plan.

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The clinical commissioning group regularly reviews and makes improvements to its EPRR plans (including Business Continuity). These plans provide assurance that the CCG has robust processes in place to meet its statutory duties.

5.19. Statement as to Disclosure to Auditors

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and that the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

Allison Cooke
Accountable Officer
27th May 2015

5.20 Accountable Officer Signature

Signed: Allison Cooke, Chief & Accountable Officer
Date: 27 May 2015

6. Remuneration Report

6.1. Remuneration Committee Report (not subject to audit)

The Remuneration Committee is responsible for approving the remuneration and contractual arrangements of the clinical commissioning group's executives. It has delegated responsibility from the Governing Body for advising it on all aspects of salary not covered by Agenda for Change, arrangements for the termination of employment, monitoring and evaluating the performance of Governing Body members and approving human resources policies and procedures.

6.1.1. Committee membership and attendance at meetings

During the past year, the Remuneration Committee has met 4 times and was quorate at all meetings. Committee membership during the financial year and since year end, and attendance at meetings during the financial year, were as follows:

Table 14: Remuneration Committee Membership & Attendance 2014-15

Member	Meetings attended / eligible to attend (2014-15)			
	May 2014	Aug 2014	Nov 2014	Feb 2015
Ian Reekie (Chair)	✓	✓	✓	✓
Paul Evans	✓	✓	✓	✓
Dr James Mbugua	✓	✓	✓	0
Dr Nick Stewart (member from Nov 2014)			0	✓
Dr Andrea Dexter (resigned October 2014)	0	0		

The Chair of the CCG, Dr Margaret Sanderson, the Chief Officer of the CCG, Allison Cooke, and a senior human resources representative attend meetings as appropriate, to advise the committee.

During the year, the Director of Commissioning for the CCG, Caroline Briggs, attended a meeting to present the policy on reimbursement of expenses for patient and public involvement.

6.1.2. Policy on remuneration of senior managers

The CCG does not have a remuneration policy or performance related pay framework for senior managers. The CCG follows national guidance in relation to remuneration for very senior managers (VSMs). Our Remuneration Committee, made up of lay members and a GP, determines the appropriate remuneration for VSMs including any reference to performance targets.

6.1.3. Senior managers' performance related pay

The CCG does not apply performance related pay for its senior managers, therefore there were no performance related payments made to senior managers in 2014-15.

6.1.4. Policy on senior managers' contracts

All senior managers (Directors – including the Chief Officer and Chief Financial Officer) are employed on VSM contracts on a permanent basis.

6.1.5. Senior managers service contracts

VSM contracts have been issued to those directors appointed. Notice periods of these contracts stand at 3 months. Contracts issued to those on VSM contracts have the following compensation for early termination:

'You are entitled to three months written notice from the CCG and you may at any time terminate your employment with three months' notice, except in the case of summary or immediate dismissal. The CCG may exercise its discretion to pay you in lieu of all or part of your notice period in accordance with clause 18.4. In the event of termination of employment contracts a payment may be required in lieu of untaken annual leave.'

GP members are usually appointed for a term of office of 4 years – with the exception of the first term of office which is up to 6 years to ensure corporate continuity during the establishment of the CCG. At the present time, GP members have between 3 and 4 years left of their term in office. Notice periods of these appointments stand at 3 months and there is no agreed severance payment for early termination of their membership.

Lay members are also usually appointed for a term of office of 4 years. Their first term of office can be up to 5 years to ensure corporate continuity as per the GP members. At the present time, lay members have 2 – 3 years left of their term of office. Notice periods of these appointments stand at 3 months and there is no agreed severance payment for early termination of their membership.

Detailed information regarding the service contracts and notice periods for the CCG's senior managers and Governing Body members is given in the table below:

Table 15: Governing Body Membership 2014-15

Name	Title	Details of Service Contract *(appointment date and end date where applicable)*	Unexpired Term at 31 March 2015	Notice Period
Dr Margaret Sanderson	Chair	1 April 2013 – 31 March 2019	4 years	3 Months
Dr Andrew Lee	CCG GP Member	1 April 2013 – 31 March 2018	3 years	3 Months
Dr Fergus MacMillan	CCG GP Member	1 April 2013 – 31 March 2017	2 years	3 Months
Dr James Mbugua	CCG GP Member	1 April 2013 – 31 March 2018	3 years	3 Months
Dr Nicholas Stewart	CCG GP Member	1 April 2013 – 31 March 2019	4 years	3 Months
Dr Robert Jaggs-Fowler	CCG GP Member	1 April 2013 – 31 March 2017	2 years	3 Months
Allison Cooke	Accountable (Chief) Officer	1 April 2013 (substantive post)	N/A	3 Months
Caroline Briggs	Director of Commissioning	1 April 2013 (substantive post)	N/A	3 Months
Catherine Wylie	Director of Risk & Quality Assurance & Governing Body Lead Nurse	1 Sept 2013 (substantive post)	N/A	3 Months
Therese Paskell	Chief Finance Officer & Business Support	1 April 2013 (substantive post)	N/A	3 Months
Paul Evans	Lay Member	1 April 2013 – 31 March 2017	2 years	3 Months
Ian Reekie	Lay Member	1 April 2013 – 31 March 2018	3 years	3 Months

6.2. Remuneration Report Detail (subject to audit)

6.2.1. Payments to senior managers

Payments were made to individuals who held office as a senior manager or member of the CGG in 2014-15 and are disclosed in section 6.2.2. below.

6.2.2. Salaries and allowances

See Table 16a for 2013/14 figures and Table 16b for 2014/15 figures overleaf.

TABLE 16 a: Salaries & Allowances 2013-14

Name	Title	Period In Office	Salary (bands of £5000)	Taxable Benefits (bands of £5000)	Annual Performance Related bonuses (bands of £5000)	Long-Term Performance Related Bonuses (bands of £100)	All Pension Related Benefits (bands of £2500)	Total (bands of £5000)
			£000's	£000's	£000's	£00's	£000's	£000's
Dr Margaret Sanderson	Chair	1 April 2013- 31 March 2014	85-90	0	0	0	0	85-90
Dr James Mbugua	CCG GP Member	1 April 2013- 31 March 2014	50-55	0	0	0	0	50-55
Dr Andrew Lee	CCG GP Member	1 April 2013- 31 March 2014	50-55	0	0	0	0	50-55
Dr Nicholas Stewart	CCG GP Member	1 April 2013- 31 March 2014	50-55	0	0	0	0-2.5	50-55
Dr Fergus MacMillan	CCG GP Member	1 April 2013- 31 March 2014	45-50	0	0	0	0	45-50
Paul Evans	Lay Member NLCCG	1 April 2013- 31 March 2014	5-10	0	0	0	0	5-10
Ian Reekie	Lay Member NLCCG	1 April 2013- 31 March 2014	5-10	0	0	0	0	5-10
Allison Cooke	Chief Officer	1 April 2013- 31 March 2014	115-120	0	0	0	-10- -7.5	110-115
Therese Paskell	Chief Financial Officer and Business Support	1 April 2013- 31 March 2014	65-70	0	0	0	20-22.5	90-95
Catherine Wylie	Director of Quality and Risk Assurance	1 Sept 2013- 31 March 2014	40-45	0	0	0	67.5-70	110-115
Karen Rhodes	Senior Officer Quality & Assurance	1 April 2013- 6 Sept 2013	25-30	0	0	0	-10- -7.5	15-20
Caroline Briggs	Director of Commissioning	1 April 2013- 31 March 2014	80-85	0	0	0	30-32.5	110-115
Dr Robert Jaggs-Fowler	CCG GP Member	1 April 2013- 31 March 2014	85-90	0	0	0	0	85-90
Dr Jag Shah	Secondary Care Doctor	1 April 2013- 31 March 2014	0-5	0	0	0	0	0-5

Please note: Pension figures could not be obtained for the GP Members in 2013/14.

This Table was also published in the CCG's 2013/14 Annual Report.

TABLE 16 b: Salaries & Allowances 2014-15

Name	Title	Period In Office	Salary & Fees (bands of £5000)	Expense payments (Taxable) (Rounded to the nearest £00)	Performance Related Bonuses (bands of £5000)	Long-term Performance Pay and Bonuses (bands of £5000)	All Pension Related Benefits (bands of £2500)	Total (bands of £5000)
			£000's	£00's	£000's	£000's	£000's	£000's
Dr Margaret Sanderson	Chair	1 April 2014- 31 March 2015	75-80	0	0	0	0	55-60
Dr James Mbugua	CCG GP Member	1 April 2014- 31 March 2015	45-50	0	0	0	20-22.5	67.5-70
Dr Andrew Lee	CCG GP Member	1 April 2014- 31 March 2015	50-55	0	0	0	0	50-55
Dr Nicholas Stewart	CCG GP Member	1 April 2014- 31 March 2015	45-50	0	0	0	0	25-30
Dr Fergus MacMillan	CCG GP Member	1 April 2014- 31 March 2015	50-55	0	0	0	0	50-55
Paul Evans	Lay Member NLCCG	1 April 2014- 31 March 2015	5-10	0	0	0	0	5-10
Ian Reekie	Lay Member NLCCG	1 April 2014- 31 March 2015	5-10	0	0	0	0	5-10
Bernard G Chalk	Interim Director of Finance	1 April 2014- 31 March 2015	20-25	0	0	0	0	20-25
Allison Cooke	Chief Officer	1 April 2014- 31 March 2015	115-120	0	0	0	0-2.5	115-120
Therese Paskell	Chief Finance Officer & Business Support	1 April 2014- 31 March 2015	65-70	0	0	0	7.5-10	75-80
Catherine Wylie	Director of Quality and Risk Assurance	1 April 2014- 31 March 2015	75-80	0	0	0	52.5-55	130-135
Caroline Briggs	Director of Commissioning	1 April 2014- 31 March 2015	80-85	0	0	0	2.5-5	80-85
Dr Jaggs Fowler *	CCG GP Member	1 April 2014- 31 March 2015	90-95	0	0	0	0	90-95
Dr Jagrit Shah **	Secondary Care Doctor	See note ** below	0	0	0	0	0	0
Prof. John Mayberry ***	Secondary Care Doctor	See note *** below	0	0	0	0	0	0

* Dr Robert Jaggs-Fowler's salary covers both his clinical and non clinical roles (i.e. across his roles as GP Governing Member/Safeguarding GP/ and Medical Director).

** Dr Jagrit Shah formally ended his employment with NLCCG at the end of February 2014. However, as part of his termination agreement he covered the May 2014 Governing body meeting which signed off the Annual Accounts, for no further remuneration

*** Professor John Mayberry was formally appointed to this role at the end of September 2014 but will commence his duties in April 2015.

Negative Entries have been replaced by zeros in the "All Pension Related Benefits" column in accordance with the issued guidance.

The figures quoted in this table are subject to Audit. Taxable benefits relate to travel reimbursement and are rounded to the nearest £100s. Pension related benefits 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).

6.2.3. Payments for loss of office

There were no payments for loss of office during 2014-15.

6.2.4. Payments to past senior managers

There were no payments made to past senior managers during 2014-15.

6.2.5. Pension benefits

See Table 17a for 2013/14 figures and Table 17b for 2014/15 figures overleaf.

TABLE 17 a : Pension Benefits 2013-14

Name	Title	Period In Office	Real Increase in pension at age 60 (bands of £2500)	Real increase in pension lump sum at aged 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2014 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent transfer value at 31 March 2013	Real increase in Cash Equivalent transfer value	Employer's contribution to partnership pension
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£00
Dr Margaret Sanderson	Chair	1 April 2013- 31 March 2014	0	0	0	0	0	0	0	0
Dr James Mbugua	CCG GP Member	1 April 2013- 31 March 2014	0	0	0	0	0	0	0	0
Dr Andrew Lee	CCG GP Member	1 April 2013- 31 March 2014	0	0	0	0	0	0	0	0
Dr Nicholas Stewart	CCG GP Member	1 April 2013- 31 March 2014	-2.5 - 0	-2.5 - 0	7.5-10	25-30	546	458	66	0
Dr Fergus MacMillan	CCG GP Member	1 April 2013- 31 March 2014	0	0	0	0	0	0	0	0
Paul Evans	Lay Member NLCCG	1 April 2013- 31 March 2014	0	0	0	0	0	0	0	0
Ian Reekie	Lay Member NLCCG	1 April 2013- 31 March 2014	0	0	0	0	0	0	0	0
Allison Cooke	Chief Officer	1 April 2013- 31 March 2014	-2.5 - 0	-5- 2.5	55-60	165-170	1,233	1,153	23	0
Therese Paskell	Chief Financial Officer and Business Support	1 April 2013- 31 March 2014	0-2.5	0-2.5	15-20	50-55	262	230	21	0
Catherine Wylie	Director of Quality and Risk Assurance	1 Sept 2013- 31 March 2014	2.5-5	7.5-10	25-30	85-90	546	458	46	0
Karen Rhodes	Senior Officer Quality & Assurance	1 April 2013- 6 Sept 2013	-2.5 - 0	-2.5 - 0	30-35	95-100	0	616	-647	0
Caroline Briggs	Director of Commissioning	1 April 2013- 31 March 2014	0-2.5	2.5-5	30-35	90-95	521	464	31	0
Dr Robert Jaggs-Fowler	CCG GP Member	1 April 2013- 31 March 2014	0	0	0	0	0	0	0	0
Dr Jag Shah	Secondary Care Doctor	1 April 2013- 31 March 2014	0	0	0	0	0	0	0	0

Please note: Pension figures could not be obtained for the GP Members in 2013/14.

This Table was also published in the CCG's 2013/14 Annual Report.

TABLE 17 b : Pension Benefits 2014-15

Name	Title	Period In Office	Real Increase in pension at age 60 (bands of £2500)	Real Increase in pension lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5000)	Cash Equivalent Transfer Value (CETV) at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value (CETV) at 31 March 2014	Employer's contribution to stakeholder pension
			£000's	£000's	£000's	£000's	£000's	£000's	£000's	£00's
Dr Margaret Sanderson	Chair	1 April 2014- 31 March 2015	(2.5 - 0)	(2.5 - 0)	40-45	35-40	235	(9)	237	0
Dr James Mbugua	CCG GP Member	1 April 2014- 31 March 2015	0-2.5	2.5-5	40-45	20-25	135	19	113	0
Dr Andrew Lee	CCG GP Member	1 April 2014- 31 March 2015	0	0	0	0	0	0	0	0
Dr Nicholas Stewart	CCG GP Member	1 April 2014- 31 March 2015	(2.5 - 0)	(5 - 2.5)	40-45	25-30	173	(10)	178	0
Dr Fergus MacMillan	CCG GP Member	1 April 2014- 31 March 2015	0	0	0	0	0	0	0	0
Paul Evans	Lay Member NLCCG	1 April 2014- 31 March 2015	0	0	0	0	0	0	0	0
Ian Reekie	Lay Member NLCCG	1 April 2014- 31 March 2015	0	0	0	0	0	0	0	0
Bernard G Chalk	Interim Director of Finance	1 April 2014- 31 March 2015	0	0	0	0	0	0	0	0
Allison Cooke	Chief Officer	1 April 2014- 31 March 2015	(2.5 - 0)	(5 - 2.5)	55-60	170-175	1,305	38	1,233	0
Therese Paskell	Chief Finance Officer & Business Support	1 April 2014- 31 March 2015	0-2.5	0-2.5	15-20	50-55	282	14	262	0
Catherine Wylie	Director of Quality and Risk Assurance	1 April 2014- 31 March 2015	2.5-5	5-7.5	30-35	95-100	623	61	546	0
Caroline Briggs	Director of Commissioning	1 April 2014- 31 March 2015	0-2.5	0-2.5	30-35	95-100	5,550	19	522	0
Dr Jaggs Fowler *	CCG GP Member	1 April 2014- 31 March 2015	0	0	0	0	0	0	0	0
Dr Jagrit Shah **	Secondary Care Doctor	See note ** below	0	0	0	0	0	0	0	0
Prof. John Mayberry ***	Secondary Care Doctor	See note *** below	0	0	0	0	0	0	0	0

* Dr Robert Jaggs-Fowler's salary covers both his clinical and non clinical roles (i.e. across his roles as GP Governing Member/Safeguarding GP/ and Medical Director).

** Dr Jagrit Shah formally ended his employment with NLCCG at the end of February 2014. However, as part of his termination agreement he covered the May 2014 Governing body meeting which signed off the Annual Accounts, for no further remuneration

*** Professor John Mayberry was formally appointed to this role at the end of September 2014 but will commence his duties in April 2015.

The figures in the tables above are subject to Audit. The accounting policy note can be found in Note 4.5 to the accounts. Certain Members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for certain Members. It is important to note that the pension values for the GPs of the Governing Body relate to their Non Practitioner employment only as provided by the Business Services Authority. Whilst this will include, from 1 April 2014, the work undertaken in their capacity as a senior manager of the CCG it might also include other, non-practitioner work. These pension values will also include contributions made in previous employments in a non-practitioner role. Lay members do not receive pensionable remuneration and hence there are no entries in respect of pensions for lay members. Cash Equivalent Transfer Values "A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies."

The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

6.2.6. Pay multiples *(subject to audit)*

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation, and the median remuneration (i.e. the middle remuneration value in a rank order sorted list of numbers) of the organisation's workforce.

As shown in the Table below, the banded remuneration of the highest paid Director in North Lincolnshire CCG in the financial year 2014-15 was £165k to £170k (2013-14 was £165k-£170k). This was 2.93 times (2013-14 2.69) the median remuneration of the workforce which was £57.07k (2013-14 £62.15k).

No employees received remuneration in excess of the highest paid Director, which is the same situation as in 2013-14, and remuneration ranged from £5.38k to £168.2k. (2013-14 £20.68k to 165.34k)

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

It should be noted that the median salary calculation is based on annualised figures for full time equivalent staff so that the figures quoted **do not** necessarily indicate figures which have been actually paid by the CCG to individuals in 2014-15. The remuneration which has actually been paid has therefore also been shown for clarity. In addition, because the Highest Paid Director (as measured by annualised salary figures is not the organisation's Chief Officer, so the Chief Officer's salary details have also been shown for comparative purposes only.

There has been little movement in the highest paid Director's salary because the GP members' of the governing body did not receive a pay rise in 2014-15. The small movement in this figure compared to last year's figure simply reflects an adjustment to the gross salary paid to one GP member, as a result of their decision to leave the NHS pension scheme in year during the financial year.

Within a small CCG staff team of 25 individuals, the median salary figure has fallen in 2014-15 because of a small number of staff appointments, including a new apprentice in their first year of training who are not at the top of their salary scale, and the retirement of a long service Director who was at the top of their salary scale. The small increase in the pay multiples figure from 2.69 in 2013-14 to 2.93 in 2014-15 is also primarily due to this factor, and unless there are major unexpected changes next year - the CCG is expected to move closer to the 2013-14 pay multiple from next year.

Table 18: Summary of Pay Multiple Calculation 2014-15

2014-15 Pay Multiple Calculation	Director's Salary (Bands Of £5k)	Clinical Duties (Bands Of £5k)	Total Duties (Bands Of £5k)	Annualised Remuneration (Bands Of £5k)
Highest Paid Director: CCG GP member of Governing Body.	15-20	30-35	**50-55**	**165-170 Mid-Point £167.50k**
Chief Officer	115-120	-	**115-120**	**115-120**
Median Salary in £s				**57,070.08**
Pay Multiple Ratio				**2.93**

6.2.7. Off-payroll engagement

The CCG makes a number of payments to GP practices for the clinical input of their GPs, and occasionally for the services of their other clinical staff and practice managers.

As at 31st March 2015 the CCG had 8 "live" engagements with GP practices for the supply of this clinical input where the individual performing the required role would be paid over £220 per day. Fuller details are shown in the Table below.

Table 19: Off Payroll Payments Made to GP Practices 2014-15

For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2015	8
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	6
for between 2 and 3 years at the time of reporting	
for between 3 and 4 years at the time of reporting	
for 4 or more years at the time of reporting	

It is confirmed that all existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought

6.2.8. Governing Body profiles

Dr Margaret Sanderson
Chair

Dr Sanderson undertook her medical training at Leicester University Medical School, qualifying in 1983. She initially pursued a career in Obstetrics and Gynaecology before changing direction to General Practice. After completing her GP training in South Manchester, she remained there for several years working firstly as a locum, and later under the GP retainer scheme. She moved to North Lincolnshire in 1992 to join Trent View Medical Practice in Keadby as a partner, where she continues to practice to date.

She holds special interests in Mental Health, Contraception and Gynaecology and Sexual Health. She has worked as a clinical assistant in the genitourinary (GUM) clinic at Scunthorpe General Hospital and has also been involved in the shared care management of substance misuse, holding the part one qualification for this from the Royal College of General Practitioners.

Dr Sanderson has held the position as Chair of the CCG since its authorisation in 2013. She is the CCG's Clinical Lead for Women and Children and Ophthalmology. She is also Chair of the CCG's Council of Members.

Dr Andrew Lee
GP Member / Vice Chair

Dr Lee qualified from the University of Sheffield in 1983. He has practised as a GP in Scunthorpe since 1987, jointly founding the West Common Lane Teaching Practice where he provides teaching and supervision. He is also a GP appraiser for NHS England.

Dr Lee has played a leading role in the development of Primary Care in North Lincolnshire, including the foundation of the GP out-of-hours service and the Protected Learning Time scheme. He was also the lead GP for the local PMS pilot which resulted in the introduction of nurse practitioner roles, and continues to play an active role on a range of advisory groups.

Dr Lee has a special interest in headache and runs a headache clinic for referred patients. He is the CCG's Clinical Lead for Primary Care Development and Musculoskeletal. He is also the Vice Chair of the CCG's Council of Members.

Allison Cooke
Accountable (Chief) Officer

Allison began her NHS career in 1975, joining the Area Treasurer's Department of the Bradford Area Health Authority. Subsequently she went on to work in Service and Capital Planning, and General Management, becoming an NHS Trust Chief Executive in 1995.

In April 2001, she established Bebington and the Wirral Primary Care Trust (PCT) as their Chief Executive. The Trust went on to achieve three-star status in the NHS performance ratings under her leadership.

	After a further period as Chief Executive of Warrington PCT, Allison spent a year in Western Australia as part of the Western Australia Country Health Service managing health services in a rural regional setting. She returned to the UK to take up the post of Chief Executive of NHS North Lincolnshire PCT in 2008. Following the authorisation without conditions of NHS North Lincolnshire Clinical Commissioning Group (CCG) in 2013, Allison was appointed their Chief Officer.
	**Therese Paskell** **Chief Finance Officer and Business Support** Therese has worked in NHS finance since 1989 and has held positions in a number of different health sectors across the region including PCTs, regional health authorities, acute trusts, mental health, community organisations and the ambulance service. She has been Chief Finance Officer and Business Support for North Lincolnshire CCG since 2013.
	**Caroline Briggs** **Director of Commissioning** Caroline's background is in accountancy in which she gained her qualification whilst working in local government finance at Wakefield Metropolitan District Council. From here she progressed to become Director of Finance and Commissioning at Eastern Wakefield PCT.

	She joined North Lincolnshire PCT in 2007 to take up the role of Director of Strategy and Commissioning, transferring to the role of Director of Commissioning for North Lincolnshire CCG from its authorisation in 2013. Caroline also chairs the North Yorkshire and Humber Renal Group on behalf of the region's CCGs, and is a Partner Governor for North Lincolnshire and Goole Foundation Trust.
	**Catherine Wylie** **Director of Risk and Quality Assurance and Nurse Member** Catherine trained as a Registered General Nurse at Stobhill General Hospital, Glasgow, qualifying in 1980. She continued her career by training as a midwife at The Queen Mother's Hospital in Glasgow and remained there for a number of years, working her way up to become a Senior Labour Ward Sister. In 1995, she moved to Lincolnshire to take up the post of Clinical Midwife Specialist and later as Head of Midwifery at Scunthorpe General Hospital. Catherine developed a specialist interest in NHS risk and quality which led to her role as Associate Director of Risk and Quality for East Lincolnshire PCT. She then became General Manager for the East Lindsey area of Lincolnshire, within the Lincolnshire Community Health Services NHS Trust, with responsibility for the provision of community health services and management of two community hospitals. She joined North Lincolnshire CCG as the Director of Risk and Quality Assurance and Lead Nurse in 2013.

Dr Robert Jaggs-Fowler
GP Member, CStJ MBBS LLM FRCGP FRSA MFMLM DCH DFSRH DRCOG

Dr Jaggs-Fowler qualified in 1985 from the Charing Cross Hospital Medical School, London, and is a Fellow of the Royal College of General Practitioners. A former Major in the Royal Army Medical Corps, he became a GP Principal in 1990 and is now the senior partner in a large rural, dispensing, teaching practice in Barton upon Humber.

As well as his appointment to the CCG's Governing Body, he is the Medical Director for the CCG, the Named GP for Safeguarding (Children and Adults), the Clinical Lead for Mental Health Services and the Lead Clinician for the Healthy Lives Healthy Futures programme for Northern Lincolnshire.

He also undertakes work as a GP appraiser for NHS England and is an elected member of the Local Medical Committee.

Dr Fergus MacMillan
GP Member (Retired March 2015)

Dr MacMillan graduated from Aberdeen University in 1980 and went on to complete his GP training in Doncaster, qualifying in 1984. He started his GP career in Liverpool as a GP principal and student health medical officer, and was responsible for the establishment of a new practice for University of Liverpool students and inner city young people.

Dr MacMillan moved to North Lincolnshire in 1996 and joined Barton Central Surgery in Barton upon Humber as a GP Principal. He later became a partner at the same practice until his retirement in March 2015.

	He has been a GP trainer and the Practice Lead for Coronary Heart Disease and Stroke. In more recent years, he developed a specialist interest in Unplanned Care and was the CCG's Clinical Lead for this area until his recent retirement.
	**Dr Nick Stewart** **GP Member** Dr Stewart completed his medical training at Sheffield University, qualifying in 1986. He undertook pre-registration jobs in York and Pontefract before undertaking his GP training in Lancaster. He has practised as a GP in Scunthorpe since 1990 and is currently a partner at the Church Lane Medical Centre, Scunthorpe. He has an interest in Long Term Conditions for which he is the CCG's Clinical Lead.
	**Dr James Mbugua** **GP Member, MBChB MRCGP** Dr Mbugua qualified as a GP in 2008 and worked in a number of practices in North Lincolnshire as a salaried GP since his qualification. He has recently become a GP partner at Trent View Medical Practice. Dr Mbugua has a specialist interest in Dermatology and was instrumental in helping to establish a Community Dermatology Service in North Lincolnshire. He is the CCG's Clinical Lead for Equality and Diversity and Ophthalmology.

Ian Reekie
Lay Member for Public and Patient Involvement

Ian is a former Chief Leisure Officer with both Scunthorpe Borough and North Lincolnshire Councils. Since his retirement, Ian has become increasingly involved in health issues from a patient perspective and has chaired various patient groups.

Ian was appointed by North Lincolnshire PCT as a non-executive director in 2008. He chaired its Quality and Governance Committee before taking on the role of lay member with responsibility for championing Patient and Public Engagement on the CCG's Governing Body from 2012.

In pursuing his particular interest in health improvement and the reduction of health inequalities, Ian has served as a community member on National Institute for Health and Care Excellence (NICE) development groups that have produced guidance on the prevention of cardiovascular disease and managing obesity.

He is currently a member of the NICE Local Government Reference Group.

Paul Evans
Lay Member for Governance

Paul is a Chartered Accountant and experienced finance director, having held positions in a range of medium sized businesses and small cap organisations, including within the pharmaceutical and professional services sector.

	He was formerly Director of Finance and Support Services for the Association of the British Pharmaceutical Industry before his retirement in 2011. He qualified as a Chartered Accountant in 1972 whilst with Andersen, specialising in computer audit. He then went on to spend ten years at Cadbury Schweppes and at BHS in development roles. He is also currently the Honorary Treasurer and Trustee of an environmental law charity. Paul joined the shadow CCG as lay member with responsibility for Governance and has continued in this role since the CCG's full authorisation in 2013.
	**Dr Jagrit Shah, BSc (Hons), MBBS, MBA, MRCP, FRCR** **Secondary Care Doctor** ***resigned 31 May 2014*** Dr Shah was appointed to the role of Consultant Neuroradiologist and Head and Neck Radiologist at Queen's Medical Centre in Nottingham in 2006. He is also the clinical lead for the Neuroradiology team and secretary for the British Society of Head and Neck Imaging. He completed his initial medical and surgical training at Guys and St Thomas' Hospitals in London followed up by membership of the Royal College of Physicians.

	He then went on to undertake Primary Radiology training at St Mary's Hospitals NHS trust, London, and subspecialty training in Neuroradiology at the National Hospital for Neurology and Neurosurgery rotation, also in London. He also holds a Masters in Business Administration (MBA) from Nottingham University. Dr Shah has a special interest in patient safety and organisational culture and is passionate about providing high quality patient centred care.
	**Professor John Mayberry** **Secondary Care Doctor** ***Appointed Sept 2014 with effect from April 2015.*** Professor Mayberry is a professor of gastroenterology at University Hospitals of Leicester NHS Trust. He completed his medical training in Cardiff at the former Welsh National School of Medicine, qualifying in 1976. He moved to Nottingham to work as a senior registrar and later progressed to become a consultant in Leicester in 1989. Professor Mayberry has a special interest in epidemiology and also undertakes medico-legal work with a focus on equitable delivery of care. He has been a chair in gastroenterology for the last seven years and has worked with NICE on guidelines for clinical management. He is a member of the Medicines and Healthcare products Regulatory Agency's (MHRA) Herbal Medicine Committee and is registered with the General Regulatory Council for Complementary Therapies to practise Al Hijama.

6.2.9. Declarations of interests

Details of the declared interests of the Governing Body and the Council of Members above can be accessed on the CCG's web site here:

http://www.northlincolnshireccg.nhs.uk/publications/?subdir=declarations-of-interest

6.2.10. Accountable Officer Signature

Allison Cooke
Accountable Officer
27th May 2015

7. 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 **Allison Cooke** to be the Accountable Officer of the Clinical Commissioning Group.

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction.

The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year. In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health and in particular to:

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

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

Allison Cooke
Accountable Officer
Date: 27th May 2015

8. Governance Statement

8.1. Introduction and context

NHS North Lincolnshire Clinical Commissioning Group (CCG) 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, NHS North Lincolnshire CCG was licensed without conditions.

The CCG comprises 19 practices covering a population of about 168,760 (2013) - an increase of 8% since 2003. It is served by one main acute provider, including community services (Northern Lincolnshire and Goole Foundation Trust, NLAG), one specialist acute provider (Hull and East Yorkshire Trust, HEYHT) and one mental health provider (Rotherham, Doncaster and South Humber Foundation Trust, RDaSH).

The CCG is largely coterminous with the Local Authority (North Lincolnshire Council). For 2014-15 it had a total budget of £214,319 million.

The CCG area is geographically large, with more than half of its population living in rural areas. This creates distinct neighbourhoods and localities, each with their own unique characteristics and sense of identity, with different population profiles and needs. For example, the Scunthorpe North locality comprises mainly younger citizens, high levels of rented accommodation, with higher levels of BME residents than elsewhere in the CCG area. Whereas the Axholme locality comprises higher number of more affluent, older people, living in private accommodation, with a higher incidence of long term conditions associated with the older population.

8.2. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG'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 CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

8.3. Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However we have used the Corporate Governance Code as a guide, including those aspects of the Code we consider relevant to the CCG and best practice.

Using the UK Corporate Code as a framework to support best practice, the CCG has conducted a Corporate Governance audit, participated in a CCG 360 degree stakeholder review against a range of performance criteria, reviewed information flows to the Governing Body and undertaken an assurance mapping exercise. The Governing Body has reviewed its key strategic objectives and risks for the year facilitated by Internal Auditors. The Board Assurance Framework is also considered at all public meetings of the Governing Body.

8.4. The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:
'The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.'

The Governance Framework

The CCG has a Constitution that has been agreed by the Council of Members and sets out the responsibilities and arrangements in place to commission services for the residents of North Lincolnshire. The Constitution includes the Scheme of Delegation and Reservation, Authority to Act, Standing Orders and prime financial policies. It identifies the governing principles, rules and procedures to ensure accountability and probity for the running of the CCG ensuring that decisions are taken in a transparent and open manner promoting the best interests for the people for who we commission services.

The CCG's Constitution includes:

- Its membership
- The geographical area it covers
- The arrangements for the discharge of our functions and those of its Governing Body
- The procedures we will follow in making decisions and securing transparency in decision making
- Arrangements for discharging our duties in relation to Registers of Interests and managing conflicts of interests

Governing Body and Committee Structure

The governance structure of the CCG is headed up by the Governing Body. The Governing Body has its functions identified as set out in the Constitution which has been agreed by member practices.

The Governing Body has met 7 times during the year and was quorate at each meeting. The Governing Body held two extraordinary meetings during the year, one in April 2014 to discuss financial accounts, and the other in June 2014 to discuss Healthy Lives Healthy Futures.

During 2014-15, the CCG priorities for organisational development were informed by the feedback received through the 360 degree Stakeholder Survey. The survey is undertaken as part of the CCG Assurance Framework and a range of stakeholders are asked to participate and provide feedback to the CCG. Stakeholders included CCG member practices via their Council of Member representatives, Local Authority partners, including the chair of the Health and Wellbeing Board, and NHS providers. The feedback received showed areas of improvement, but also member practices on the whole were not as positive as might be expected.

A joint meeting of the Council of Members and CCG Governing Body was held and with the assistance of an independent facilitator, member practices' areas of concern were discussed and a number of ways of more effective working and communications were agreed and subsequently put in place.

Work that helped promote Governing Body assurance and effectiveness included:

- Full and active participation in the Health and Wellbeing Board and its supporting working groups
- Working as part of the Better Care Fund Joint Board and the Health and Social Care Board (Frail and Elderly) with equal membership between the local authority and the CCG
- Positive CCG support for the Health and Wellbeing Board WBB to undertake the Local Government Association HWBB Peer Review Challenge, which was completed in March 2015
- Following the Department of Health Gateway Review of the Healthy Lives Healthy Futures Programme Board recommendations, a strengthening of the governance arrangements going forward
- Review at each meeting of the CCG's Board Assurance Framework
- Training for the Governing Body lay members, including preparation for the establishment of the Joint Commissioning Committee
- Reviewing 'Do-Buy-Share' options for securing sound commissioning support in light of Yorkshire & Humber Commissioning Support failing to gain a place on the Lead Provider Framework

With the appointment of a new GP and Secondary Care Doctor to the Governing Body, it is intended to review the Organisational Development Plan for 2015-16 and the plan will include an integral evaluation of Governing Body effectiveness.

To support the Governing Body four strategic groups have been established as set out below.

The Audit Group

Chaired by the Lay Member for Governance, the Audit Group has met 5 times during the year and was quorate at each meeting. It has delegated responsibility for oversight of risk management and internal control, internal audit, external audit, reviewing the findings of other significant assurance functions, counter fraud and financial reporting.

Highlights of its work include:

- Jointly with the Governing Body, review of draft accounts for 2013-14 and approval of audited accounts before submission as well as preparedness for 2014-15 accounts.
- Approval of updated CCG financial policies underneath those incorporated in the CCG's Constitution
- Tackling compliance issues e.g. taxation; legal and constitutional (e.g. waivers) issues and gaining relevant assurances
- Increasing involvement in the Audit Group and internal/ external assurance from Yorkshire & Humber Commissioning Support throughout the year on internal controls which, for example, included financial services and continuing healthcare old year claims
- Improved external assurances from Deloitte's Service Audit reporting for Yorkshire & Humber Commissioning Support
- Improved Information Governance (IG) toolkit and reporting of information risks and incidents, maintaining the Information Asset Risk Register and Information Asset Owners & Controllers List and receiving positive assurance from the Information Governance Group
- Successfully recouping fraudulent payments
- Improved working with Internal Audit and the development of assurance mapping to record internal, semi-independent assurance to the CCG linking with the Board Assurance Framework
- An Audit Group self-assessment for improving future effectiveness

The Engine Room

This group has met 22 times during the year and has been quorate at each meeting other than on two occasions. One other meeting was cancelled and used as the Extra-ordinary Governing Body meeting to discuss the accounts in April 2014.

The Engine Room is chaired by the CCG Chair with delegated authority from the Council of Members. Its remit is to support clinical leadership, working with managers for the mobilisation of service changes in-year, promote working with the Council of Members and act as a forum for discussion and agreement on clinical, financial and operational matters including commissioning principles and issues.

Highlights of its work include:

- Setting the strategic direction- Healthy Lives Healthy Futures,
- Continuing development of the Operational Plan 2014-15
- Overview and selection of clinical pathway redesign and management of Quality Improvement Prevention and Productivity (QIPP)
- Overseeing contracting and delivery of operations and strategy
- Invitation of a range of speakers to inform and provide information on specific work areas including the consideration of service offers
- Holds Yorkshire & Humber Commissioning Support and other relevant organisations to account for operational, financial and performance issues
- Support the establishment of the Frail & Elderly Strategy and links to the Better Care Fund

The Quality Group

The Quality Group is chaired by the CCG's Director of Risk & Quality Assurance and the Lay Member for Public and Patient Involvement is vice chair. It has met 12 times during the year and the meetings were quorate. Its remit is, on behalf of the Governing Body, to monitor and review the quality of services commissioned by the CCG and promote a culture of continuous improvement and innovation in:

- The safety of treatment and care received by patients
- The effectiveness of treatment and care received by patients
- The experience patients and their carers have of treatment and care received

Highlights of its work include:

- Obtaining wide ranging assurances on provider services quality and patient safety
- Implementation of the Keogh mortality plan for Northern Lincolnshire and Goole NHS Foundation Trust leading to improvements in performance
- A programme of focused visits to provider organisations giving commissioners contextual information on quality initiatives and challenges faced by providers – information that is tri-angulated with other assurance data
- Invitations to providers to attend Quality Group meetings to discuss and focus on specific concerns and review actions being taken to strengthen service safety and quality
- Introduction of an incident reporting 'app' making it easier for general practices to report patient safety concerns and collate soft intelligence – in the first quarter since its introduction (Q4) reporting has increased 132%
- Ensuring that the CCG discharged its statutory responsibilities appropriately with regard to safeguarding children and young people, safeguarding vulnerable adults, domestic violence, multi-agency protection arrangements and other relevant guidance

- Held a conference to promote inter-agency understanding of Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) and established a multi-agency forum to oversee joint working and promote best practice
- Approve and regularly review locally agreed quality indicators and metrics including QIPP, Quality Impact Assessments and Commissioning for Quality & Innovation (CQUINs) to demonstrate continual improvement in safety
- Clinical effectiveness and patient experience of commissioned services
- Independent review and challenge of IG issues and work of the lead officer for IG (Yorkshire & Humber Commissioning Support) and establishment of an IG sub-group
- Establishment of the Primary Care Development Group and the Quality Strategy for Primary Care

The Remuneration Committee

The Remuneration Committee is chaired by the Lay Member for Public and Patient Involvement. The Group has delegated responsibility from the Governing Body for advising it on all aspects of salary not covered by Agenda for Change, arrangements for the termination of employment, monitoring and evaluating the performance of Governing Body members and approving human resources policies and procedures.

The Remuneration Committee met four times during the year and was quorate at all meetings. A meeting held in May 2014 dealt with 2014-15 business including remuneration of Very Senior Managers and payments of expenses to patients and members of the public participating in engagement activities. The August 2014 meeting reviewed an option for performance related pay and the November 2014 and February 2015 meetings dealt with arrangements for the recruitment of a new Accountable Officer.

Highlights of its work/performance include:

- Review of remuneration, terms and conditions for all posts not subject to Agenda for Change
- Approval of human resource policies
- Salaries and contracts for employees not covered by Agenda for Change

Co-Commissioning

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

A list of attendees at the Council of Members, Governing body, and Committees of the governing body, which were operational in 2014/15, are all attached as Appendix 1 on page 96 of this report.

8.5. The Clinical Commissioning Group Risk Management Framework

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

Risk management is embedded within the activities of the CCG through the risk process. The Board Assurance Framework is reviewed by the Executive Team monthly which ensures that the process is kept live and relevant. Members of staff are able to report any concerns through the incident reporting process which is openly encouraged and each incident is reviewed and investigated as applicable.

The CCG is committed to eliminating any form of discrimination and aims to commission services that are accessible, delivered in a way that respects the needs of each individual whilst being inclusive to everyone.

All new policies, projects or functions undergo Equality Impact Assessments (EIA's). The CCG has a tool and guidance for use by staff to help identify the likely impact. Specific training has been provided to our CCG members and staff and our Governing Body will consider the results of this analysis during the decision making process.

The CCG actively engages with public stakeholders for example:

- Partnership working with the Local Authority through the Health and Wellbeing Board
- A Risk Register has been held for the Better Care Fund, which is reviewed at least monthly
- Council of Members which is made up of a healthcare representative from each CCG member practice. The Council of Members participate and are engaged in the development of CCG strategy and plans
- Governing Body meetings are held in public allowing a transparent and public decision making process

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 organisation is an on-going process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of the CCG

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

The Audit Group has assured itself that the organisation has adequate arrangements in place for countering fraud and reviews the outcomes of counter fraud work. The CCG implements anti-fraud prevention measures and counters fraud risks in compliance with NHS Protect Standards on countering fraud, bribery and corruption. To ensure compliance with the Standards, the CCG contracts with an external provider, the East Coast Audit Consortium, who supply Local Counter Fraud Specialist (LCFS) services to the organisation via an annual fraud plan. The Fraud Plan includes initiatives to promote fraud awareness, deterrence and prevention and also to investigate suspected cases of fraud. If required the plan allows for a range of potential sanctions including criminal, civil and disciplinary measures. Progress against the Internal Audit Plan is monitored at each meeting of the Audit Group. The Local Counter Fraud Specialist is directly responsible to the Chief Financial Officer and all fraud work is reported to the CCG Audit Group.

The CCG's policies have been updated to reflect counter fraud policy and the 2010 Bribery Act as standard.

The key elements of the Risk Management Strategy are:

- To support the Governing Body in carrying out its duties effectively, the Quality Group provide assurance that the Risk register and Assurance Framework are regularly reviewed and updated. They also ensure that corresponding robust risk treatment plans exist and are being adequately progressed. The Audit Group provide independent assurance

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

  New risks identified for inclusion on the Risk Register and the Board Assurance Framework are assessed for likelihood and consequence using a 5 x 5 risk matrix in accordance with the risk management strategy. The Board Assurance Framework identifies the risks to the delivery of the organisation's strategic objectives whilst the Risk Register focuses on operational risks.

  If the assessment of the risk is higher than the risk appetite, further action should be taken to reduce the likelihood and/or impact of the risk occurring. If this is not possible, contingency plans should be put in place to bring the risk exposure level (residual risk) back within the accepted range.

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

8.6. The Clinical Commissioning Group Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG 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 Board Assurance Framework is reviewed regularly by the Governing Body, the Audit Group and Quality Group to ensure that risks have been identified and appropriate mitigating actions are in place. The risk register is reviewed by the Quality Group and the Executive Team.

8.7. Information Governance

Data security risks are addressed through mapping all information assets for the CCG, identifying data owners and risk assessing all data flows in and out including security during transfers and at rest. The IT environment has also been risk assessed to ensure that adequate security for information on the networks is in place.

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 CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG has an Information Governance Management Framework that it applies to the management of all information assets. The framework includes an Information Governance sub group of the Quality Group. The CCG continues to develop information governance processes and procedures with Yorkshire & Humber Commissioning Support in line with the IG toolkit and Senior Information Risk Officer (SIRO) guidance, ensuring it is embedded amongst CCG and commissioning support staff. The CCG ensures that all qualifying staff undertake annual information governance training and a number of measures have been implemented so that staff are aware of their information governance roles and responsibilities.

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

Processes implemented allow the CCG to fulfil its requirements under the Freedom of Information Act and Data Protection Act relating to the protection, use and the processing of subject access requests.

The CCG has an incident reporting system that encompasses information governance incidents allowing staff a single point of reporting. The development of policies and the framework has allowed us to achieve a level two compliance with all the relevant information governance toolkit standards.

The CCG has included information risk within the CCG's Risk Management Policy and has processes in place to identify information asset owners and controllers. The CCG has processes in place whereby these information asset owners assess risks to assets in their areas and report to the SIRO annually.

The CCG has developed an information governance dashboard to summarise its performance. The dashboard summarises performance against mandatory information governance requirements. It is reviewed on a quarterly basis by the CCG Quality Group.

The CCG is developing information risk assessment and management procedures as part of overall risk management and on-going work is being undertaken to fully embed an information risk culture throughout both the CCG and Yorkshire & Humber Commissioning Support who hold the majority of the CCG's confidential information sources.

8.8. Risk assessment in relation to governance, risk management and internal control

The CCG recognises the need for a robust focus on the identification and management of risks and therefore places risk within an integral part of our overall approach to governance. Consequently, risk management is an explicit process in every activity the CCG and its staff takes part in.

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

The Risk Management Strategy reflects the risk management processes within the CCG and its responsibilities for management of risks. Those risks which were deemed to be a strategic risk have been allocated to the Board Assurance Framework and risk owners asked to identify assurances on control, positive assurances, gaps in control and gaps in assurance. The operational risks remain on the Risk Register.

The Board Assurance Framework has been developed throughout the year and provides a structure and process to enable the organisation to focus on the risks that might compromise the achievement of its strategic objectives. It maps out the key controls to mitigate the risks and provide a mechanism to inform the Governing Body of the assurances received about the effectiveness of these controls.

It is a dynamic tool and will be reviewed bi-monthly by the Governing Body and monthly by the Quality Group. The Audit Group provides independent assurance. The Board Assurance Framework provides an effective focus on strategic and reputational risk rather than operational issues, and highlights any gaps in control and assurances. It provides the Governing Body with confidence that systems and processes are in place and that it operates in a way that is safe and effective.

Risk Profile

Table 20: Risk Profile Information 2014-15

	Low risk (rated 1 - 3)	Moderate risk (rated 4 - 6)	high risk (rated 7 - 12)	Extreme risk (rated 13 - 25)	Total
Risk Register	0	4	8	2	14
Assurance Framework	0	0	0	6	6
Total	**0**	**4**	**8**	**8**	**20**

The high level strategic risks (rated 15 and above) are summarised in the following table:

Table 21: High Level Strategic Risks 2014-15

Risk	Current Risk Rating
Risk that lack of collated or accurate data on out of hospital mortality means areas of high risk are not identified and/or addressed.	16
Patients may not die in their preferred place at end of life care in circumstances that are avoidable.	16
Failure to engage and work with key partners and stakeholders (including Local Authorities, GPs, Public) posing a threat to the delivery of strategic objectives.	16
CCG could face financial challenges (i.e. fail to deliver a balanced budget) and therefore does not achieve statutory financial obligations in 2014-15 and beyond into 2015-16 including Better Care Fund.	16
Risk of delayed delivery of Continuing Care services due to workforce capacity which may impact on the ability to conduct timely assessments (including retrospectives) and increased challenges through Independent Review Panel (IRP) and ombudsman resulting in a reputational risk to the CCG.	16
Failure to agree an acceptable / affordable option for Healthy Lives Healthy Future in a timely manner.	20

Each risk is owned by a lead director and is reviewed and updated monthly at the Senior Management Team. The Quality Group review the risk register and assurance framework monthly. The Governing Body review the assurance framework bi-monthly. The Audit Group review the assurance framework and risk register at every meeting and provides independent assurance to the Governing Body. This gives significant assurance that systems are now in place and that there is a clear audit trail.
The CCG recognises that it remains on a journey of improvement and intends to review, improve and strengthen its approach with a range of improvements next year. This work will include:

- More emphasis on pro-active approach to risk identification
- Conducting a risk maturity review to promote embedding risk management in CCG activities and as a key tool in the strategic leadership of the CCG
- A review of the Risk Register to determine its most effective structure to capture risks and involve all CCG staff
- Provision of more links to strategic risks that identify full range of mitigating actions being taken by the CCG
- A stronger focus on partnership risks and in relation to procurement

It is anticipated that going forward into 2015-16 the Better Care Fund work will be one of the biggest risks for the CCG.

8.9. Review of economy, efficiency and effectiveness of the use of resources

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance (its main function). The CCG's Constitution allows for the delegation of responsibility to ensure appropriate arrangements are in place for the CCG to fulfil this duty to the Audit Group and requires that it undertakes functions as set out in its Terms of Reference as agreed by the Governing Body. The Audit Group receives regular reports on financial governance and reviews the Annual Accounts, Annual Governance Statement and Head of Internal Audit Opinion. The Governing Body receives a Finance Report from the Chief Finance Officer and Business Support at every meeting, where open challenge takes place.

The Chief Finance Officer and Business Support is a member of the Governing Body and is responsible for providing financial advice to the CCG and for ensuring financial control and accounting systems are in place. The role of Chief Finance Officer and Business Support 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 and monitor the CCG's finances
- Overseeing robust audit and governance arrangements leading to propriety in the use of the CCG's resources
- Advising 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
- 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 Intelligence

The CCG has a service level agreement (SLA) in place with Yorkshire & Humber Commissioning Support for its financial services and financial management arrangements. Therefore the Business Services Director for Yorkshire & Humber Commissioning Support is also held accountable, via the SLA, to the Chief Officer at Executive Team meetings and to the Audit Group. For Yorkshire & Humber Commissioning Support, 2015-16 will be a transition year following its failure to gain a place on the Lead Provider Framework.

In terms of annual accounts, for 2014-15 a clear process was identified which followed the guidance in the Manual for Accounts 2014-15 and largely mirrored or strengthened arrangements in 2013-14. This ensured that CCG accounts were effectively closed down and accounts produced. Accounts scrutiny and sign-off is via the Audit Group in April for the draft accounts, and May for the audited accounts.

8.10. Review of the effectiveness of governance, risk management and internal control

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

8.11. Capacity to handle risk

An interactive risk management workshop session was held with the Governing Body on 12 March 2015, facilitated by East Coast Audit Consortium. The aim of the workshop was to review and re-assess the CCG's risks on both the Assurance Framework and Risk Register. Voting equipment was used to update and refine the risks including clarifying, updating and re-scoping some of the risk descriptions. The workshop was very productive and generated significant discussion around the risks and their implications.

8.12. Review of effectiveness (includes Internal Audit Opinion)

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. 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 CCG 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 provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed.

I have been advised on the implications of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Group and Quality Group and, where appropriate, a plan is in place to address weaknesses and ensure continuous improvement of the system.

My review is also informed by:

- External Audit providing progress reports to the Audit Group, the Annual Audit Letter, Annual Governance Report and overview of cost effectiveness within the CCG
- Internal Audit reviews of systems of internal control and progress reports to the Audit Group, especially the Head of Internal Audit Opinion
- Assurance reports on risk and governance received from the Audit Group
- Performance management systems
- Internal committee structure with delegated responsibility for risk identification, evaluation, control, review and assurance
- Review of the Assurance Framework. Action plans to address any identified weaknesses and ensure continuous improvement of the system are in place via the Assurance Framework action plan and also via action plans embedded within the Risk Register

- The Risk Register
- Initial part in year self-assessment of Audit Group effectiveness by questionnaire
- The CCG's strategy which captures clear clinical priorities, QIPP priorities and key risks

The following committees and officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2014-15 and have managed risks assigned to them.

Governing Body: Responsible for providing clear commitment and direction for risk management within the organisation. The Governing Body delegates responsibility for oversight and independent assurance on risk management to the Audit Group. It delegates responsibility for operational and clinical risk management to the Quality Group.

Audit Group: Responsible for providing an independent assurance of the arrangements for risk management within the organisation, with specific responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews Internal and External Audits, the Assurance Framework, financial governance reports and the Register of Interests.

Quality Group: As the committee with overarching responsibility for risk management, it provides assurance to the Governing Body that appropriate clinical risk management arrangements are in place across the organisation. The Quality Group is underpinned by various sub-groups covering areas including safeguarding, information governance, infection control, quality in contracts, incidents and medicines management.

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

Chief Finance Officer and Business Support: As senior responsible officer for NHS finances across the CCG, the Chief Finance Officer and Business Support is responsible for ensuring that the organisation complies with the CCG's Constitution to achieve financial targets and reports financial risks to the Governing Body.

NHS England Area Team: We have quarterly assurance reviews with the local Area Team of NHS England. All reviews in 2014-15 have been positive, and have also served to strengthen the co-commissioning relationship with NHS England. The reviews have covered authorisation domains and the national CCG Assurance Framework.

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

> Significant assurance can be given that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of particular objective at risk, specifically in relation to healthcare procurement and partnership governance.

Limited assurance reviews

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

Partnership working – Better Care Fund (governance and funding)

The main aim of this review was to ensure that the CCG has effective and efficient governance and operational arrangements in place to support the delivery of the Better Care Fund involving total pooled funding of over £12 million in 2015-16. This included reviewing the activities of the Joint Health and Social Care Board (Frail and Frail Elderly) which has the lead role in overseeing the Better Care Fund programme. It also examined the operation of the Frail and Frail Elderly Implementation Group. It identified issues relating to the linkages between this group, the Joint Health and Social Care Board (Frail and Frail Elderly) and sub-groups of the Health and Wellbeing Board.

Subsequent to the review, an action log is now produced as part of each of these meetings with designated leads and timescales.

In addition, the Terms of Reference of the Frail and Frail Elderly Implementation Group are being reviewed to ensure that they link with the work of the Integrated Working Partnership and supports wider organisational programmes and groups such as the Health and Wellbeing Board.

Furthermore, the Terms of Reference for the Integrated Commissioning Partnership are to be reviewed.

Healthcare procurement

The main objective of the review was to ensure that the CCG had effective, consistent and robust processes for managing healthcare procurement. Overall the audit only provided limited assurance with regard to the adequacy of processes, particularly in respect of the procurement service from Yorkshire & Humber Commissioning Support.

A number of actions have been agreed since the review including the development of monitoring systems to ensure that all elements of the procurement specification are being delivered; the availability of a single overall contract list with an advance warning system for all contracts due for renewal and; development of a public facing website that is updated to show contracts currently out for tender and those awarded.

8.13. Data quality

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

8.14. Business critical models

The CCG and its key partner, Yorkshire & Humber Commissioning Support, recognise the principles as captured in the Macpherson report as a direction of travel for business modelling in respect of service analysis, planning and delivery. Currently quality assurance systems are in place including risk registers and logs to manage business risks. The CCG continues to work to ensure that appropriately qualified members of staff provide leadership for planning and modelling services within a quality assurance framework that is subject to internal and external challenge.

8.15. Data security

The CCG has submitted a satisfactory level of compliance with the IG toolkit assessment following completion of actions from the internal audit report. Further work required is highlighted in the Audit Group / Information Governance sections of this statement.

The CCG had no lapses of data security during 2014-15.

8.16. Discharge of statutory functions

Following establishment, the arrangements put in place by the CCG (and explained within the Corporate Governance Framework) and developed with extensive expert external legal input, have been reviewed to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Council of Members and Governing Body decision and the scheme of delegation.

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

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

8.17. Conclusion

2014-15 has proved both rewarding and challenging for the CCG. Good progress has been made in consolidating the governance arrangements through the course of the year. The CCG understands the platform from which it needs to meet the challenges of commissioning improved quality of care and health outcomes from finite resources.

Through the course of the year, no significant internal control issues have been identified. This statement identifies two reviews where limited assurance has been given and I am confident that actions are being taken as a consequence.

I look forward to our continued progress in 2015-16.

Allison Cooke
Accountable Officer
27th May 2015

APPENDIX 1

ATTENDANCE AT KEY CCG MEETINGS IN 2014/15

1 COUNCIL OF MEMBER MEETINGS

2 GOVERNING BODY MEETINGS

3 COMMITTEE OF THE GOVERNING BODY MEETINGS

A) Audit Committee

B) Remuneration Committee

C) Quality Group

D) Engine Room

1) Council of Members (CoM)

Name	Title	Attendance in 2014/15
Robert Jaggs-Fowler	CCG Member/General Practitioner/Medical Director	11
Dr Margaret Sanderson	GP Member	9
Dr Fergus MacMillan	GP Member	11
Dr James Mbugua	GP Member	12
Dr James Taylor	GP Member	12
Dr Muhammad Nasim	GP Member	13
Dr Tilak Tarigopula	Deputy Member	4
Dr Shambhu	GP Member	2
Dr Hardik Gandhi	GP Member	13
Dr Dean Wellings	Deputy Member	4
Dr Nicholas Stewart	GP Member	11
Dr Dimitri Oplopoaidis	GP Member	10
Dr Avinash Pillai	GP Member	11
Dr Gary Armstrong	GP Member	8
Dr Geeta Bhorchi	GP Member	11
Dr Sami ul Ahmed	GP Member	8
Dr Neveen Samuel	GP Member	8
Dr Satpal Shekhawat	GP Member	10
Dr James Ojidu	GP Member	12
Dr Andrew Lee	GP Member	12
Dr Shivnath Rajkumar	GP Member	12
Dr Salim Modan	GP Member	3
Dr Clare Chambers	GP Member	9
Dr Toby Blumenthal	GP Member	7
Dr Ted Willis	GP Member	1
Dr Ugargol	Deputy Member	1
Dr Neveen Samuel	GP Member	5
Dr Thelma Turner	Deputy Member	1
Dr Robert Chisabingo	Deputy Member	2
Dr Muraleedharan	GP Member	8
Dr Elango	GP Member	6
Dr Andrew Whitaker	Deputy Member	1
Dr Andrew Clark	Deputy Member	2
Dr Balasanrhiran	GP Member	3
Dr Faisel Baig	LMC	3
Dr Pavan Tandon	Deputy Member	1
Dr Sheena Kurien-George	Deputy Member	1
Dr John Gallagher	Deputy Member	1
Angela Elsom	Deputy Member	1
Dr Uzma Khan	Deputy Member	1
Dr Russell Walshaw	LMC	1

2) Governing Body

Name	Title	Attendance in 2014/15
Dr Margaret Sanderson	CCG Chair/GP Member	8
Allison Cooke	Chief Officer	7
Therese Paskell	Chief Finance Officer & Business Support	6
Caroline Briggs	Director of Commissioning (Co-opted member Non-Voting)	6
Catherine Wylie	Director of Risk & Quality Assurance/Nurse Member	8
Dr Fergus Macmillan	GP Member	7
Dr Robert Jaggs-Fowler	GP Member	5
Dr Nick Stewart	GP Member	5
Dr James Mbugua	GP Member	7
Dr Jagrit Shah	Secondary Care Doctor	
Ian Reekie	CCG Lay Member, Patient & Public Involvement/Vice CCG Chair	8
Paul Evans	CCG Lay Member, Governance	7
Frances Cunning	Director of Public Health (Co-opted Member - Non-voting)	7
Dr Andrew Lee	GP Member	2
Bernard Chalk	Interim Chief Finance Officer	2

a) Audit Group		
Name	**Title**	**Attendance in 2014/15**
Paul Evans	Lay Member (Chair)	5
Ian Reekie	Lay Member	4
Dr Satpal Shekhawat	GP Member	4
Dr Tehmina Mubarika	GP Member	3

b) Remuneration Committee		
Name	**Title**	**Attendance in 2014/15**
Ian Reekie	Lay Member/Chair	4
Paul Evans	Lay Member	4
Dr James Mbugua	GP Member	3
Dr Nick Stewart	GP Member	1

c) Quality Group		
Name	**Title**	**Attendance in 2014/15**
Catherine Wylie	Director of Risk and Quality Assurance	9
Sarah Glossop	Safeguarding Children Designated Nurse	7
Dr Robert Jaggs-Fowler	Medical Director	7
Dr Anita Kapoor	GP Member	8
Jane Ellerton	Senior Manager Commissioning	8
John Pougher	Assistant SO Quality & Assurance	9
Deborah Pollard	Designated Nurse Safeguarding Adults	8
Dr Fergus Macmillan	GP Member	1
Dr Andy Lee	QIPP Lead	2
Ian Reekie	CCG Lay Member	7
Dr Faisel Baig	GP Member	2
Dr Gary Armstrong	GP Member	1

d) Engine Room		
Name	**Title**	**Attendance in 2014/15**
Dr Margaret Sanderson	CCG Chair/General Practitioner	18
Allison Cooke	Chief Officer	18
Caroline Birggs	Director of Commissioning	17
Bernard Chalk	Interim Chief Finance Officer	4
Dr Nick Stewart	GP Member	15
Dr Fergus MacMillan	GP Member	17
Catherine Wylie	Director of Risk & Quality Assurance/Nurse Member	18
Dr Robert Jaggs-Fowler	GP Member	15
Dr Andrew Lee	GP Member	18
Dr James Mbugua	GP Member	20
Therese Paskell	Chief Finance Officer & Business Support	15

9. Primary Financial Statements and Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	1,185	1,093
Operating Expenses	5	211,924	206,463
Other operating revenue	2	(3,437)	(3,150)
Net operating expenditure before interest		**209,672**	**204,406**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**209,672**	**204,406**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**209,672**	**204,406**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	1,016	993
Operating Expenses	5	3,159	3,306
Other operating revenue	2	(6)	(107)
Net administration costs before interest		**4,169**	**4,192**
Programme Income and Expenditure			
Employee benefits	4.1.1	169	100
Operating Expenses	5	208,765	203,157
Other operating revenue	2	(3,431)	(3,043)
Net programme expenditure before interest		**205,503**	**200,214**

Other Comprehensive Net Expenditure		2014-15 £000	2013-14 £000
Impairments & 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		0	0
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		**209,672**	**204,406**

The notes on pages 104 to 142 form part of this statement

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	13	19	25
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		**19**	25
Current assets:			
Inventories	16	0	1
Trade and other receivables	17	3,227	710
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	77	205
Total current assets		**3,304**	916
Non-current assets held for sale	21	0	0
Total current assets		**3,304**	916
Total assets		**3,323**	941
Current liabilities			
Trade and other payables	23	(13,170)	(12,157)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total current liabilities		**(13,170)**	(12,157)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(9,847)**	(11,217)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(9,847)**	(11,217)
Financed by Taxpayers' Equity			
General fund		(9,847)	(11,217)
Revaluation Reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(9,847)**	(11,217)

The notes on pages 104 to 142 form part of this statement

The financial statements on pages 100 to 103 were approved by the Audit Group on 27/05/2015 and signed on its behalf by:

Chief Accountable Officer
Allison Cooke

Statement of Changes In Taxpayers Equity for the year ended 31 March 2015

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(11,217)	0	0	**(11,217)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(11,217)**	**0**	**0**	**(11,217)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	(209,673)			(209,673)
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	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(209,673)**	**0**	**0**	**(209,673)**
Net funding	211,044	0	0	211,044
Balance at 31 March 2015	**(9,846)**	**0**	**0**	**(9,846)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	**0**	**0**	**0**	**0**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**1**	**0**	**0**	**1**
Adjusted NHS Commissioning Board balance at 1 April 2013	**1**	**0**	**0**	**1**
Changes in NHS Commissioning Board taxpayers' equity for 2013-14				
Net operating costs for the financial year	(204,406)			(204,406)
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	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Commissioning Board Expenditure for the Financial Year	**(204,405)**	**0**	**0**	**(204,405)**
Net funding	193,189	0	0	193,189
Balance at 31 March 2014	**(11,216)**	**0**	**0**	**(11,216)**

The notes on pages 104 to 142 form part of this statement

Statement of Cash Flows for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(209,673)	(204,406)
Depreciation and amortisation	5	6	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	(2,517)	(710)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	1,012	12,157
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(211,172)**	(192,959)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	(25)
(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**	(25)
Net Cash Inflow (Outflow) before Financing		**(211,172)**	(192,984)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		211,044	193,189
Other loans received		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		**211,044**	193,189
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(128)**	205
Cash & Cash Equivalents at the Beginning of the Financial Year		**205**	0
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**77**	205

The notes on pages 104 to 142 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2014-15* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, 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 clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group 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 clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:
· The assets the clinical commissioning group controls;
· The liabilities the clinical commissioning group incurs;
· The expenses the clinical commissioning group incurs; and,
· The clinical commissioning group"s share of the income from the pooled budget activities.
If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:
· The clinical commissioning group"s share of the jointly controlled assets (classified according to the nature of the assets);
· The clinical commissioning group"s share of any liabilities incurred jointly; and,
· The clinical commissioning group"s share of the expenses jointly incurred.

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group"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 clinical commissioning group"s accounting policies that have the most significant effect on the amounts recognised in the financial statements:

Disclosure of the critical judgements made by the clinical commissioning group's management, as required by IAS1.122. The clinical commissioning group occupies property owned and managed by NHS Property Services Ltd. While our arrangements with NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.

1.7.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the clinical commissioning group"s accounting policies that have the most significant effect on the amounts recognised in the financial statements:

1.7.2 Key Sources of Estimation Uncertainty (continued)

Disclosure of information about the key assumptions for the clinical commissioning group, as required by IAS1.125. The CCG has included certain accruals within the financial statements which are estimates. The key assumptions concern the following areas and the basis for them has been agreed with the Chief Finance Officer and reported to the CCG Audit Group.

Continuing Care (CHC)
The primary basis for estimating the forecast level of expenditure not yet invoiced is recorded package costs in the Broadcare patient database. Analysis during 2014/15 has shown that due to peaks and troughs in the numbers of packages for individual months this basis can produce unjustifiably fluctuating expenditure trends. The solution adopted has therefore been to:
- generate a three month rolling trend
- reduce the projection by a further proportion up to 6.74% to reflect that delays in assessments and other factors led to an excess accrual of this level in previous periods.
Further adjustments required were:
- Provisional packages are recorded when an application for a patient to receive CHC funding is made. The majority of these do not become eligible for full NHS CHC funding and therefore a reduction of 83% was required to reflect this, based on historic trends.
- Checklist patients are put on a paid for package on discharge from hospital, however around 10% are subsequently found to be ineligible for CHC following full assessment, based on historic trends and therefore an adjustment is required to reflect this.
- NHS England are responsible for legacy cases that were included in the risk pool, therefore an adjustment will be made to ensure all such cases are not reflected in the CCG estimates.

Out of Area Mental Health & Learning Disability
The projected cost of packages recorded on the patient log to the end of the accounting period has been used as the basis for accruing expenditure to the year end.

Prescribing
There is a delay of almost two months between the end of an accounting period and receipt of the Practice Prescribing Monitoring Document (PMD) showing the actual prescribing expenditure by GPs. As a result data for March prescribing expenditure was not available at the time of production of the annual accounts. An estimate of outstanding prescribing expenditure was therefore calculated on the basis of the trend in PMD prescribing forecasts for each period in the year to date.

Healthcare Non Contract Activity
Due to the time lag between the end of a period and the invoicing of activity data to CCGs an estimate has been made of expenditure, estimated based on year to date and prior year expenditure.

Notes to the financial statements

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 clinical commissioning group 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 clinical commissioning group commits itself to the retirement, regardless of the method of payment.

No 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 clinical commissioning group"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 clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:
· It is held for use in delivering services or for administrative purposes;
· It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
· 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.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the clinical commissioning group"s services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
· Land and non-specialised buildings – market value for existing use; and,
· Specialised buildings – depreciated replacement cost.
HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

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.

Notes to the financial statements

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 clinical commissioning group"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 clinical commissioning group;
· Where the cost of the asset can be measured reliably; and,
· Where the cost is at least £5,000.

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

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

1.12.2 Measurement

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

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

1.13 Depreciation, Amortisation & Impairments

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group 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 clinical commissioning group 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.
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.

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.

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.

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.

Notes to the financial statements

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 Clinical Commissioning Group 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 clinical commissioning group"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 Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group"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 clinical commissioning group"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 clinical commissioning group 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 clinical commissioning group"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 clinical commissioning group"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.

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 Clinical Commissioning Group 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 clinical commissioning group"s Statement of Financial Position.

1.18.6 Other Assets Contributed by the Clinical Commissioning Group to the Operator

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group 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 clinical commissioning group, 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 value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, an equivalent deferred income balance is recognised, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

Notes to the financial statements

1.19 Inventories

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

1.20 Cash & Cash Equivalents

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

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

1.21 Provisions

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

· Timing of cash flows (0 to 5 years inclusive): Minus 1.50%
· Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
· Timing of cash flows (over 10 years): Plus 2.20%
· All employee early departures: 1.30%

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

A restructuring provision is recognised when the clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group.

1.23 Non-clinical Risk Pooling

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group, 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 clinical commissioning group. 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.

Notes to the financial statements

1.27 Financial Assets

Financial assets are recognised when the clinical commissioning group 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 clinical commissioning group"s surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.27.2 Held to Maturity Assets

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

1.27.3 Available For Sale Financial Assets

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

1.27.4 Loans & Receivables

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

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

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

At the end of the reporting period, the clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group"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 clinical commissioning group 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.

Notes to the financial statements

1.3 Foreign Currencies

The clinical commissioning group"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 clinical commissioning group"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 clinical commissioning group 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 clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 Subsidiaries

Material entities over which the clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group"s accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group"s share of the entity"s profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.37 Research & Development

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

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

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

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

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

2 Other Operating Revenue

	2014-15 Total	2014-15 Admin	2014-15 Programme	2013-14 Total
	£000	**£000**	**£000**	£000
Recoveries in respect of employee benefits	92	0	92	47
Patient transport services	0	0	0	0
Prescription fees and charges	34	0	34	286
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	3,253	0	3,253	2,444
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	373
Other revenue	58	6	52	0
Total other operating revenue	**3,437**	**6**	**3,431**	**3,150**

3 Revenue

	2014-15 Total	2014-15 Admin	2014-15 Programme	2013-14 Total
	£000	**£000**	**£000**	£000
From rendering of services	3,437	6	3,431	3,150
From sale of goods	0	0	0	0
	3,437	**6**	**3,431**	**3,150**

Revenue is totally from the supply of services. North Lincolnshire Clinical Commissioning Group receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	963	963	0	826	826	0	137	137	0
Social security costs	98	98	0	85	85	0	13	13	0
Employer Contributions to NHS Pension scheme	124	124	0	105	105	0	19	19	0
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	**1,185**	**1,185**	**0**	**1,016**	**1,016**	**0**	**169**	**169**	**0**
Less recoveries in respect of employee benefits (note 4.1.2)	(92)	(92)	0	0	0	0	(92)	(92)	0
Total - Net admin employee benefits including capitalised costs	**1,093**	**1,093**	**0**	**1,016**	**1,016**	**0**	**77**	**77**	**0**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**1,093**	**1,093**	**0**	**1,016**	**1,016**	**0**	**77**	**77**	**0**

2013-14	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	890	888	2	808	806	2	81	81	0
Social security costs	88	88	0	80	80	0	8	8	0
Employer Contributions to NHS Pension scheme	115	115	0	105	105	0	11	11	0
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	**1,093**	**1,091**	**2**	**993**	**991**	**2**	**100**	**100**	**0**
Less recoveries in respect of employee benefits (note 4.1.2)	(47)	(47)	0	0	0	0	(47)	(47)	0
Total - Net admin employee benefits including capitalised costs	**1,046**	**1,044**	**2**	**993**	**991**	**2**	**53**	**53**	**0**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**1,046**	**1,044**	**2**	**993**	**991**	**2**	**53**	**53**	**0**

4.1.2 Recoveries in respect of employee benefits

2014-15				2013-14		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits - Revenue						
Salaries and wages	(92)	(92)	0	(47)	(47)	0
Social security costs	0	0	0	0	0	0
Employer contributions to the NHS Pension Scheme	0	0	0	0	0	0
Other pension costs	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0
Total recoveries in respect of employee benefits	**(92)**	**(92)**	**0**	**(47)**	**(47)**	**0**

4.2 Average number of people employed

	2014-15			2013-14
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**17**	**17**	**0**	15
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	184	55
Total Staff Years	19	18
Average working Days Lost	**9.7**	**3.1**

Final figures are awaited from H.M.Treasury.

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	0	0
	£000	**£000**
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

No exit packages have been agreed in the year (2013-14 None).

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions 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.

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

4.5.1 Accounting valuation

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

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

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

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

4.5 Pension costs

4.5.3 Scheme Provisions

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

• The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

• With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as “pension commutation”;

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

• Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year"s pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

• For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive net expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment; and,

• Members can purchase additional service in the Scheme and contribute to money purchase AVC"s run by the Scheme"s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	697	528	169	660
Executive governing body members	489	489	0	433
Total gross employee benefits	**1,186**	**1,017**	**169**	**1,093**
Other costs				
Services from other CCGs and NHS England	3,824	2,288	1,536	4,398
Services from foundation trusts	126,154	39	126,115	119,741
Services from other NHS trusts	19,473	0	19,473	20,852
Services from other NHS bodies	2	0	2	516
Purchase of healthcare from non-NHS bodies	25,485	0	25,485	25,105
Chair and Non Executive Members	392	381	11	494
Supplies and services – clinical	79	0	79	103
Supplies and services – general	4,215	206	4,009	4,896
Consultancy services	30	0	30	1
Establishment	113	97	16	116
Transport	0	0	0	3
Premises	243	44	199	888
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	6	6	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	72	72	0	79
Other non statutory audit expenditure				
· Internal audit services	0	0	0	30
· Other services	0	0	0	21
General dental services and personal dental services	0	0	0	0
Prescribing costs	29,949	0	29,949	28,566
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	1,546	0	1,546	404
Other professional fees excl. audit	16	16	0	234
Grants to other public bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	21	10	11	17
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
CHC Risk Pool contributions	302	0	302	0
Other expenditure	0	0	0	0
Total other costs	**211,922**	**3,159**	**208,763**	**206,464**
Total operating expenses	**213,108**	**4,176**	**208,932**	**207,557**

Explanatory Note

Services from foundation trusts Admin expenditure of £39k includes £25k for Internal Audit Services.

6.1 Better Payment Practice Code

Measure of compliance	**2014-15 Number**	**2014-15 £000**	**2013-14 Number**	**2013-14 £000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	7,579	36,735	6,350	30,774
Total Non-NHS Trade Invoices paid within target	7,228	34,046	6,074	29,038
Percentage of Non-NHS Trade invoices paid within target	**95%**	**93%**	**96%**	**94%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,007	150,000	1,342	144,958
Total NHS Trade Invoices Paid within target	1,853	149,192	1,270	144,061
Percentage of NHS Trade Invoices paid within target	**92%**	**99%**	**95%**	**99%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2014-15 £000**	2013-14 £000
Amounts included in finance costs from claims made under this legislation	0	0
	0	0
Total	**0**	**0**

7 Income Generation Activities

North Lincolnshire Clinical Commissioning Group does not undertake any income generation activities (31 March 2014: £Nil).

8. Investment revenue

North Lincolnshire Clinical Commissioning Group has not received any investment revenue in 2014-15 (31 March 3014 £Nil).

9. Other gains and losses

North Lincolnshire CCG had no other gains and losses to report for the year ended 31 March 2015 (31 March 2014: £Nil).

10. Finance costs

North Lincolnshire CCG had no other finance costs to report for the year ended 31 March 2015 (31 March 2014: £Nil).

11. Net gain/(loss) on transfer by absorption

North Lincolnshire Clinical Commissioning Group has not made any gain or loss on absorption in 2014 -15 (2013-14 £Nil).

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	Land	**Buildings**	**Other**	**2014-15**	2013-14
	£000	**£000**	**£000**	**Total £000**	Total £000
Payments recognised as an expense					
Minimum lease payments	0	243	9	**252**	885
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**243**	**9**	**252**	**885**

Whilst our arrangements with Community Health Partnership's Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangements only

12.2 As lessor

North Lincolnshire Clinical Commissioning Group holds no leases as a lessor (2013-14 None).

13 Property, plant and equipment

2014-15	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2014	0	0	0	0	0	0	25	0	25
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	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
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**25**	**0**	**25**
Depreciation 1 April 2014	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	6	0	6
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**6**	**0**	**6**
Net Book Value at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**19**	**0**	**19**
Purchased	0	0	0	0	0	0	19	0	19
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**19**	**0**	**19**
Asset financing:									
Owned	0	0	0	0	0	0	19	0	19
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**19**	**0**	**19**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

North Lincolnshire CCG had no assets under construction to report at 31 March 2015 (31 March 2014: £Nil).

13.2 Donated assets

North Lincolnshire CCG had no donated assets to report at 31 March 2015 (31 March 2014: £Nil).

13.3 Government granted assets

North Lincolnshire CCG had no government granted assets to report at 31 March 2015 (31 March 2014: £Nil).

13.4 Property revaluation

North Lincolnshire CCG had no property revaluations to report for the year ended 31 March 2015 (31 March 2014: £Nil).

13 Property, plant and equipment cont'd

13.5 Compensation from third parties

North Lincolnshire CCG has received no compensation from third parties for assets impaired, lost or given up in the year ended 31 March 2015 (31 March 2014: £Nil).

13.6 Write downs to recoverable amount

North Lincolnshire CCG has written down no assets to recoverable amounts in the year ended 31 March 2015 (31 March 2014: £Nil).

13.7 Temporarily idle assets

North Lincolnshire CCG had no temporary idle assets to report at 31 March 2015 (31 March 2014: £Nil).

13.8 Cost or valuation of fully depreciated assets

North Lincolnshire CCG had no fully depreciated assets to report at 31 March 2015 (31 March 2014: £Nil).

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	3	5
Furniture & fittings	0	0

14 Intangible non-current assets

North Lincolnshire Clinical Commissioning Group had no Intangible Assets as at the 31 March 2015 (31 March 2014: £Nil).

14.1 Donated assets
North Lincolnshire CCG had no donated assets to report at 31 March 2015 (31 March 2014: £Nil).

14.2 Government granted assets
North Lincolnshire CCG had no government granted assets to report at 31 March 2015 (31 March 2014: £Nil).

14.3 Revaluation

North Lincolnshire CCG had no asset revaluations to report at 31 March 2015 (31 March 2014: £Nil).

14.4 Compensation from third parties

North Lincolnshire CCG has received no compensation from third parties for assets impaired, lost or given up in the year ended 31 March 2015 (31 March 2014: £Nil).

14.5 Write downs to recoverable amount

North Lincolnshire CCG has written down no assets to recoverable amounts in the year ended 31 March 2015 (2013-14 £Nil).

14.6 Non-capitalised assets
There are no significant intangible assets controlled by the NHS North Lincolnshire Clinical Commissioning Group that are not recognised as assets because they didn"t meet the recognition criteria of IAS 38 (2013-14 £Nil)

14.7 Temporarily idle assets

North Lincolnshire CCG had no temporary idle assets to report at 31 March 2015 (2013-14 £Nil).

14.8 Cost or valuation of fully amortised assets

North Lincolnshire CCG had no fully amortised assets to report at 31 March 2015 (2013-14 £Nil).

14.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	0	0
Computer software: internally generated	0	0
Licences & trademarks	0	0
Patents	0	0
Development expenditure (internally generated)	0	0

15 Investment property

North Lincolnshire Clinical Commissioning Group had no investment property as at 31 March 2015 (31 March 2014: £Nil).

16 Inventories

North Lincolnshire CCG had no inventories as at 31 March 2015 (31 March 2014: £1k).

17 Trade and other receivables	**Current 2014-15 £000**	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	2,318	0	508	0
NHS receivables: Capital	0	0	0	0
NHS prepayments and accrued income	626	0	0	0
Non-NHS receivables: Revenue	230	0	175	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments and accrued income	53	0	10	0
Provision for the impairment of receivables	0	0	0	0
VAT	0	0	17	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	0	0	0	0
Total Trade & other receivables	**3,227**	**0**	**710**	**0**
Total current and non current	**3,227**		**710**	
Included above:				
Prepaid pensions contributions	0		0	

17.1 Receivables past their due date but not impaired	**2014-15 £000**	2013-14 £000
By up to three months	7	21
By three to six months	12	27
By more than six months	144	0
Total	**163**	**48**

It has subsequently been agreed to credit £88k of the amount above to the customer after the statement of financial position date. An accrual for this value is reflected in these financial statements to reduce the reported level of income and receivables.

17.2 Provision for impairment of receivables

North Lincolnshire CCG made no provision for the impairment of receivable for the year ended 31 March 2015 (31 March 2014: £Nil).

18 Other financial assets

North Lincolnshire CCG had no other financial assets at 31 March 2015 (31 March 2014: £Nil).

19 Other current assets

North Lincolnshire CCG had no other current assets at 31 March 2015 (31 March 2014: £Nil).

20 Cash and cash equivalents

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	205	0
Net change in year	(128)	205
Balance at 31 March 2015	**77**	**205**
Made up of:		
Cash with the Government Banking Service	77	205
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	**77**	**205**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2015	**77**	**205**
Patients‟ money held by the clinical commissioning group, not included above	0	0

21 Non-current assets held for sale

North Lincolnshire CCG had no Non-current assets held for sale at 31 March 2015 (31 March 2014: £Nil).

22 Analysis of impairments and reversals

North Lincolnshire CCG had no impairments or reversals to report at 31 March 2015 (31 March 2014: £Nil).

23 Trade and other payables	**Current 2014-15 £000**	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	0	0	0	0
NHS payables: revenue	752	0	3,186	0
NHS payables: capital	0	0	0	0
NHS accruals and deferred income	1,666	0	(1,144)	0
Non-NHS payables: revenue	1,527	0	1,150	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals and deferred income	8,717	0	8,637	0
Social security costs	17	0	17	0
VAT	0	0	0	0
Tax	25	0	24	0
Payments received on account	0	0	0	0
Other payables	466	0	287	0
Total Trade & Other Payables	**13,170**	**0**	**12,157**	**0**
Total current and non-current	**13,170**		**12,157**	

Other payables include £23.3k outstanding pension contributions at 31 March 2015.

24 Other financial liabilities

North Lincolnshire CCG had no other financial liabilities to report at 31 March 2015 (31 March 2014: £Nil).

25 Other liabilities

North Lincolnshire CCG had no other liabilities to report at 31 March 2015 (31 March 2014: £Nil).

26 Borrowings

North Lincolnshire CCG had no borrowings at 31 March 2015 (31 March 2014: £Nil).

27 Private finance initiative, LIFT and other service concession arrangements

North Lincolnshire CCG had no private finance initiative, LIFT and other service concession arrangements at 31 March 2015 (31 March 2014: £Nil).

28 Finance lease obligations

North Lincolnshire CCG had no finance lease obligations at 31 March 2015 (31 March 2014: £Nil).

29 Finance lease receivables

North Lincolnshire CCG had no finance lease receivables to report at 31 March 2015 (31 March 2014: £Nil).

30 Provisions

North Lincolnshire CCG had no provisions to report at 31 March 2015 (31 March 2014: £Nil).
Pension payments are made quarterly and amounts are known. The pension provision is based on life expectancy.
Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them.

31 Contingencies

North Lincolnshire CCG had no contingencies to report at 31 March 2015 (31 March 2014: £Nil).

32 Commitments

North Lincolnshire CCG had no capital or other financial committments to report at 31 March 2015 (31 March 2014: £Nil).

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 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 NHS Clinical Commissioning Group 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 clinical commissioning group 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 clinical commissioning group in undertaking its activities.

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

The Clinical Commissioning Group 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 clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the NHS Clinical Commissioning Group and revenue comes parliamentary funding, NHS Clinical Commissioning Group 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.

33.1.3 Liquidity risk

NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,318	0	2,318
· Non-NHS	0	230	0	230
Cash at bank and in hand	0	77	0	77
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**2,625**	**0**	**2,625**

	At „fair value through profit and loss" 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	508	0	508
· Non-NHS	0	175	0	175
Cash at bank and in hand	0	205	0	205
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**888**	**0**	**888**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,418	2,418
· Non-NHS	0	10,710	10,710
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**13,128**	**13,128**

	At „fair value through profit and loss" 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,042	2,042
· Non-NHS	0	9,787	9,787
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**11,829**	**11,829**

34 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	213,108	(3,436)	**209,672**	3,324	(13,170)	**(9,846)**
	0	0	**0**	0	0	**0**
Total	**213,108**	**(3,436)**	**209,672**	**3,324**	**(13,170)**	**(9,846)**

Reconciliation between Operating Segments and SoCNE

	31-Mar-15 £'000
Total net expenditure reported for operating segments	209,672
Reconciling items: Commissioning of Healthcare Services	0
Total net expenditure per the Statement of Comprehensive Net Expenditure	209,673

Reconciliation between Operating Segments and SoFP

	31-Mar-15 £'000
Total assets reported for operating segments	3,324
Reconciling items: Commissioning of Healthcare Services	0
Total assets per Statement of Financial Position	**3,324**

	31-Mar-15 £'000
Total liabilities reported for operating segments	(13,170)
Reconciling items: Commissioning of Healthcare Services	0
Total liabilities per Statement of Financial Position	**(13,170)**

35 Pooled budgets

The NHS Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2014-15 £000	2013-14 £000
Income	14,250	14,110
Expenditure	(14,790)	(14,920)

NHS North Lincolnshire CCG has a pooled budget arrangement with North Lincolnshire Council for Adult Mental Health Services. This is hosted by NHS North Lincolnshire CCG. The memorandum account for the pooled budget is:

Memorandum Account for the Adult Mental Health Pooled Budget for the period 1 April 2014 to 31 March 2015

	2014/15 £000	2013/14 £000
Gross Funding		
NHS North Lincolnshire CCG	**12,066**	11,876
North Lincolnshire Council	**2,184**	2,234
	14,250	14,110
Expenditure		
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	**11,901**	12,061
North Lincolnshire Council Adult Mental Health Services	**2,579**	2,583
Contribution to North Lincolnshire Council Social Care Services (Sandfield)	**119**	119
Challenge Fund	**83**	83
Contingency	**35**	-
MIND	**73**	74
Total Expenditure	**14,790**	14,920
Net Underspend/(Overspend)	**(540)**	(810)

The Adult Mental Health Pooled Budget has been established under Section 75 (NHS Act 2006) partnership arrangements for the commissioning of integrated services. NHS North Lincolnshire CCG is the lead for the Mental Health Services pooled budget.

Learning Disability Pooled Budget
NHS North Lincolnshire CCG is a partner in the Learning Disability Pooled Budget arrangements hosted by North Lincolnshire Council.
The CCG has contributed £374k in 2014-15 to the Learning Disability pool (£380k in 2013-14).
The CCG contributed £43,063 for the CTLD Manager in 2014-15.

From 2015-16 the Pooled Budget will include the Better Care Fund.

36 NHS Lift investments

North Lincolnshire CCG had no NHS LIFT investments to report at 31 March 2015 (31 March 2014: £Nil).

37 Intra-government and other balances

	Current Receivables 2014-15 £000	**Non-current Receivables 2014-15 £000**	**Current Payables 2014-15 £000**	**Non-current Payables 2014-15 £000**
Balances with:				
· Other Central Government bodies	2	0	66	0
· Local Authorities	221	0	884	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	50	0	188	0
· NHS Trusts and Foundation Trusts	2,894	0	2,230	0
Total of balances with NHS bodies:	**2,944**	**0**	**2,418**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	60	0	**9,802**	0
Total balances at 31 March 2015	**3,227**	**0**	**13,170**	**0**

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	0	0	66	0
· Local Authorities	86	0	145	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	140	0	133	0
· NHS Trusts and Foundation Trusts	368	0	1,909	0
Total of balances with NHS bodies:	**508**	**0**	**2,042**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	116	0	9,904	0
Total balances at 31 March 2014	**710**	**0**	**12,157**	**0**

38 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
DECLARATION OF INTEREST NORTH LINCOLNSHIRE CCG GOVERNING BODY				
Mrs A Cooke				
Chief Officer				
Partner Governor for Rotherham, Doncaster & South Humber NHS Foundation Trust	13,586	157	0	30
Dr M L Sanderson				
CCG Chair				
Partner at Trent View Medical Practice.	2,323	1	0	0
Husband is a Consultant employed by Northern Lincolnshire & Goole Hospitals NHS Foundation Trust.	106,589	0	0	0
Mrs T Paskell				
Chief Finance Officer & Business Support				
Husband is Deputy Director of Finance at Doncaster and Bassetlaw Hospitals NHS Foundation Trust.	3,038	0	0	0
Governor of Sheffield Teaching Hospitals FT	1,345	0	0	0
Dr R M Jaggs-Fowler				
GP Member/Medical Director				
Partner in Dr Jaggs-Fowler & Partners, Barton & Humber.	3,159	0	0	0
Mrs Caroline Briggs				
Director of Commissioning				
Partner Governor of Northern Lincolnshire & Goole NHS Foundation Trust	106,589	0	0	0
Dr A Lee				
GP Member				
Partner of West Common Lane Teaching Practice, Scunthorpe	720	0	0	0
Dr N Stewart				
GP Member				
Partner in Church Lane Medical Centre, Scunthorpe	1,641	0	0	0
Wife works as a Community Staff nurse for Northern Lincolnshire & Goole NHS Foundation Trust	106,589	0	0	0
Dr J Mbugua				
GP Member				
Partner in Cambridge Avenue Medical Centre, Scunthorpe	2,660	0	0	0
Partner in Trent View Practice	2,323	1	0	0
Work in Dermatology & the OOH GP unit at Northern Lincolnshire & Goole NHS Foundation Trust	106,589	0	0	0
Wife works as a Nurse at Northern Lincolnshire & Goole FT	106,589	0	0	0
Mr I Reekie				
Lay Member				
Wife works as a receptionist at the private Spire - Hull & East Riding Hospital.	800	0	0	0
Dr F MacMillan				
GP Member				
Partner in Dr Jaggs-Fowler & Partners, Barton & Humber	3,159	0	0	0

Explanatory Note

The payments to related parties listed above are the total value of expenditure between the CCG and the named organisation rather than transactions attributable to the listed individual. The purpose is to report total expenditure that could be influenced with the identified supplier.

38 Related party transactions (contd)

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

- NHS England (including NHS Yorkshire and Humber Commissioning Support Units);
  NHS Commissioning Board
  NHS North East Lincolnshire CCG

- NHS Trusts
  East Midlands Ambulance Service NHS Trust
  Hull & East Yorkshire Hospitals NHS Trust
  Leeds Teaching Hospitals NHS Trust
  Lincolnshire Community Health Services NHS Trust
  Mid Yorkshire Hospitals NHS Trust
  Nottingham University Hospitals NHS Trust
  United Lincolnshire Hospitals NHS Trust
  Yorkshire Ambulance Service NHS Trust

- NHS Foundation Trusts
  Derby Hospitals NHS Foundation Trust
  Doncaster & Bassetlaw Hospitals NHS Foundation Trust
  Harrogate & District NHS Foundation Trust
  Humber NHS Foundation Trust
  Northern Lincolnshire & Goole NHS Foundation Trust
  Rotherham Doncaster & South Humber NHS Foundation Trust
  Sheffield Children's NHS Foundation Trust
  Sheffield Teaching Hospitals NHS Foundation Trust
  University College London Hospitals NHS Foundation Trust
  York Teaching Hospital NHS Foundation Trust
- NHS Litigation Authority; and,
- NHS Business Services Authority.
- NHS Property Services

In addition, the clinical commissioning group 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 Lincolnshire Council
HM Revenue and Customs
National Insurance Fund

39 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of North Lincolnshire Clinical Commissioning Group.

40 Losses and special payments

North Lincolnshire CCG had no losses or special payments to report at 31 March 2015 (31 March 2014: £Nil).

41 Third party assets

	2014-15 £'000	2013-14 £'000
Third party assets held by North Lincolnshire CCG	0	0

42 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2014-15 Target	**2014-15 Performance**	2013-14 Target	2013-14 Performance
Expenditure not to exceed income	217,755	213,109	211,584	207,556
Capital resource use does not exceed the amount specified in Directions	0	0	25	25
Revenue resource use does not exceed the amount specified in Directions	214,319	209,673	208,409	204,406
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	4,371	4,169	4,230	4,192

43 Impact of IFRS

North Lincolnshire CCG had no impact to report in relation to IFRS at 31 March 2015 (31 March 2014: £Nil).

44 Analysis of charitable reserves

North Lincolnshire CCG had no charitable funds to report at 31 March 2015 (31 March 2014: £Nil).

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10. Audit Opinion and Report

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

We have audited the financial statements of NHS North Lincolnshire Clinical Commissioning Group for the year ended 31 March 2015 on pages 100 to 142, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes. These financial statements have been prepared under applicable law and the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Members of North Lincolnshire CCG, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Members of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, set out on page 75, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

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

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

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

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and

- the information given in the Strategic Report and Members' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- in our opinion, the Governance Statement does not reflect compliance with NHS England's Guidance;

- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or

- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of, the audit.

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

Respective responsibilities of the CCG and auditor

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

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

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

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

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

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

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

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

Conclusion

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

Certificate

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

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

Chartered Accountants
1 The Embankment
Leeds
LS1 4DW

27 May 2015