NHS
North Lincolnshire
Clinical Commissioning Group

NHS North Lincolnshire Clinical Commissioning Group

2015-16

Annual Report

For Submission to NHS England on 27/05/16

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Section 1

Performance Report

1.1. Overview

1.1.1. Introduction

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

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

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

For further information, assistance or to request a copy of the report in your preferred format, please contact:

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As a publicly accountable body, the CCG is committed to being open and transparent with its staff, partners, patients and the wider community. The CCG holds six Governing Body meetings and an Annual General Meeting each year, all of which can be attended by members of the public. For dates, times and venues of all meetings held in public, please contact the CCG via the details above or visit the CCG's website:

http://www.northlincolnshireccg.nhs.uk/theboard/our-meetings

The CCG is always very keen to hear from people who use health or care services in North Lincolnshire as well as from their carers or families. Your experiences can help us to learn from the people best placed to inform us, you. Your voice really can help to shape future services and we would encourage you to attend one of the events we organise throughout the year or contact us via the details above.

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1.1.2. Welcome from the Chair and Chief Officer

Some things really matter to everyone. The health services and care that we or the people who are important to us need – whether it's now or things we will almost certainly need in the future - are probably top of the agenda for most of us. Those of us who are proud to work for North Lincolnshire Clinical Commissioning Group (CCG) have the responsibility to plan and buy that care and to make sure safe, affordable and compassionate services will continue to be there when our population needs them into the future.

Welcome to our latest Annual Report and Financial Accounts for 2015-16, which tells the story of how we have progressed and performed as an organisation over the last 12 months.

It is no secret that health funding is no longer keeping pace with the growing demand of a population that is living with more and more complex health needs. As a result, this last year has again not been an easy one. Our challenge as a CCG remains to put in place strong foundations that will ensure people living in North Lincolnshire will continue to be able to access the high quality, safe and caring services they need for years to come; services that treat them like people, not statistics.

The journey towards achieving this means that sometimes services may have to change or be delivered in a different way to that which people are used to. It also means that sometimes the decisions we have to make may feel tough. However, we are confident we can depend on the commitment, expertise and professionalism of our staff, provider colleagues, member practices and the other local and regional organisations we work with, to pull effectively together in order to build on what has already been achieved since the CCG was created in 2013 and meet these challenges head on.

The transformation the CCG wishes to achieve cannot be achieved in a single year as it needs change to be made across the entire health and care system. Some of our progress in 2015-16 has been about laying good foundations for the future such as the work carried out to develop our new Care Networks. Care Networks are an exciting new way to bring together the health, care and voluntary sectors to deliver genuinely joined-up health and care services in communities and reduce hospital admissions.

Other projects have seen more immediate results that people using local services in North Lincolnshire – particularly frail elderly people and their carers - are already benefitting from and you can read about these a little later in this overview.

The CCG has made good progress against its operational plan for 2015-16 and beyond with new plans for the next 12 months described in this Overview. We continue to meet most of the performance and financial targets set out in our constitution. However, there have been a number of areas that have challenged us during the past 12 months, including referral-to-treatment times and achievement of the A&E four hour waiting time. You can read about this in more detail in our Performance Summary, but this includes, for example, 18 week referral-to-treatment targets with Orthopaedics, Ophthalmology and General Surgery, which are under particular pressure.

As a CCG, we continue to strive to place our patients, their carers and families at the heart of everything we do. During 2015-16 the CCG held two well-attended Health Matters events, where almost 200 people came along to share their views on topics ranging from proposed changes to non-emergency Patient Transport, to exciting new services being developed with our partners in acute, mental and social care.

North Lincolnshire CCG itself has seen great change over the past 12 months. On a personal level, I am co-writing this introduction with our clinical chair Dr Margaret Sanderson in my first months here in North Lincolnshire, having joined the organisation from Leeds North CCG in January. My predecessor Allison Cooke retired from the Chief Officer role in December 2015 after leading the CCG through its transition from the former NHS North Lincolnshire PCT and its first two years of operation. Allison is missed by her former colleagues and we all hope she is enjoying her retirement with her family and dogs.

Chief Finance Officer Therese Paskell also left the CCG in December for a new stage in her career, and this post currently remains vacant; although Kieran Lappin is serving in the interim. The CCG Governing Body also recently said goodbye to the Director of Public Health, Frances Cunning, who had held the joint post with North Lincolnshire Council since 2009.

This does seem like a lot of departures, but in fact our CCG has warmly welcomed more staff during the latter part of 2015-16. Since its inception in 2013, many essential support functions for the CCG were carried out by the Yorkshire and Humber Commissioning Support Unit. However, this organisation was recently wound up and our gain was a number of people coming to work either for us or with us (in partnership with our neighbours at North East Lincolnshire CCG) to provide services key to the CCG's smooth running.

Finally, thank you very much for your interest in our CCG and for taking the time to read this report. There is a lot of material we are required to include in the Annual Report and Accounts which can make it an unwieldy document! However, we hope the new format with its Overview section will make it a lot more accessible and we warmly welcome any feedback as to how we can make it more user friendly.

Dr Margaret Sanderson
Clinical Chair

Liane Langdon
Chief Officer

Dr Margaret Sanderson
Clinical Chair

Liane Langdon
Chief Officer

1.1.3. Who we are and what we do

Clinical Commissioning Groups or CCGs were established in April 2013 and are made up of family doctors, other people who work in health or care and members of the public who are not NHS employees who together decide what healthcare services should be available in their local area.

Our organisation is led by GPs who represent 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 NHS England, the executive, non-departmental public body for the Department of Health. The number of support staff within the CCG increased during late 2015 with the disbandment of Yorkshire and Humber Commissioning Support, which had previously provided certain back-office functions for CCGs. Some of these functions – such as Communications and Engagement and Contract Management - are now being carried out as shared services between North and North East Lincolnshire CCGs with staff employed by one CCG or the other. Going forward, other functions will be provided by health consortium eMBED and North East Commissioning Support (NECS).

Each year, CCGs are told by the Government how much money they have available to spend on health services. They then have to decide how to share this money across the wide range of services that local people need. These are services like life-saving emergency care, the treatment of acute physical and mental illnesses, routine family health care and managing long term health conditions. Long term health conditions include dementia, heart and breathing problems, and diabetes and its complications, which we see a lot of in this area. Like all other CCGs, we are not responsible for commissioning preventative, or some very specialist, health services.

The money we are allocated by NHS England comes in two parts. In 2015/16, the CCG was allocated £216.859 million by NHS England to commission NHS services. We were also allocated £4.083 million to pay for the management and operation of the organisation.

Our budget is based on a complex funding formula which looks at the overall health and wellbeing of people living in our area. The CCG shares in large parts the same administrative boundary as our local authority, North Lincolnshire Council, covering an area of approximately 328 square miles (850 square kilometres). 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's residents. The remaining 52% live in the six market towns of Barton, Brigg, Crowle, Epworth, Winterton and Kirton Lindsey and in the 80 surrounding villages.

The latest population estimates 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 1,200 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 people between now and 2037.

North Lincolnshire's population is not only growing, it is also growing older. Currently, more than 32,000 of our residents are aged over 65. This is 22.6% more than in 2003. The most significant growth in the retirement age population has been amongst people aged over 90 and amongst older men in particular. In the 10-year period between 2003 and 2013, the number of residents aged over 85 grew by more than 46%.

It is good news that people are enjoying longer lives but it is also one of the challenges faced by the CCG as it means more people experience one or more long-term and often complex health conditions. This does put extra demand on services and has affected waiting times and costs. Health funding is not keeping pace with this increased demand and this means our resources need to be stretched further. However, when organisations work collectively, we are able to respond better to these challenges and make the budgets stretch further.

The CCG continues to work closely with its neighbouring CCG in North East Lincolnshire and Northern Lincolnshire and Goole Foundation Trust on the Healthy Lives, Healthy Futures review of services. This is helping us to understand the funding gap and find affordable models of care which can be delivered into the future. Complementing this has been the implementation of the Better Care Fund plan which sets out new models of care, particularly for the frail and elderly in our communities.

2015/16 year has seen new or enhanced services put in place that will enable more people to be cared for in their own home, or a home-like environment, with support to return to independence after a period in hospital.

Public engagement continues to play a key role in shaping and developing both the Healthy Lives Healthy Futures and Better Care Fund plans so far, and this engagement will continue throughout 2016-17.

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 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 the coming year.

The CCG commissions hospital and community services from Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and hospital 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 jointly commissions services with partners, such as our neighbouring North East Lincolnshire CCG for health care and local authority North Lincolnshire Council for social care services.

CCGs were not initially responsible for directly commissioning primary care (GP) health services, which were 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 other 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 and you can read about these in the Annual Governance Statement of this report in Section 2.1.3 below.

1.1.4. Our year in brief

Looking back to 2014-15, last year's Annual Report summarised the CCG's progress and performance against key local and national priorities in its second year of operation. The report also provided 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 pleased to be able to update on the progress of these plans during the past 12 months.

Locality Teams – the new Care Networks

Last year we told you we planned:

"Further enhancement of Integrated Locality Teams to deliver a multidisciplinary 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."

Work began in Autumn 2015 with many of our partner agencies to design three multi-agency, multi-disciplinary Care Networks, centred on GP registered populations and covering the geographical area of North Lincolnshire. Partners include Primary Care (GP Practices), Social Services, Community Nursing Teams from Northern Lincolnshire and Goole Foundation Trust (NLaG), Public Health, mental health teams from Rotherham, Doncaster and South Humber Foundation Trust (RDASH), voluntary agencies and residential care homes.

This is part of the North Lincolnshire response to the Health Lives Healthy Futures programme of change. Development of the governance structures for the Care Networks has been the focus for the first part of 2016, with a view to them going live in April 2016. The initial focus of the Care Networks is to provide 'joined-up' care within the community setting, to reduce unnecessary hospital admissions (especially for unplanned care), to improve the services for the frail elderly, those with multiple long-term conditions and dementia, and to provide a better quality of end-of-life care.

Rapid Assessment Time Limited Service (RATL)

Last year we told you there would be:

"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."

Since the 24/7 Rapid Assessment Time Limited Service (RATL) was implemented in October 2015 more than 1,000 patients have been able to receive care at home or in the community. Run by the unscheduled care team at Northern Lincolnshire and Goole NHS Foundation Trust, RATL provides a fast community response, 24 hours-a-day, seven days-a-week, to mainly elderly or frail people who are in urgent need of care.

One patient to benefit from the service and avoid a hospital admission was referred with a suspected urinary tract infection. On previous occasions they had been admitted to hospital with similar symptoms for assessment and treatment. However, under the RATL service the unscheduled care practitioner visited the patient at home, completed an assessment and diagnosed an uncomplicated urinary tract infection and mild dehydration. Antibiotics were prescribed and advice and support was provided to the patient, their relatives and carers. As the patient was prone to sepsis, daily assessments from an unscheduled care practitioner were undertaken for 48 hours to ensure the treatment was working.

Dr Robert Jaggs-Fowler, medical director at North Lincolnshire Clinical Commissioning Group and lead clinician for the Healthy Lives Healthy Futures Programme, says the service aims to support people to continue to live at home for as long as possible. He said: “Hospital stays can be overwhelming, and most people tell us they want to stay in familiar surroundings whenever that’s possible.

“Hospital admissions are necessary at times, but this service is enabling many more elderly or very poorly people to remain at home or in their usual place of care whilst they still get the most appropriate treatment.”

Urgent Care Model

Last year we told you there would be:

“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.”

Northern Lincolnshire and Goole NHS Foundation Trust has developed its Ambulatory Emergency Care model during 2015/16 and now manages patients with a small range of conditions in this way. This enables people to be rapidly assessed and treated and then discharged home with follow-up care in their own home or on a clinic basis if needed. We are continuing to work with the Trust to increase the number of people managed in this way by increasing the range of health conditions managed through the unit.

Dr Faisel Baig, a local GP who was CCG unplanned care lead when the unit opened, explained: "The new centre means many people will be assessed, treated and be able to return home the same day - all without having to get into a hospital bed.

“Patients will have fast access to a senior clinician, and there is a dedicated team available to support them at home, so it means they will be getting exactly the same care and treatment as if they had been admitted overnight. Most people tell us they would much rather be treated and recover in familiar surroundings, and this avoids the upheaval of spending time on a busy ward, feeling more poorly because you're in a hospital bed and, at the end of your treatment, waiting to be discharged."

Carers

Last year we told you there would be:

"*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."*

North Lincolnshire's new 'All Age Carers Commissioning Strategy' was launched during Carers Week in June last year. The strategy has been created jointly with North Lincolnshire Council and the CCG and outlines the commissioning intentions for carers across North Lincolnshire to ensure that by understanding their needs, we can design, shape and transform services to meet these needs.

Caroline Briggs, Director of Commissioning at the CCG, said: "It is important that carers are supported to balance their caring role with looking after their own health and wellbeing.

"The new strategy acknowledges the wealth of expertise, understanding and quality of care provided by people every single day, right across North Lincolnshire. Taking care of another person can often take its toll and we want to make sure the right support is there to prevent what is often a full-time role having an adverse impact on the carer."

Improving dementia diagnosis rates

Last year we told you we aimed for:

"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."

The CCG achieved a dementia diagnosis rate of 62.8% in February. The work plan is to continue through 2016/17 including targeted support to GP practices to improve diagnosis rates and review of model for support to care homes. This positive progress means that increasing numbers of people with dementia are now able to consider and access treatment, care and support options and make decisions about their future alongside their carers and families.

Better Care Fund Plan during 2015-16

During 2015-16, our Better Care Fund (BCF) plan set about ensuring the needs of the Frail and Frail Elderly in North Lincolnshire are better managed and supported. The plan 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. 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.

As well as the Rapid Assessment Time Limited Service (RATL) described above, Better Care Funding has been used to create and further enhance the following services:

Seven Day Hospital Social Workers – North Lincolnshire Council

Based at Scunthorpe General Hospital, the hospital team has been in operation since November 2014 and fully operational, working 8am to 8pm, since December 2014. The team has already developed good working relationships with the discharge liaison team within the hospital. This new joint approach helps to manage and support the safe discharge of people from hospital back into the community. Hospital 'board rounds' are now attended by the team each day, supporting safe hospital discharge.

Frail Elderly Assessment Service Team (FEAST) - Northern Lincolnshire and Goole Foundation Trust

This new joint multidisciplinary/agency approach was developed to support individuals assessed as being frail and elderly in accordance with the well-documented Bournemouth criteria. These patients were deemed to then benefit from a comprehensive geriatric assessment and plan of on-going care by the specialist FEAST service. The patient may then spend time being assessed in a new 'chair based' unit with a plan to discharge on the same day or be admitted within a designated bed base with an aim to return home within 72 hours.

The new team consists of a consultant geriatrician, therapists, advanced nurse practitioners, health care support workers and work alongside older people's mental health liaison services and the existing hospital social care team.

The new team, working with existing wards teams including 7-day social workers and older people mental health services, also works closely with community services and GPs to ensure appropriate care and support when patients go home. The service commenced on 9th September and was fully launched on October 1st. 2015, including the newly refurbished chair-based area.

Locality Teams – Northern Lincolnshire and Goole Foundation Trust/North Lincolnshire Council

The aim of the scheme is to manage and support patients closer to their home, by a workforce that knows their local area better and are able to provide treatment, advice and signposting locally.
The new locality co-ordinator posts have been recruited to, and have commenced in post in October 2015. The scheme also supported 7-day working for therapies, which started at the end of July 2015. To support better end of life care closer to home, new Macmillan nurses have been funded through the Better Care Fund, and they are also now in post. They began 7-day working in October 2015.

The community equipment service has also been extended on an interim basis to 6-day working with 1-day on call from the end of July. These investments support the development of the Care Networks as we move into 2016/17

Acute Liaison - Older Peoples Mental Health Services (OPMH) – Rotherham Doncaster and South Humber Foundation Trust

The OPMH service, initially a pilot last winter, aims to rapidly assess older people admitted to hospital who have been perceived to have a mental health problem such as dementia or depression.

The service currently provides on-going consultation, support, education and advice to those with mental health problems and their carers. Due to the success of the pilot, recruitment progressed during the first two quarters of 15/16. The nurse consultant, therapists and support workers have been in post since August 2015, working across five days, and the consultant Psychiatrist (aligned to the new role on a part-time basis) from mid-September 2015. More recently, they have successfully recruited to all three additional nursing posts and, as a result, the service became fully operational 08.00-20.00 from 4th January 2016.

Community Wellbeing Hubs – North Lincolnshire Council

The five wellbeing hubs outlined in the BCF plan are all fully operational in Scunthorpe, Brigg, Epworth, Barton and Winterton. In addition, further satellite hubs in Broughton and Crowle are being developed by the council.

The hubs that have been refurbished are dementia friendly environments with 'changing places' type toilets (two are fully compliant). In order to target individuals requiring additional support, the hubs operate a registration scheme. The Hub teams are currently providing targeted interventions on a 1:1 basis and working with 116 individuals. These numbers are steadily rising month-on-month as the population and other agencies become more aware of the services offered.

There have been 5,500 newsletters distributed across the community outlining the support and activity available at the hubs. The wellbeing offer and hubs are being promoted to GP practices, so that people can be referred and sign posted to early help and support.

Identification of the most vulnerable communities and people within those communities is done through the use of profiling data and partnership working. The hubs are actively working with the hospital team to create support links for service users admitted to hospital, in order to help at discharge, and are also looking at ways to work differently with the intermediate care service at Sir John Mason House. The service is piloting the Healthy and Active passport, which will give citizens access to services and schemes aimed at improving health and wellbeing. Wellbeing hubs are also being designated as Spaces of Safety (SOS).

Disabilities Funding Grant (DFG) – North Lincolnshire Council

The capital element of the BCF includes expenditure on DFGs. The council's Home Assistance team process all recommendations made by the Occupational Therapy (OT) service/social services for adaptations to a home.

A recommendation is made when it is identified that an adaptation would support keeping a vulnerable elderly or disabled adult or child safe at home. The council as a Housing Authority has a statutory duty to provide mandatory Disabled Facilities Grants under the Housing Grants, Construction and Regeneration Act 1996. Service performance is currently monitored using end-to-end times. There are national guidelines on the time taken from the OT visit to the completion of the work, which the service is monitored against. A multi-agency working group is reviewing the process involved in order to identify how timescales can be further improved for delivery in the coming year.

Other areas of progress against 2015/16 plans

New model of care for patients with Diabetes

2015/16 saw development of our long term conditions pathways which reflects views gathered through the Experience-Led Commissioning programme.

This included the implementation of a new community-based model of care for Diabetes.

Most patients have stable uncomplicated diabetes which is best looked after by their GP practice. From November 2015, some people who previously had to attend hospital for appointments about their diabetes were able to routinely see GP practice staff instead.

The new model allows the hospital diabetes team to concentrate on those with more complicated diabetes including Children and adolescents, people with diabetes with foot problems and expectant mums with diabetes or women with diabetes who are planning a baby.

Community MSK services

A community-based MSK clinical assessment and treatment service was designed during 2015/16, again reflecting involvement of patients with long term conditions. Mobilisation of a new provider will take place during 2016/17.

Non-Emergency Patient Transport Services

Alongside our neighbours in North East Lincolnshire, the CCG wished to ensure Patient Transport Services (PTS) were able to continue to meet what will be a growing local need well into the future. This meant drawing up a new specification for the service that was informed by what local patients and their carers told us about their needs, with more than 500 people taking part in person and more than 170 people completing a survey about their experiences.

A competitive procurement exercise took place during 2015/16 and the CCGs recently announced a new provider to deliver non-emergency Patient Transport Services across the two areas.

The contract has been awarded to Thames Ambulance Service whose parent company The Thames Group operates across a number of health economies in England. Thames Ambulance Service has a local base in Doncaster in South Yorkshire but will be opening a new base in the North and North East Lincolnshire locality shortly, once a suitable site has been identified.

Mental Health

Child and Adolescent Mental Health Services (CAMHS)

A plan to transform CAMHS services in North Lincolnshire was developed during in 2015/16 which will be implemented in the coming year.

Adult Mental Health Services

2015/16 saw development of an adult mental health action plan which reflects views gathered through the Experience-Led Commissioning programme. Implementation of the plan has already commenced and the coming year will see full implementation and monitoring of impact.

Communication and education regarding early detection of cancer

Communication and education regarding early detection of cancer to Primary Care staff has continued through 2015/16 with the appointment of a Macmillan GP facilitator. Work on raising awareness of early symptoms of cancers will continue over the coming year in conjunction with Public Health teams.

1.1.5. How we are doing

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 many of the targets. However, there remain some challenges.

NHS Constitution Standards – Performance by Exception

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 Hardwick 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 2015-16, with a year-end position yet to be confirmed. However, it will not achieve the required 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 System Resilience Group, which brings together representation from health and social care services including EMAS, Northern Lincolnshire & Goole Hospitals NHSFT (NL&GHFT), North Lincolnshire Council (NLC), NHS East Riding of Yorkshire CCG (ERCCG), and the NHS England Area Team, to understand and address the issues impacting on performance against this target. The full implementation of the integrated urgent care model and Better Care Fund schemes will contribute towards sustained improvement in performance during 2016-17 and beyond.

Cancer Waiting Times

The CCG has experienced difficulties with some of the pathways at different times during 2015/2016 although, on the whole, delivery of cancer waits has been strong.
Some areas where performance was affected related to cross trust pathways and specific issues around the reliability of equipment and delays in diagnostics.
These areas continue to be reviewed by providers and commissioners, supported also at a network level.

Referral to Treatment Times

The local providers have failed to achieve the required levels of performance in this area towards the end of 2015/2016, with performance significantly below required levels in a number of specialties. Work is on-going with both local Trusts to understand the reasons for breaches. The local Trust is undertaking root-cause analysis on breaches, and recovery actions are monitored by the CCG. Dialogue with the Trust continues to ensure shared understanding of the reasons for breaches and the appropriate remedial action.

CCG Assurance Framework – Other Indicators

In addition to the NHS Constitution Indicators, the CCG position against the Assurance Framework has been strong. It has achieved required levels of performance in relation to Improving Access to Psychological Therapies (IAPT), Mental Health Care Programme Approaches (CPA) and Eliminating Mixed Sex Accommodation.

At the close of 2015/2016 there had been 2 cases of MRSA for which thorough root-cause analysis was undertaken, and actions identified, to be taken forward by the Infection Control Group.

The number of *C Difficile* cases was managed within the tolerance level for 2015/2016.

A more detailed Performance Analysis is included in the Section 1.2.1. of this report.

1.1.6. What we want to achieve

Our vision is that North Lincolnshire should be a healthy place to live, where everyone enjoys improved wellbeing, and where inequalities are significantly reduced; all delivered within the resources available to us. More care should take place in or close to people's homes. People should feel able to take care of themselves and should feel they get the appropriate support to do so. Services should be proactive in their approach to enable people to remain independent for as long as possible.

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

Our strategy has been informed by talking to patients, their carers and families, front line staff and members of the public (you can read more about how we do this later on in the Annual Report) and is based on enabling people to take care of their own health and accept more responsibility for their lifestyle choices.

To make sure we can do this against the difficulties described earlier, we will sometimes need to do things in a different way to that which people are used to. In fact, we are already doing this in some services and you might have already noticed some changes. This may mean sharing some health services with neighbours in other parts of Lincolnshire or the North Bank, for example, or by making better use of technology such that sometimes you may speak to a doctor or nurse on the telephone or through a video link instead of in person.

The graphic (below) shows how we are looking at health and care differently, using services in different places or in a different way and sometimes directing people to a different kind of clinical professional to the one they might expect to see.

Most of us are used to going to our doctor's surgery for some things and going to the local hospital for others, and relying on the resources that are there. When health and care organisations (both in the same area and in neighbouring towns and cities) work properly together, we can provide care in a completely different way that is designed around what an individual patient needs. This can then support them to regain as much of their health and independence as possible, as quickly as possible.

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

Things we plan to do for the coming year span the entire age spectrum of our population (you will be able to read this in full by visiting NL CCG's website for the Operational Plan link) and **include**:

Starting well/Growing well	Evaluation of Children's Community Nursing model
Working well	Implementing the Diabetes Prevention Programme Development and implementation of dual diagnosis pathway for people with mental health needs and substance misuse issues Improving access to mental health crisis beds
Ageing well	Development of new models of care to support the frail and elderly including improved GP support into people living in care homes, use of tele-health to support people in care homes and education and support to care home staff Development of Practice Health Champions who are recruited and supported as a group to work closely with their General Practice to create new ways for patients to access non-clinical support
Dying Well	Full roll-out of Gold Standard Framework across all practices
All Life Stages	Further development and implementation of Care Networks. Improved co-ordination and integration of care through new out of hospital models of care; person centred, needs led, prevention focussed, delivered by integrated health, social care, third sector teams. Development of primary care enhanced services: General Practice, optometry and pharmacy services

1.1.7. The risks that could affect our plans

The revenue resources available to the CCG at the start of the year were set out in the CCG's financial plan for 2015-16 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 adopts an integrated approach to risk management which enables us to consider the potential impact of all types of risks on everything we do - all of our processes, activities, stakeholders and commissioned services. The CCG Risk Management Framework aims to provide strategic direction and guidance on embedding the integrated risk management approach in all CCG business. Further analysis of the main risks, can be found in the 'risk assessment' section of the Annual Governance Statement.

1.1.8. Going Concern Declaration

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.

1.1.9. Different Language Versions of This Document

If you would like this information explaining to you in your own language, please tick the appropriate box and send it to the address below:

Polish ☐

Jeśli potrzebują Państwo wyjaśnienia tych informacji w języku polskim, proszę zaznaczyć właściwą kratkę i odesłać formularz na adres:

Swahili ☐

Kama ungependa kupata habari hii kwa lugha yako, tafadhali tia alama katika kisanduku kinachofaa, na utume kwa:

Mandarin ☐

如果您希望此信息按您自己的语言进行说明，请勾选相应的方框并将其发送：

Farsi ☐

اگر مایل هستید این اطلاعات به زبان خودتان برای شما شرح داده شود، لطفاً در مربع مربوطه علامت زده و به اینجا بفرستید:

Kurdish ☐

ئەگەر دەخوازیت ئەم زانیارییەت بە زمانی خۆت بۆ ڕوونبکرێتەوە، 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

العنوان أدناه:

Russian ☐

Если Вы хотите что бы эту информацию, Вам объяснили на Вашем родном языке, то пожалуйста, отметьте соответствующее поле галочкой и отправить все по указанному ниже адресу:

Imię i nazwisko / Isim / 姓名 / نام / ناو	
Adres / Adres / 地址 ناونیشان / آدرس	
☎	

1.2 Performance Analysis

1.2.1 Performance Measures

Summary Position as at 12th May 2016

Below is an updated summary position on an exception basis on the national performance indicators as set out in the NHS Outcomes Framework and Everyone Counts guidance and which form part of the CCG Assurance Framework.

In all cases of deviation from target an **Exception Report** is raised whereby the lead in this area must provide underlying cause information as well as recovery actions if applicable. These reports are available on the BIZ and in 2016/17 the key information will be more extensively incorporated within this report.

1. CCG Assurance

Are patient rights under the NHS Constitution being promoted?

Overall Constitution Indicator Performance

In 2015/16 the CCG has been developing the way it counts/reports the constitution indicators (CIs). This has resulted in the number of CIs changing between reports. In 2016/17 a detailed explanation of any changes will be incorporated within this report.

5	3	18

The following indicators all remain strong and are achieving the required level of performance or more:

- RTT 52 Week Waits
- 12 Hour Trolley Waits
- 2 Week Cancer Referral to First Seen
- 2 Week Cancer Referral to First Seen – Breast Symptoms
- 31 Day Cancer Diagnosis to Treatment
- 31 Day Cancer Subsequent Treatment Waits (Drug Regimens and Radiotherapy)
- 62 Day Cancer Referral to Treatment - Consultant Upgrade Status
- Mixed Sex Accommodation Breaches
- Cancelled Operations (including 2nd Cancellations)
- IAPT Entering Treatment and Recovery Rates
- Mental Health Care Programme Approach (CPA) Follow Up

Areas by Exception:

Area	RAG	⇩⇧	Comments	Lead
Referral to Treatment Times: Admitted, Non-Admitted and Incomplete Pathways <18 Weeks	R		All 3 RTT 18 Week indicators have again failed to meet the required levels in March 2016 and the closing 2015/2016 position has also not met the target. The main driver behind this is the position locally at Northern Lincolnshire & Goole Hospitals (NL&GFT). Significant pressure specialties continue to be Orthopaedics, Ophthalmology and ENT. The Trust have confirmed that a range of proactive improvement measures have been instigated across the Trust to regularly manage and monitor the 18 week performance position, including capacity and demand plans by clinical groups for all specialities. A Validation Team has been created to improve quality of data to support improved performance monitoring. A weekly performance report highlighting the 18 week position is submitted to the Executive Team and Associated Chief Operation Officers' meetings. At the NL&G Quality Contract (QCR) Meeting, on the 21st April, members formally requested further assurance of the Trusts approach to managing RTT. Members of the QCR agreed to escalate this request to the NL&G Executive Contract Board (ECB). Commissioners were informed, by the Trust at the NL&G QCR meeting, that the RTT Remedial Action Plan is due to be submitted to NL&G Executive Team on Tuesday 26th April for review and approval, it was agreed that this Action Plan would be circulated to members of the NL&G ECB and members of the NL&G QCR once it has been approved by the Trust. As part of the contract negotiations for 2016/2017 the Trust has calculated the cost of the position returning to plan. This is currently being reviewed by the CCG.	CB
A&E 4 Hour Waiting Times	R		A&E Performance in March 2016 did not meet the required 95% level but did improve from the previous month. The local Scunthorpe position has been stronger than Grimsby but both sites failed to meet the target. The Trust has a full detailed action plan in place to address performance in this area, a copy of which is available on request and as part of the exception report. A summary provided by the Trust identifying the main challenges during the period include: • Inpatient bed availability • Physical space - Urgent Care Centre at Scunthorpe • Large volumes of medical outliers and pressure on existing Physicians • Increased complexity of patient presentations	CB

			Faced with these difficulties the Trust has put into place several initiatives. These include enhanced medical support at the weekend with an additional Consultant Physician and Junior Doctor to support weekend discharging at both Diana Princess of Wales site in Grimsby and the Scunthorpe site. The Urgent Care Centre workforce weekend was also strengthened during the winter period with an additional middle grade or junior grade on Saturdays and Sundays at both sites. It is expected that the Trust will return to 95% by the end of June 2016. Actions shown in the action plan and associated milestones will support the improvement expected. Actions to Support Recovery are as follows: **Inpatient discharges –** focus on earlier discharge during the day and continued work on weekend discharges to even out the flow of patients through the 7 day week. **Development of Acute Care Physician model** – recruitment to additional acute care physicians with further development of ambulatory care in the Trust. **Physical space at SGH** - the ECC will be redesigned to create separate minors and majors entrances and patient flows within the department . **ECC workforce** – both medical and nursing workforces have been reviewed and are being optimised to better match workforce against patient flow. **Nursing recruitment and retention** – the Trust will continue to pursue recruitment of nurses through a variety of UK and overseas channels. It will also increase its focus on retention of nurses by carefully managing nurses recruited from overseas and where/how they are placed within the organisation to improve integration.	
Patients receiving first definitive treatment for cancer within 62 Days of referral from NHS Cancer Screening Services	R		The March 2016 position failed to meet the 90% target, at 66.7%. The number of patients on this pathway however is very small and the percentage only represents 2 patients out of a total of 6. Both patients were initially seen at Hull & East Yorkshire, one of which was subsequently treated at NLAG, the other remaining in Hull. This data became available on the 6th May 2016 so is in initial stages of investigation with the providers involved, but supporting information will follow in due course and will be contained in an exception report on the BIZ.	CB

			There is work underway locally in response to performance in these areas and all cancer pathways. NLAG have reported that they have introduced a Trust wide Action Plan and a weekly Chief Operating Officer led Task & Finish Group to support implementation with oversight at Executive level. The Action Plan includes all aspects of pathway management, breach review and reporting to support improved performance. In addition a new detailed report monitoring performance, Trust wide and by tumour site, has been introduced and deployed on a weekly basis. A weekly Chief Executive challenge meeting is also in place to support delivery of recovery actions. RCA for all patients breaching treatment targets is undertaken. Areas that the Trust are reviewing are: • Improving time to 1st outpatient appointment • Managing the increased number of 2ww referrals • Timely access to diagnostics (MR/CT & prostate biopsies) • Proactive management of patient pathways to improve efficient flow • Availability of patients The Trust are currently undertaking some analysis of referral trends as there has been a significant increase in referrals on a 2ww basis and a subsequent drop in treatment conversion rates. Attached are the cancer action plans that the Trust has recently circulated to QCR and ECB.	
Category A Ambulance Response Times 8 Minute RED 1	R		Performance at East Midlands Ambulance Trust (EMAS) against the Category A 8 minute indicator for RED1 calls did not reach the required level in March 2016 (64.1%) *The position for all ambulance Cat A response times are assessed at Trust level. The RED1 North Lincolnshire position at March 2016 is 69.1%.*	CB
Category A Ambulance Response Times 8 Minute RED 2	R		EMAS overall performance remains well below the required level at 47.0% in March 2016. *North Lincolnshire performance in March 2016 is also below the target at 64.2% but to a lesser extent.*	CB
Category A Ambulance Response Times 19 Minute	R		EMAS overall performance is 79.4% in March 2016. *North Lincolnshire performance in March 2016 is stronger but also below the target at 86.6%.* Performance for all three standards continues to fall below the National Standards, with A19 now being **unachievable for the year.** The revised Remedial Action Plan (RAP) has been received and shared with Chief Officers and County leads. Once agreed, it will be monitored both through the Partnership Board and through the monthly county level contract meetings if appropriate. EMAS have informed the coordinating commissioning team that the current national performance standards will not be achieved in Quarter 1 2016/17 so the RAP will be continued into the next contractual year.	CB

			The 2015/16 contract began as a Block but the majority of CCGs agreed to block the position based on the forecast outturn at Month 8. Most commissioners also agreed to make an additional non recurrent payment to EMAS to support them with the additional costs they incur due to Handover delays at Acute Hospitals. Inclusive of the points summarised, the 2015/16 year resulted in a total underspend of £3m against the initial annual expected contract value. The CQC have issued an improvement notice to EMAS which highlights staffing levels and handovers as areas for concern. This notice will be shared on 10th May.	

Are health outcomes improving for local people (CCG Assurance Indicators Only)?

Areas of Exception:

Area	RAG	⇩⇧	Comments	Lead
Reducing potential years of life lost from causes considered amenable to healthcare (all ages)	R		The indicator is calculated using the Office for National Statistics Mortality data and the mid-year population data as a directly standardised rate (DSR) per 100,000 registered patients. The target of 2083 has not been met as at September 2015 the rate has deteriorated to 2250.5 (DSR). Causes considered amenable to healthcare are those from which premature deaths should not occur in the presence of timely and effective health care. The Office for National Statistics (ONS) defines amenable mortality as follows: "A death is amenable if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare" The actions from the CCGs strategic plan and commissioning intentions will all contribute to the improvement in this indicator. Specifically as outlined in the Strategic Plan 2014/15 – 2018/19 the following 3 interventions are aligned to securing additional year of life: • Long Term Condition (LTC) Self Care • Whole System Approach to LTC Care • Early Cancer Diagnosis A joint piece of work is underway by the CCG and Public Health team to look at a full breakdown of the indicator to allow the CCG to get assurance as to what we are currently doing that will improve areas and other areas to look at. The outcome of this work will be discussed by the CCG executive team and outcome of which brought back to a future CCG Governing Body.	AC
Treating and caring for people in a safe environment & protecting them from avoidable harm – C Difficile	G		The CCG has remained inside its tolerance level for 2015/2016, with 31 cases against a tolerance level of 31 cases. Details of each RCA can be found as part of the exception report on the BIZ along with the weekly HCAI report.	CW

Treating and caring for people in a safe environment & protecting them from avoidable harm – MRSA	A		During 2015/2016 there was only 1 MRSA case reported. This was in November 2015 at Scunthorpe General Hospital. It was identified as a community acquired infection. The patient had been transferred from a GP practice to A&E. The patient had long standing problems and was known to have previous history of MSSA and MRSA. Decolonisation attempts had been unsuccessful. Patient attended both the GP practice nurse and community Podiatry service weekly for dressings from April 2015 The lead nurse for infection control has provided the full details of the RCA (Route Cause Analysis) of this case which can be found in the exception report on the BIZ. No further breaches were reported.	CW

2a. CCG Quality Premium - 2015/2016

The premium is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reductions in inequalities in access and in health outcomes. This will be based on the following measures that cover a combination of national and local priorities.

A CCG will not receive a quality premium if it is not considered to have operated in a manner that is consistent with Managing Public Money or ends the 2015/16 financial year with an adverse variance against the planned surplus, breakeven or deficit financial position, or requires unplanned financial support to avoid being in this position incurs a qualified audit report in respect of 2015/16.

NHS England also reserves the right not to make any payment where there is a serious quality failure during 2015/2016

NHS North Lincolnshire 1516 Quality Premium Dashboard

Measure	Short Name	% of Premium	Current Target	Current Performance (period)	RAG	Comments
Reducing potential years of life lost *(Source: HSCIC Indicator Portal: CCG OIS 1.1)*	Potential Life Year Lost	10%	2126.1	2250.5 (2014)		Next update due September 2016.
Urgent & Emergency Care - Achieving a reduction in avoidable emergency admissions *(Source: Levels of Ambition Atlas: Composite of all avoidable emergency admissions (ISR))*	Avoidable Emergency Admissions	30%	2505	2863.9 (2013/14)		
Mental Health - Reduction in the number of people with severe mental illness who are smokers *(Source: Data Extract by GPES)*	The number of people with SMI who are Smokers	8%				Comparison of % between 31/3/15 and 31/3/16. No current access /availability of data extracted by GPES to ascertain baseline, set target or get a current position.
Mental Health - Reduction in the number of patients with A&E 4 hour breaches who have attended with a mental health need together with a defined improvement in coding of pateints attending A&E	A&E 4 Hour Breaches who have attended with a Mental Health need	10%	95%			Reporting in Development.
Mental Health - Increase in the proportion of adults with secondary mental health conditions who are in paid employment *(Source: HSCIC Indicator Portal: CCG OIS 3.17)*	Adults with SMI Conditions who are in Paid Employment	6%	12.3	9.9 (2014/15)		Mar 2016: Oct14-Sep15 position suppressed due to small numbers. Next update due September 2016.
Mental Health - Improvement in the health-related quality of life for people with a long-term mental health condition *(Source: GP Patient Survey, CCG OIS 2.1 & 2.16)*	Health-Related Quality of Life for People with a Long-Term Mental Health Condition	6%	0.195	2014/15 data suppressed due to small numbers		This is a comparison between 14/15 and 15/16. 2014/15 data available September 2015. 2015/16 data available September 2016.
Improving antibiotic prescribing - reduction in the number of antibiotics prescribed in primary care *(Source: e-Pact)*	Antibiotics Prescribed in Primary Care	10%	1.213	1.132 (Mar'15 to Feb'16)		Although seeing a slight increase compared to previous month, performance remains below target.
Improving antibiotic prescribing - reduction in the proportion of broad spectrum antibiotics prescribed in primary care *(Source: e-Pact)*	Broad Spectrum Antibiotics Prescribed in Primary Care		13%	10.3% (Mar'15 to Feb'16)		Further reduction seen and remains below target.
Improving antibiotic prescribing - secondary care providers validating their total antibiotic prescription data *(Source: ?)*	Secondary Care Providers Validating their total Antibiotic Prescription Data		NLAG - Yes			Confirmed by lead that main provider (NLaG) do participate in this validation exercise. Monitoring in development.
Local Measure 1 - Emergency readmission within 30 days of discharge from hospital *(Source: Local SUS Data: crude rate)*	Emergency Readmission <30 days of Discharge from Hospital	10%	14.5	Q4 15/16 = 17.9 (Final 14/15 = 17.7)		Next update (Final 2015/16) due July 2016.
Local Measure 2 - Hip fracture - timely surgery *(Source: NHFD Commissioner Report / HSCIC Indicator Portal: CCG OIS 3.12)*	Hip Fracture - Timely Surgery	10%	75.5%	December 2015 = 58.5%		Next update due December 2016.

Due to data availability it is too soon to forecast a value of the quality premium, however based on current performance the only element that would attract a financial payment is the 10% medicines management indicators. Based on the population of 171,000 this would be circa £86K (out of a total circa £860K).

The total quality premium payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum four-hour waits in A&E departments, (c) maximum 14-day wait from a urgent GP referral for suspected cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

The following table summarised this position and the potential percentage reduction of available premium:

Quality Premium – NHS Constitution rights and pledges gateway	%	Current Achievement	Status	MET?
Referral to treatment times 18 weeks incomplete (92%)	30%	N (92.9%)	G	YES
A&E 4 Hour Waits (95%)	30%	N (93.09%)	R	NO
Cancer 2 week waits from urgent GP referral (93%)	20%	Y (97.9%)	G	YES
Category A Red 1 ambulance calls (75%)	20%	N (69.1%)	R	NO

The above indicates that due to the performance in these 4 areas at March 2016, the CCG is only expected to achieve any 50% of the premium for 2015/2016 *(subject to confirmation by NHSE).*

Based on the calculations of the current performance above (circa £86K) this would be reduced to £43K due to the constitutional penalties.

2b. CCG Quality Premium - 2016/2017

For 2016/2017 the gateways in relation to Quality and Finance remain the same, as do the Constitutional penalties (with a slight adjustment to % weighting). These will be reflected in the 2016/2017 report.

The following details the specific quality premium measures and targets set by the CCG for 2016/2017.

2016/2017 Quality Premium

National Measures	Ambition	Weighting
Cancer - Diagnosis at Stage 1 or 2	Achieve 60% diagnosed at Stage 1 or 2 or improve by 4% points.	20%
GP Patient Survey	Achieve 85% having a 'good experience' or improve by 3% points.	20%
E-Referrals	Achieve 80% by March 2017 or March 2017 performance to exceed March 2016 performance by 20% points.	20%
Improved antibiotic prescribing in primary care	Part A) Reduction of 4% (or greater) reduction on 2013/14 performance or equal to (or below) the England 2013/14 mean performance of 1.161 items per STAR-PU Part B) number of co-amoxiclav, cephalosporins and quinolones as a proportion of the total number of selected antibiotics prescribed in primary care to either =<10% or to reduce by 20% lower than 2014/15 value	10%

Local Measures - Linked to NHS Right Care	Ambition	Weighting
Reduction in Non-Elective COPD Admissions	5% Reduction	10%
Reduction in Elective Gastroscopy	15% Reduction	10%
Improve recorded prevalence of AF on GP registers against expected prevalence	5% Increase	10%

1.2.2. Financial Performance

The CCG has a number of financial duties under the National Health Service Act 2006 (as amended), and Note 17 summarises the CCG's performance against these duties and directions. In brief, the CCG:

- Met its Target Revenue Surplus for the Year, and;
- Managed expenditure so that it did not exceed income.
- Ensured that both capital and revenue resource use on specified amounts did not exceed the amount specified in the directions.
- Ensured that expenditure on "Revenue Administration" AKA. "Running or Management costs" did not exceed the amount specified in the directions.

1.2.3. Statutory duties

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 in 2015/16 and previous years, the CCG has actively sought 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 has recently reviewed how it monitors its processes to increase robustness. This has included revising and developing an integrated impact assessment which includes a quality impact assessment. The Equality and Diversity sub group has reviewed the CCG's EDS action plan in year. The CCG was one of only 8 CCGs nationally that took part in Stonewall assessment in relation to LGBT and benchmarked well against other CCGs

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 contributes to the delivery of the Strategy primarily through priority actions around:

- Improving Health Literacy
  Health literacy work includes the way the CCG promotes and supports self-management and self-care both for the general population and for those residents living with one or more long term health conditions. This would include communications and engagement around choosing the most appropriate NHS services for a patient's needs and self-care support and advice including integrating the wider NHS Winter Health campaign into local messages.
  In terms of long term health conditions, during 2015/16 this included the launch of a new model of care for patients with Diabetes and the design of a new community MSK service.

- Advocating and modelling behaviour change
  This involves CCG work around the early detection, treatment and management of serious lifestyle-associated health conditions such as heart disease.

The CCG is also developing its plans around Social Prescribing along with colleagues in North Lincolnshire Council.

Equality and Diversity

The CCG published the Equality and Diversity 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

Objective 1:

(a) Increasing input from representatives of the protected groups:

The CCG strengthened its engagement with the LGBT community as a result of our participation in the Stonewall Health Index in 2014. Stonewall delivered LGBT awareness training, made available to GP practices and CCG staff, however, we recognise that uptake was low. We have since asked practices to identify equality and diversity champions to attend training and share good practice and information with practice staff.

An Equality Matters session was delivered a the 2016 Health Matters 3 event, highlighting what the CCG is doing to meet its equality duties and engaging with attendees about what the CCG could do better. Participants were positive about the CCG's approach to equality, but also highlighted areas that need further focus, including increasing participation by black or ethnic minority residents. Issues were also raised about support for veterans as well as challenges faced by people in rural areas. These are being followed up within the CCG and feedback will be provided to those who raised the queries.

A number of people registered an interest to receive further information about the CCG's equalities work, including the Equality Delivery System and the formation of an Equality Reference Group.

The CCG is in the early stages of developing an Equality Reference Group which will strengthen engagement on equality impact assessments and provide feedback on the CCG's performance on the Equality Delivery System.

Equality monitoring of CCG engagement events is now regularly reported to Equality and Diversity Committee.

(b) Ensuring systems are in place to embed equality in all our commissioning decisions:

Equality impact assessment (EIAs) for commissioning pieces of work has been reviewed: an overview of all commissioning projects is held by a Senior Manager for Commissioning, with an indication of whether an EIA has been completed or not. If not, this is followed up with the relevant lead.

All commissioning decision papers discussed in the Engine Room and CCG Board Engine Room and public Board meetings include an equality impact assessment where appropriate.

A detailed audit is being undertaken to consider the quality on EIAs and to ensure leader challenge EIAs appropriately.

Equality impact of human resource, corporate and clinical policies is standard and published on the CCG website

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

The CCG has an Equality & Diversity Action Plan, which is overseen by the E&D Committee, with quarterly updates on progress. This is reported to the Quality Committee quarterly, with an annual report to the Governing Body.

This includes progress against mandatory NHS England equality standards, including the Equality Delivery System, the Workforce Races Equality Standard (WRES), the Accessible Information Standard.

In 2016-17 the CCG will also prioritise becoming a Two Ticks positive about disability as well as a Mindful Employer.

Equality Objectives 2017

The CCG will be due to publish new equality objectives by 31 January 2017. Work done on the Equality Delivery System throughout 2015 and 2016 will inform these objectives.

Public Involvement

Working alongside other NHS trusts, partners and members of the public the North Lincolnshire Clinical Commissioning Group 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 our population is by involving members of the public, partner organisations and of course, our member GP practices in the development of services. Therefore it is vital that the public and clinical community are not only informed of the process but engaged in it and offered the opportunity to be involved. In order to be trusted and valued the CCG must be transparent and open in its approach, and effective communications and engagement form the cornerstone of this.

The CCG's communications and engagement strategy sets out how we 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 we engage

North Lincolnshire Public and Patient Engagement Network (Embrace)

In 2014 we launched our Public and Patient Engagement Network (Embrace) membership database to capture the contact details and particular interests of patients and the public within our 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.

We have seen a steady increase in numbers of people signing up to Embrace over the year, and membership currently stands at 156. Embrace members receive regular communications from the CCG including:

- Electronic or hard copy of our Healthlinc newsletter
- Information about national and local engagement opportunities in their areas of interest
- Information about CCG Board meetings and events

To join up, please contact us or visit our website www.northlincolnshireccg.nhs.uk/Embrace

This year we worked with a local community group to develop an audio version of the HealthLIncs newsletter which can be accessed on our website and CD copies are sent out to Embrace members who have requested this format.

Stakeholder list

We have 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.

NL Healthwatch

Our Chief Officer holds quarterly meetings with the Chair and staff lead at North Lincolnshire. This year we have continued to work in partnership with Healthwatch to develop links with local Patient Participation Groups (PPGs)

An overview of engagement and consultation in North Lincolnshire 2015/16

Healthy Lives, Healthy Futures

North Lincolnshire CCG is working in partnership with North East Lincolnshire CCG and the Northern Lincolnshire & Goole Hospitals NHS Foundation Trust to develop a vision for how health care services will look in Northern Lincolnshire in the future. The review aims to make sure the Northern Lincolnshire area has a health service that is high quality, meets the needs of its population.

Health Matters Public & Stakeholder Engagement Events

Following on from the success of its first health matter public and stakeholder engagement event the previous year the CCG held two further engagement events Heath Matters 2 in August 2015 and Health Matters 3 in January 2016. These events provide opportunities for the public to engage 1-1 at themed 'market stalls' covering a range of topics, running parallel to this is a programme of presentations and discussion/focus groups. Both sessions were well-attended, with around 100 participants at each one.

At the event, people were able to find out more or have their say about:

- The CCG's priorities for 2016/17
- Local Care Networks
- Community Equipment and Independent Living Services
- Long term conditions
- Mental health services for adults and children
- Equality and Diversity
- CCG Experience Led Commissioning programmes
- Patient Transport Services

Also partners from across the health, care and wellbeing community joined us to share information about their services including:

- Healthy Ageing and support to help people to stay well
- Hospital services including community nursing
- Carers support and information services for adults

All participants along with Embrace members and contacts on the CCGs Stakeholder list are then sent a follow-up briefing note in which all facilitators provide an update on progress.

http://www.northlincolnshireccg.nhs.uk/news/?post=health-matters-3-update

Experience Led Commissioning

Experience Led Commissioning (ELC) is built around the idea that if we listen to and deeply understand people's experiences, we will design better, more person-centred services that deliver better care for people in North Lincolnshire. The difference between this approach and other ways of commissioning is that it is experience led. Many people complain that often their experience of NHS care leaves them feeling more like a number rather than a person. They often get the right care and medical treatment; yet the human element is missing. We want to ensure that we change this and focus on what people tell us matters to them and what would make the biggest difference to a great experience of care.

In 2015/16 the ELC approach was used to look at services for Children with Long Term conditions and asked the commissioning question: ***"what needs to happen so children living with long term conditions (and their families) can live life to the full"***

During the first stage of the process ELC practitioners and facilitators spoke to children and their parents during their outpatient appointments and at primary care centres; and engaged with health professionals at staff meetings and via online survey. This work is on-going and the findings from this ELC programme will inform the CCG's future commissioning plans.

Patient Participation Chairs Meetings

Together with Healthwatch, the CCG Lay Member jointly facilitates quarterly PPG chairs meetings and delivers training sessions for developing PPG's. In November 2015 the CCG jointly-hosted a PPG conference which was attended by about 50 PPG members from North Lincolnshire and from neighbouring authority areas. Keynote speaker was - Paul Devlin the Chief Executive of the National Association for Patient Participation Groups. The session also considered:

- Health Lives Healthy Futures
- Demystifying General Practice Contractual Arrangements
- Making Your PPG Inclusive and Effective
- Transforming Urgent and Long Term Conditions Care in North Lincolnshire

Patient Transport Engagement

The CCG join forces with neighbouring North East Lincolnshire to jointly commission non-emergency Patient Transport Services. We carried out extensive engagement across the area to gather community views to inform the service specification during the summer of 2015.

We talked to 535 people at the 23 community and stakeholder groups we visited. We sent out a survey and information leaflet to 500 stakeholder contacts representing a wide range of stakeholders groups including those with protected characteristics under the Equality Act. The survey was also sent to 2780 Accord (NEL) and Embrace (NL) members (the CCGs Public Patient Involvement schemes) and it was promoted elsewhere.

We received 172 survey responses with 1083 comments.

The link to the full engagement report was sent to all participating groups, stakeholders and Embrace members http://www.northlincolnshireccg.nhs.uk/get-involved/patient-transport/ this will be followed up with a 'You Said – We Did' progress report in the Spring of 2016.

Focus/Special Interest Groups

We have met with a number of community and special interest groups over the course of the year to inform our engagement across the commissioning cycle including the Carers Advisory Group, local seniors forums, disability clubs and support groups.

The CCG is a member of North Lincolnshire Health and Wellbeing Board and has regularly engaged with the Board about the progress made towards its commissioning plans during 2015/16 following the Board's strategic health and wellbeing priorities for the local area. This progress is described in the Annual Report Overview alongside our progress in 2015/16 towards achieving the Better Care Fund plans agreed with the Health and Wellbeing board.

Improving Quality

The CCG is committed to continually improving health services for the people of North Lincolnshire. Led by the Governing Body and supported by a Quality Group it discharges this responsibility in a number of ways. These include:

- Having robust systems in place to identify, evaluate and disseminate learning from incidents. A dedicated Incident Monitoring Group reviews and evaluates incident reports from providers and checks effective learning has taken place. An electronic reporting App has been developed for all CCG staff and General Practices to help capture more incidents, making it easier to report them and facilitate speedier feedback.
- Providing regular patient experience reports including Friends & Family Test that monitor patient experience, trends and lessons learnt.
- Monitoring local provider performance against key quality indicators, working with external stakeholders and undertaking site visits to support and obtain assurance from local providers.
- Ensuring robust safeguarding adults and children strategies and action plans are in place both as a service commissioner and amongst our local providers.
- Promoting effective infection prevention and control within the local health economy, providing training, advice and reviewing incidents to promote learning.

Some more detail of how NL CCG is promoting quality can be found in the Annual Governance Statement under the heading Quality Group.

1.2.4. Sustainable Development

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 we introduced our first Sustainability Development Management Plan in 2014. The following information provides commentary on our key achievements to date.

Governance

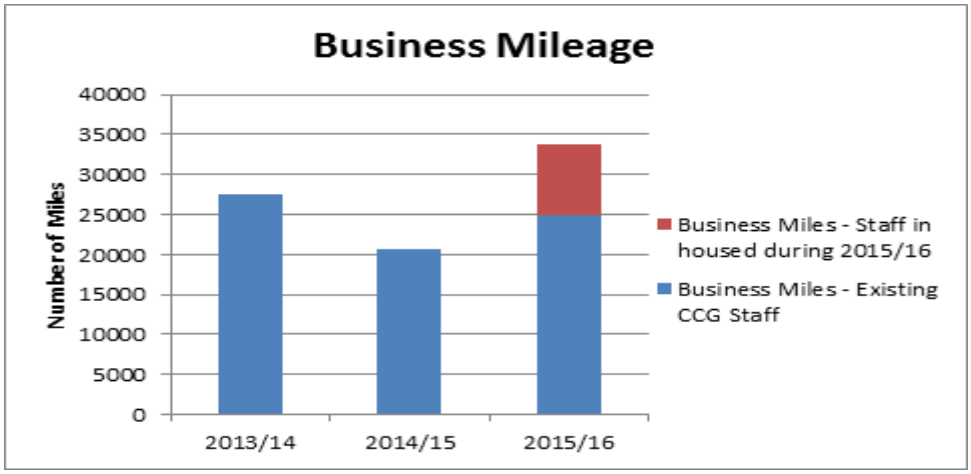
North Lincolnshire CCG designed, developed and implemented a Sustainability Impact Assessment (SIA) template. This tool enables the CCG to assess and anticipate the likely sustainability implications of a policy, strategy or service design/redesign. The template is embedded within the organisations corporate templates that support decision making functions. During 2016/2017, we will look to review the SIA process, with the aim of establishing a process that encompasses a wider, more holistic approach to undertaking impact assessments, underpinned by quality assessments with clear mitigating actions identified where appropriate.

Travel

To support our ambition to reduce our carbon footprint we have introduced unified communications tools as an alternative to face to face meetings; these include videoconferencing and teleconferencing. In addition to this the organisation has developed and introduced a number of policies to support and further encourage its staff to consider new ways of working; these include a Remote Access & Home Working Policy.

Due to the movement of staff realigned to the CCG travel miles presented below are not comparable with last year's figures. However, we will use the figure presented as the organisational base line of travel miles and will aim to see this reduce during 2016/17. As an organisation, we will, whenever possible, offer the possibility of teleconference/video conference opportunities for regular meetings, to reduce the travel requirements of key partners/organisations.

Table 1 Business Mileage

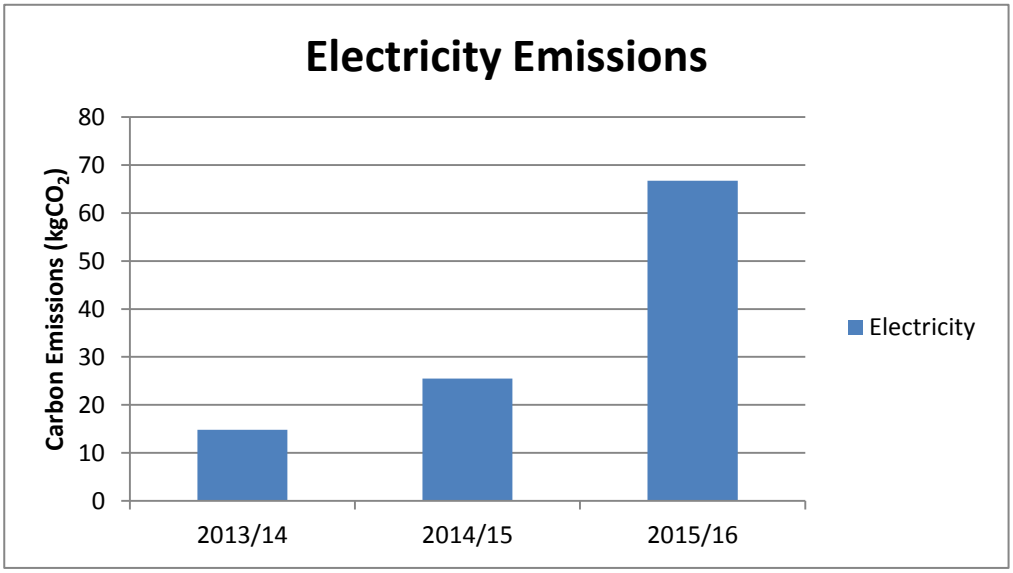


Facilities Management

NHS Property Services (NHSPS) manage the building from which the CCG operates. The CCG has a lease/rental agreement with NHSPS and all utility bills go directly to them as 'landlord'. We have been working with NHSPS to obtain our baseline position for electricity, gas, waste and water. The following tables highlight our carbon footprint for travel, gas, electricity, water and waste for 2015/16. Unfortunately we have been unable to obtain consistent data, partly due to the changes in the CCG staffing structure and further utilisation of the building. The figures presented below are therefore not a reliable comparative measure to assess our progress to reducing our carbon footprint. We will however, be using the current data to establish a baseline for developing targets to reduce out carbon footprint during 2016/17.

Energy

Table 2: Electricity Usage [$kgCO_2$]



Please note that with the re-housing of services from Yorkshire & Humber CSU from December 2015, the CCG had taken responsibility of the whole of Health Place by 31st March 2016, but was only a minority occupier of Health Place in 2014/15.

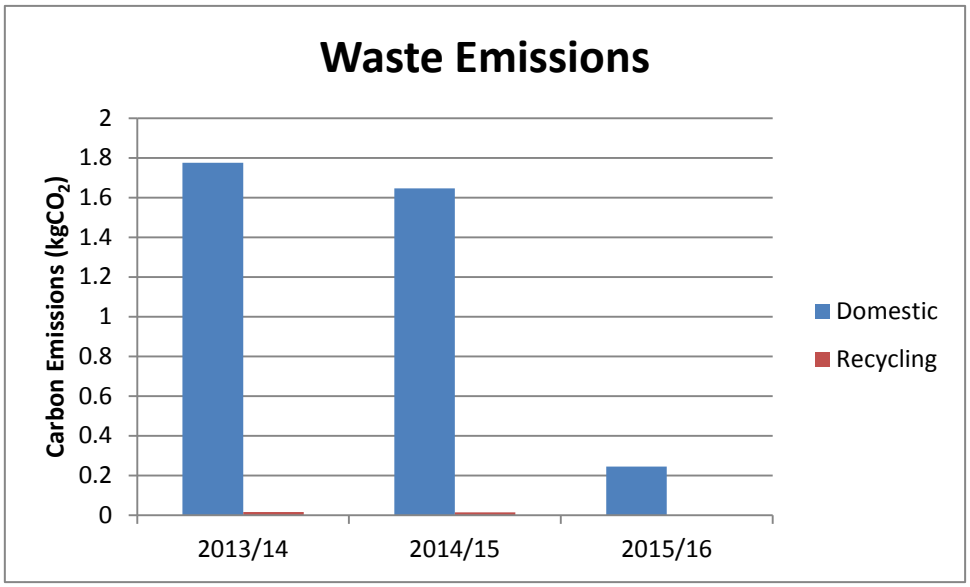
Water

Table 3: Water

Water	2013/14	2014/15	2015/16
Use (m^3)	398	376	202
Cost	£1,100	£1,165	£670

Waste - figures for waste management are shown in table 4 below.

Table 4: Waste Recycling



Procurement

As a commissioner of services our aim is to assure the sustainability of the organisation and that of our commissioned services. We continue to work collaboratively with our procurement and commissioning colleagues to identify and maximise opportunities to integrate sustainability considerations within our commissioning processes and functions. This has resulted in the development and implementation of our Ethical Procurement Policy which will be reviewed during 2016/2017.

NL CCG Sustainability Task Group

During 2015/16 we established a North Lincolnshire CCG Sustainability task group to generate ideas for reducing our carbon footprint and reducing waste. The group has developed an action plan that includes:

- Identification of Sustainability Champions in the building
- Recycling facilities to be extended
- Reducing the number of individual kettles in offices
- Screensavers to be installed on PC's with sustainability messages that include a 'switch off' campaign for lights and computers
- Corporate message on all agendas to say that meeting papers will NOT be printed for meetings
- Baseline for travel miles to be established and monitored quarterly
- a review of the use of our photocopying and printing facilities and setting CCG printers to double-sided, grey scale printing by default.
- Audit for one month on the usage of paper used at Health Place with view to develop a target for reduced printing
- Our organisation's office consumables such as printer cartridges and paper waste are routinely collected for the purpose of recycling
- Request review of heating system at Health Place

Our 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. Current policies that promote wellbeing whilst at the same time aim to reduce our carbon footprint include, remote access and home working policy, absence management and flexible working. Staff are also encouraged to suggest new ways and approaches of raising the sustainability profile of the CCG through the Sustainability task group and regular team meetings..

Community Engagement

Shaping and commissioning services now and for the future is key to delivering sustainable services for our local population. To support our vision we have developed our Communication and Engagement Strategy and throughout 2015/16 our Experience Led Commissioning (ELC) approach to engagement and service re-design ensured patients and their carers had opportunities to come together with health professionals to co-design the care that the CCG would go on to commission. This approach ensures our services are fit for purpose and sustainable).

The key objectives of our communication and engagement strategy are to;

- Effectively engage and communicate with member practices.
- Have a community that is well informed and interested in its own health.
- Ensure stakeholders and other interested parties are engaged within a two way continuous process.
- Have supported and valued staff who are well informed and engaged.
- Actively engage with local providers and secondary clinicians.

During 2016/17 we will collaborate with our communications and engagement leads to ensure that sustainability considerations are integral to training engagement processes and practices. Our approach to planning and buying health services during 2016/17 will be built around the ability to listen to and acknowledge peoples' experiences and provide opportunities for patients and their carers to come together with health professionals to co-design the care that the CCG will go on to commission. This approach ensures our services are fit for purpose and sustainable.

Adapting to climate change

Climate change brings new challenges to the CCG both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our Governing Body approved plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events. The organisation has identified the need for the development of a board approved plan for future climate change risks affecting our area. Through our Care Networks models of care approach, we will continue to work in partnership with social care and other commissioning partners and providers to promote Health and Wellbeing and continue to influence the use of SIAs in order to develop sustainable service plans.

In collaboration with our strategic partners we have developed policies to take account of health needs of our local population caused by climate, environmental and social changes, These include emergency preparedness, resilience and response policy, business continuity policy and Fuel Plan. Through collaborative work with our strategic partners, such as our Integrated Commissioning Partnership, we will continue to ensure that we are better able to plan, prepare and respond to any occurrence.

Models of Care - Through our models of care approach, we continue to work in partnership with primary care, community care, social care and other commissioning partners and providers. We actively promote Health and Wellbeing and continue to influence the use of SIAs in order to develop sustainable service plans. The strategic direction of travel and strategic priorities of the CCG reflect the recognition that services need to be sustainable and meet the needs of local people. Our future model of care is reflected in Healthy Lives Healthy Future Model which aims to support people to access care closer to home, self-care where possible - hospital where appropriate and specialist when needed in specialist centre for best outcome.

Corporate Approach: Good Corporate Citizen

A '**good corporate citizen'** is an organisation that accepts the importance of being collectively responsible for its local community and environment as an integral part of their core business. The Good Corporate Citizen Tool allows organisations to assess their level of commitment to the sustainability agenda against 6 core areas:

- Travel
- Procurement
- Facilities management
- Workforce
- Community Engagement
- Buildings
- Adaptation
- Models of Care

Once completed, the assessment allows organisations to establish a base line from which to develop action plans for year on year improvement. Results can be published to allow CCGs to compare their result with other CCGs, on a national, regional and local level.

NL CCG scored 60% overall in the Good Corporate Citizen assessment, the results of which have been utilised to develop a detailed action plan to monitor improvement during 2016/17 with achievement targets developed and monitored through the sustainability task group and reported to the Governing Body.

Key actions for 2016 relating to the Good Corporate Citizen assessment include:

- Review and assess transport and travel options
- Calculate the carbon footprint of our business travel
- Develop active travel plan
- Monitor and report travel mileage and transport mode – miles avoided
- Proactively promote energy efficiency through task and finish group (turn off computer/lights, heating, not on stand-by etc)
- Develop sustainability comms strategy – sub group – to include sustainability objectives and training opportunities
- Sustainable development in all job plans going forward
- Induction programme to include sustainability

Next steps

- Develop energy, water and waste reduction targets
- Implement the Good Corporate Citizen action plan
- Reduce business miles expended by CCG employees
- Develop Active Travel/Green Travel plan
- Contracting to work with providers to ensure there are plans in place to reduce carbon emissions
- Review the Sustainable Development Management Plan
- Work with strategic partners and local stakeholders to support sustainable development preparing and adapting to the predicted effects of a future changing climate.

1.2.5. Access to information (FOI)

Access to Information

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

	2015/16
Number of FOI requests processed	231
Percentage of requests responded to within 20 working days	100%
Average time taken to respond to an FOI request	14.9 days

The CCG did not provide the information requested in 2 cases because an exemption was applied when information was accessible by other means or information was intended for future publication. The CCG did not provide information in 37 cases where the CCG did not hold the information and, where possible, the applicant was redirected to the correct organisation for the information.

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

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

1.2.6. Priorities for 2016/17

During 2016/17, we will increase our focus on how we can, in conjunction with partners, prevent ill health and progression of disease to keep people healthier for longer

We will continue to develop the three Care Networks to deliver integrated services close to people's homes, reducing the need for hospital admission where is it safe to deliver care in a community setting

We will seek to embed self-care for people with long term conditions, equipping them with the knowledge and support to look after themselves

We will implement our plan for children and adolescents with Mental Health needs (CAMHs Transformation plan)

We will continue our work on transforming care for people with learning disabilities

Further detail can be found in our operational plan (link to final version)

1.2.7. Use of Earmarked Funds 2016/17

During the latter part of 2015/16 the CCG received £298,000 of Quality premium funding to spend on either Programme or Running cost expenditure, related to performance targets which were achieved in 2014/15.

Rather than waste this scarce non recurrent funding, the CCG has decided to defer the use of this funding to allow firm expenditure proposals to be developed and piloted in Practices, as appropriate.

The Quality Premium funding has been re-provided by including a specific ringed fence budget for this expenditure in 2016/17, as the literal carry forward of this funding into the new financial year was not possible.

1.3 Accountable Officer Declaration

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

Liane Langdon
Accountable Officer
Date: 26 May 2016

Section 2
Accountability Report

2.1. Corporate Governance Report

2.1.1. Directors & Members Report

2.1.1.1. Disclosure Statement

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

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.

2.1.1.2. Governing Body

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

Governing Body meetings are held regularly in public. Papers are published on the CCG website prior to each meeting.

The CCG's Governing Body combines a wide range of experience and expertise. It comprises of the following members, as shown in the table on the following page.

Governing Body 2015/16		
Dr Margaret Sanderson 	Chair	Dr Sanderson trained at Leicester University Medical School, qualifying in 1983. She pursued a career in Obstetrics and Gynaecology before changing direction to General Practice. After completing GP training in South Manchester, she remained there for several years before moving to North Lincolnshire in 1992 to join Trent View Medical Practice in Keadby as a partner, where she continues to practice. 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 RCGP. Dr Sanderson has been CCG Chair since its authorisation in 2013. She is the Clinical Lead for Women and Children and Ophthalmology and is Chair of the Council of Members.
Allison Cooke 	Chief Officer until Dec 2015	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. Allison retired in December 2015
Liane Langdon 	Chief Officer from Dec 2015	Liane took up her role at NHS North Lincolnshire CCG in January 2016. Liane joined the NHS in 1998 as a graduate trainee and has worked in and around health and social care ever since. She has held a variety of roles in the health service, including; finance, service re-design, strategy, public health, governance, organisational development, informatics and commissioning, most recently as the Director of Commissioning and Strategic Development at NHS Leeds North CCG. Liane has particular interests in working with people to design services which work, mental health and well-being and bringing services together to make sense for the people using them. She has worked in provider, commissioner and oversight organisations and is passionate about creating systems which work and deliver high quality care for the people of North Lincolnshire.

Therese Paskell 	Chief Finance Officer until December 2015	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 organisationsand the ambulance service.
Keiran Lappin 	Interim Chief Financer Office from Jan 2016	Kieran commenced with the CCG in January, 2016. He is a qualified accountant with 36 years NHS experience. Kieran has held 7 NHS Board Director Posts including Finance Director at two Primary Care Trusts, a Mental Health Trust, an Ambulance Trust, a Community Trust and 11 consecutive years at Hereford Hospitals NHS Trust. He has worked at many levels of the NHS including Department of Health, Regional Health Authority, Health Authority, both Provider and Commissioning Trusts and Clinical Commissioning Groups. Kieran is married with 2 children
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 h Hospitals.

Dr Robert Jaggs-Fowler, CStJ MBBS LLM MA FRCGP FRSA MFMLM 	Medical Director/GP Member	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, until January 2016, was 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 Unplanned Care (formerly the Clinical Lead for mental health) 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 a member of the Local Medical Committee.
 Professor John Mayberry	Secondary Care Doctor	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.
Dr Andrew Lee 	GP Member	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, and plays an active role on a range of advisory groups. Dr Lee has a special interest in headache, and runs a special clinic for this area of medicine for referred patients. He is the CCG's Clinical Lead for Primary Care Development and Musculoskeletal, and Vice Chair of the CCG's Council of Members.

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	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.
Dr Faisel Baig 	GP Member	Dr Baig completed his medical training at Manchester Medical School and went onto train as a GP on the South Manchester Vocational Training Scheme. After moving back to North Lincolnshire, Dr Baig practised as a part-time locum GP at The Birches Medical Practice in Scunthorpe, where he has recently taken up a salaried position. He has a keen interest in undergraduate medical education and is a small group tutor, interviewer and finals examiner at Sheffield Medical School. He is also a clinical and professional advisor to the CQC. Dr Baig is the Lead clinician for Mental Health & Dementia.

Paul Evans 	Lay Member, 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.
Ian Reekie 	Lay Member Public and Patient	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.

Caroline Briggs 	Director of Commissioning Non Voting Member	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.
Frances Cunning 	Non Voting Member until February 2016	Frances was Director of Public Health in North Lincolnshire taking up post in 2009 at the PCT before moving to the Local Authority in April 2013. She started her working life as a radiographer in Glasgow before going to Kenya to do voluntary work for a number of years. It was in Kenya where Frances' passion for public health developed. Frances has been working in the Public Health and Health Promotion arena since 1986, initially as a Co-ordinator for a Community Health Project run by the Open University before more mainstream health promotion and PH roles.

Details on committees and sub-committees of the Governing Body can be found in the Annual Governance Statement at section 2.1.3. of this report below.

2.1.1.3. Our Member Practices

We are a clinically-led organisation, which brings together 19 local GP Practices and other health professionals to plan and design services to meet local patients' needs.

Our member practices are as follows, with Practice mergers leading to 19 separate Practice organisations :

- 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

2.1.1.4. Council of Members

Representatives from the above practices who were members of the CCG's Council of Members at the time of publication are detailed in the table below:

Practice	Member Representative
Ancora Medical Practice, Scunthorpe	Dr James Taylor
Ashby Turn Primary Care Centre, Scunthorpe	Dr Muhammad Nasim
Bridge Street, Brigg	Dr Andrew Whitaker
Cambridge Ave Medical Centre, Bottesford	Dr Elango
Cedar Medical Practice, Scunthorpe	Dr Hardik Gandhi
Central Surgery, Barton	Dr Toby Blumenthal
Church Lane Medical Centre, Scunthorpe	Dr Nicholas Stewart
Market Hill, Ironstone Centre, Scunthorpe	Dr Chhitij Mohan
Riverside Surgery, Brigg	Dr Avinash Pillai
South Axholme Practice, Epworth	Dr Gary Armstrong
The Killingholme Practice	Angela Elsom, Nurse Practitioner
The Birches Medical Practice, Ironstone Centre	Dr Gary Armstrong
The Medical Centre, Barnetby	Dr S Ahmed
The Medical Centre, Oswald Road, Scunthorpe	Dr Sheena Kurien-George
The Surgery, Winterton	Dr Neveen Samuel
Traingate Surgery, Kirton	Dr Satpal Shekhawat
Trent View Medical Practice, Keadby	Dr James Ojidu
West Common Lane Teaching Practice, Scunthorpe	Dr Andrew Lee
West Town Surgery, Barton	Dr Uzma Khan

2.1.1.5. Audit Group

Members of the CCG's Audit Group during the financial year were as follows:

Audit Group Members 2015/16

NAME	APPOINTMENT
Paul Evans	Chair
Ian Reekie	Lay Member
Dr Satpal Shekhawat	GP
Dr Tehmina Mubarika	GP (Until December 2015)
Dr Toby Blumenthal	GP (from March 2016)

Therese Paskell, Chief Finance Officer & Business Support, attended meetings to advise the group as required until her departure from the organisation.

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:

Non CCG Staff Audit Group Attendees 2015-16

NAME	ORGANISATION REPRESENTED
Benita Jones	East Coast Audit Consortium
Robert Bassham	East Coast Audit Consortium
Shaun Fleming	Counter Fraud Manager / Specialist, 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
Nick Stephenson	Finance Manager , Yorkshire & Humber Commissioning Support

In addition, during the year the following individuals attended particular meetings for specific issues and / or reports: Joanne Sinclair, Auditor KPMG, Public Sector North; Rob Walker, Manager KPMG - Public Sector North; Nikki Cooper Local Counter Fraud Specialist, Nikki Cooper, Local Counter Fraud Specialist, East Coast Audit Consortium; Liane Langdon, Chief Officer, North Lincolnshire CCG.

2.1.1.6 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

2.1.2. Additional Disclosures

2.1.2.1. 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 six 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.

Complaint Information 2015/16

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.

2.1.2.2. 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 considered in 2015/16, with support of staff consultation and approved (with the exception of items marked *) include:

- Disciplinary Policy
- Managing Work Performance Policy
- Annual Leave Policy
- Working Time Directive Policy
- Change Management Policy
- Pay Protection Policy (* Yet to be agreed)
- Travel & Expenses Policy
- Starting Salaries Policy.

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

2.1.2.3. 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.

2.1.2.4 Emergency preparedness, resilience and response

Under the Health and Social Care Act 2012, the Civil Contingencies Act 2004 (CCA 2004) and the 'NHS England Emergency Preparedness Resilience and Response Framework 2015', 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 role and responsibilities in relation to EPRR include:

- Ensuring all contracts with all commissioned provider organisations (including independent and third sector) contain relevant EPRR elements, including business continuity
- Monitor compliance by each commissioned provider organisation with their contractual obligations in respect of EPRR and with applicable Core Standards
- Ensure robust escalation procedures are in place so that if a commissioned provider has an incident the provider can inform the CCG 24/7
- Ensure effective processes are in place for the CCG to properly prepare for and rehearse incident response arrangements with local partners and providers
- Be represented at the Local Health Resilience Partnership (LHRP), either on their own behalf or through a nominated lead CCG representative
- Provide a route of escalation for the LHRP in respect of commissioned provider EPRR preparedness

- Support NHS England in discharging its EPRR functions and duties locally, including supporting health economy tactical coordination during incidents (Alert Level 2-4)

- Fulfil the duties of a Category 2 responder under the CCA 2004 and the requirements in respect of emergencies within the NHS Act 2006 (as amended)

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 2015 the CCG was completed the national assurance process around EPRR planning as part of 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 full. An action plan for 2016/17 has been developed based on the outcome of the assurance process that will further develop and refine the CCGs plans and processes for EPRR .

The CCG has a 24/7 on-call rota in place and reviewed and up-dated the NL CCG Pandemic Influenza Plan, Infectious Disease Outbreak Plan and Fuel Shortage plan during 2016.

During 2015 the CCG took part in a regional multi-agency table top exercise to 'test' the North Lincolnshire CCGs Pandemic Influenza Plan and Infectious Disease Outbreak Plan, we also commissioned 'Strategic Leadership in a Crisis training' that was undertaken by the CCG senior team.

Going forward into 2016/17 there will be a review of the CCGs Major Incident Plan and Business Continuity Plans and a local table top exercise to test business continuity.

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS England Emergency Preparedness Resilience and Response Framework 2015. 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.

2.1.2.5 Disclosure of "serious incidents"/personal data related incidents

During 2015/16, 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 at Section 2.1.3. in this report below.

2.1.2.6 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.

Liane Langdon
Chief Officer
Date : 26 May 2016

2.1.2.7. 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 Liane Langdon 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.

Liane Langdon
Accountable Officer
Date :

2.1.3 Annual Governance Statement

Introduction and context

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

As at 1 April 2015, the North Lincolnshire CCG was licensed without conditions.

North Lincolnshire CCG comprises 19 practices covering a population of about 171,272 (July 2015). 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).

North Lincolnshire CCG is largely coterminous with the Local Authority (North Lincolnshire Council). For 2015/16 it had a total budget of £220.9 million.

North Lincolnshire 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 Black and Minority Ethnic (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.

Scope of responsibility

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

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

Compliance with the 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 an Audit Group effectiveness review
- Participated in a 360 degree stakeholder review against a range of performance criteria
- Undertaken an assurance mapping exercise
- Conducted a Board Governance review facilitated by East Coast Audit Consortium
- The Boards Assurance Framework is considered at all public meetings of the Governing Body

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

North Lincolnshire 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 whom we commission services.

The North Lincolnshire CCG Constitution includes:

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

Governing Body and Committee Structure

The Governance structure of North Lincolnshire 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.

During 2015-16 The Governing Body met 13 times and was quorate at each meeting. Attendance figures are attached at the **Appendix 1.**

During 2015/16 the CCG priorities for organisational development were informed by the feedback received through the 360 degree Stakeholder survey. A range of stakeholders are asked to participate and provide feedback to the CCG which is undertaken as part of the CCG Assurance Framework. Stakeholders include CCG Member Practices via Council of Member representatives, Local Authority partners including Health and Wellbeing Board Chair, and NHS providers. The feedback received showed some areas of improvement, but also Member Practices identified a number of areas for improvement including engagement with members and clinical and overall leadership of the CCG. The results were reviewed at a Board workshop in July 2015 and actions are being undertaken as part of the CCG OD Plan.

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 LA and North Lincolnshire CCG.
- Review at each meeting of the Board Assurance Framework
- Reviewing Do-Buy-Share options for securing sound commissioning support in light of Yorkshire & Humber CSU failing to gain a place on the Provider Framework.
- Evaluation of Board Effectiveness facilitated by East Coast Audit Consortium using the Governance Maturity Matrix

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

<u>The Audit Group</u>

Chaired by the Lay Member for Governance, the Audit Group has met 6 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, the review of draft accounts for 2015/16 and approval of audited accounts before submission as well as preparedness for 16/17 accounts.
- Tackling compliance issues e.g. taxation, legal and constitutional (e.g. waivers) issues and gaining relevant assurances.
- Significant involvement with internal/ external assurance from Yorkshire & Humber CSU (Y&H CSU) on internal controls which included financial services and continuing healthcare old year claims for example.
- Review of final SAR report for Yorkshire & Humber Commissioning Support
- IG toolkit and reporting of reporting 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.
- 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 facilitated by Internal Audit for improving future effectiveness.

<u>The Engine Room</u>

This Group has met 22 times during the year and has been quorate at each meeting. 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 2015/16 Operational Plan
- Overview and selection of clinical pathway redesign and management of 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 the CSU and other relevant organisations to account for operational, financial and performance issues.

The Quality Group

The Quality Group is chaired by the CCG's Director of Risk and Quality Assurance & Chief Nurse. The lay member with the lead for quality and patient involvement is Vice Chair. This Group has met 10 times during the year and all meetings were quorate. The remit of the quality group is to monitor and review the quality and safety of the services commissioned by the CCG and promote a culture of continuous improvement and innovation.

Its main aims are:

- The safety of treatment and of 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 the work undertaken by the group:

- A commissioned review of mental health inpatient unit following concerns regarding risk assessment. This concluded positively with assurance of patient safety and full engagement of the Trust to make service improvements where identified.
- The group have invited a variety of provider representatives to present to the meeting on a range of services to provide additional assurance and to inform the members of innovations and quality improvements. This includes nursing models of care and nutrition and hydration.
- The group completed a comprehensive visit to the acute trust and visited the following range of services:
    - Urgent care department
    - Medical wards
    - Frail and elderly wards
    - Endoscopy unit
    - Paediatric and Maternity units.

The visit was extremely valuable in providing assurance on clinical and nursing care and also enabled the group members to learn more about the service delivered and engage with staff.

- The development of a quality dashboard to ensure the Quality Group and Governing Body are clearly and accurately informed about the quality patient safety issues within each provider and data is appropriately analysed and considered.
- Implementation of a community action plan to address premature mortality and ensure partnership working with the acute trust and other agencies.
- Develop and regularly review locally agreed quality indicators and metrics including QIPP, Quality impact assessments and commissioning for quality and Innovation [CQUINS]
- A programme of focussed visits to address concerns or gaps in assurance to provide contextual information that is triangulated with other assurance data including care homes and primary care.
- Monitoring and review of primary care prescribing data and medicines management quality improvement programme.
- The support and implementation of revalidation for nurses.
- Ensuring that the CCG discharges its statutory responsibilities appropriately with regard to safeguarding children and adults through a variety of areas such as child sexual exploitation, PREVENT and female genital mutilation.
- Assessment and support of clinical effectiveness and patient experience of commissioned services.
- Providing the CCG with valuable soft intelligence across the local community.
- Support of a locally produced electronic Incident App that since its inception (Jan 2015 to Jan 2016 inclusive), the CCG has seen a 121% increase of incident reporting in general practice. This was further rolled out to CCG staff in February 2016 for staff incident reporting in place of the accident book.

The Remuneration Committee

The Remuneration Committee is chaired by the Lay Member for Patient and Public 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 3 times during the year and was quorate at each meeting.

Highlights of its work/performance include:

- Review of remuneration, terms and conditions for all posts not subject to Agenda for Change
- Appointment of new Accountable Officer
- Approval of Human Resource Policies
- Salaries and contracts for employees not covered by Agenda for Change

The Clinical Commissioning Group Risk Management Framework

As outlined in its Risk Management Strategy, North Lincolnshire 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.

From April 2015 to December 2016 Risk Management support was provided by Commissioning Support. In January 2016 the risk management function came back to the CCG to be wholly managed in-house.

Risk Management is embedded within the activities of North Lincolnshire CCG through the risk process. The 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 an electronic desk top incident reporting process, which is actively encouraged and each incident is reviewed and investigated as applicable.

North Lincolnshire 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 have an equality impact assessment conducted on them. The CCG has a tool and guidance for use by staff to help identify the likely impact. Specific training has been provided to CCG members and staff.

North Lincolnshire 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 North Lincolnshire 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 North Lincolnshire 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.

North Lincolnshire CCG implements anti-fraud prevention measures and counter 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, and if, required apply 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 provides assurance (and Audit Group independent assurance) that the risk register and assurance framework are regularly reviewed and updated and that corresponding robust and adequately progressed risk treatment plans exist. Internal Auditors have facilitated a review in year of key strategic risks for the Board/Assurance Framework
- 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 assurance framework are assessed for likelihood and consequence using a 5 x 5 risk matrix in accordance with the risk management strategy. The Assurance Framework identifies the risks to the delivery of the organisations strategic objectives whilst the Risk Register focuses on operational risks.

If the assessment of the risk is higher than the risk appetite, further action will 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 CCGs incident reporting system and notified to the Information Governance Manager for investigation.

Risk Assessment in Relation to Governance, Risk Management & 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 take 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 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 corporate register or directorate risk registers.

The 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 is reviewed at all public meetings of the Governing Body and monthly by the Quality Group. The Audit Group provides independent assurance. The 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.

The key risks on the assurance framework as of the end of March 2016 are highlighted below.

Risk	Current Risk Rating
If there is a lack of collated or accurate data on out of hospital mortality there is a potential that areas of high risk are not identified and/or addressed.	**16**
If patients are not supported they may have limited choice re their end of life care.	**12**
Risk to CCG regarding delayed delivery of retrospective claims	**16**
If the CCG fails to agree an acceptable / affordable option for Healthy Lives Healthy Future in a timely manner there is a risk of system failure.	**20**
If the CCG fails to deliver a balanced budget there will be no resources to support investment and the CCG could lose ability to self-direct from NHS England	**16**
If the CCG fails to engage and work with key partners and stakeholders (including Local Authorities, GPs and public) the delivery of the CCG strategic objectives could be threatened.	**12**
Inability to recruit sufficient GPs could lead to difficulty maintaining current level of service and quality outcomes for patients.	**20**

Each risk is owned by a lead director and is reviewed and updated on a regular basis as required. The Quality Group review the corporate risk register and assurance framework monthly. The Governing Body review the assurance framework bi-monthly. The Audit Group review the assurance framework at every meeting and provides independent assurance to the Governing Body. This gives significant assurance that systems are 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 further 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 Registers and Assurance Framework 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 and project initiatives

The Clinical Commissioning Group Internal Control Framework

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

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

The 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 Senior Team

Information Governance

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

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.

North Lincolnshire CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have an information governance management framework that the CCG applies to the management of all information assets. The framework includes an Information Governance Group which is a sub group of the Quality Group. The CCG continued to develop information governance processes and procedures with Y&H CSU in line with the Information Governance toolkit and Senior Information Risk Officer (SIRO) guidance and ensuring it is embedded amongst CCG staff. The CCG has ensured all qualifying staff undertake annual information governance training and have implemented a number of measures to ensure all staff members 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 for fill its requirements under the Freedom of Information Act and Data Protection Act relating to the protection, use and processing of subject access requests.

The CCG has an incident reporting system for all staff and GPs 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 have processes in place to identify information Asset Owners and Controllers. We have processes where the Information Asset Owners assess risks to assets in their areas and report to the SIRO annually.

The CCG uses an IG 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 undertaken to fully embed an information risk culture throughout the organisation.

Review of economy, efficiency & effectiveness of the use of resources

The Governing Body has overarching responsibility for ensuring that North Lincolnshire CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Groups 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 is a member of the Governing Body and is responsible for providing financial advice to the group and for ensuring financial control and accounting systems are in place. The role of Chief Finance Officer includes:

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

North Lincolnshire CCG had an SLA in place with Y&H CSU for its financial services and financial management arrangements for part of the year and during this period therefore the CSU Business Services Director was also held accountable via the CSU SLA to the Chief Officer at Executive Team meetings and to the Audit Group. Responsibilities were transferred to back to the CCG with the demise of the CSU on the 1st of December 2015.

In terms of annual accounts, for 2015/16 a clear process was identified which followed the Manual for Accounts 2015/16 guidance and largely mirrored or strengthened arrangements, which 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.

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

Northern Internal Audit and Fraud Services (NIAFS) audit of NHS Payroll Services (the CCG's payroll provider) concluded there was significant assurance with no issues of note in relation to Payroll Master File and Pensions. NIAFS also gave significant assurance in relation to payroll governance and key performance indicators.

Deloitte LLP provided independent auditing opinion on Yorkshire and Humber Commissioning Support who provided a number of services to the CCG during the year. The audit concluded that appropriate controls were in place for the following services provided to the CCG: accounts payable, accounts receivable, financial ledger and treasury and cash management.

Review of the effectiveness of Governance, Risk Management & Internal Control

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

Review of Effectiveness

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 Assurance Framework itself 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 and Annual Governance Report within the CCG.
- Internal Audit review 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 is in place via the Assurance Framework and also via action plans embedded within the Risk Register.
- The Corporate Risk Register
- Initial part in year self-assessment of Audit Group effectiveness by questionnaire.

The following committees and officers have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2015/16 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 and 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 Business Support: As Senior Responsible Officer for NHS finances across the CCG, the Chief Finance Officer 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 2015/16 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.

Head of Internal Audit Opinion

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

> "My overall opinion is:
>
> **Significant Assurance** can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of a particular objective at risk.
>
> Notwithstanding this overall opinion, it is important to note that the CCG continues to face a number of challenges, particularly in relation to the challenging financial environment and the risks associated with the transition of services formerly provided by Yorkshire & Humber Commissioning Support, which will need to be carefully managed and monitored during the coming year".

During the year, Internal Audit issued no audit reports that identified any significant risks to the organisation.

Data Quality

Data was collated and managed by Y&H CSU on behalf of North Lincolnshire CCG. Data is presented to the Governing Body its sub committees and Council of Members, it is sourced from national systems and local data sources. Where possible the data is triangulated from national systems and alternative sources to ensure accuracy. The CSU had in place internal procedures and controls in order to ensure data presented was of the best quality possible. Any data issues noted in source data is reviewed and identified with the source provider. Should data issues arise resulting from internal CSU processes, a route cause analysis is undertaken, corrective actions put in place and on-going learning identified.

Business Critical Models

The CCG and its key support services partner for 2015/16 (Yorkshire & the Humber Commissioning Support) recognise the principles as reflected in the Macpherson report as a direction of travel for business modelling in respect of service analysis, planning and delivery.

Key business critical models have been identified however further work is planned during 2016/17 to provide additional details of why these areas are business critical, associated key risks and to further develop the quality assurance process. In line with the Macpherson report we recognise and have identified that policy simulation (its impact on people and finances), forecasting, financial evaluation, allocation, workforce, procurement and planning are key areas where we use models.

Relevant information about the CCG's quality assurance processes relating to these models is to be provided to the Analytical Oversight Committee, chaired by the Chief Information Analyst at the Department of Health.

Current quality assurance systems are in place to manage our business risks including:

- Business Intelligence reporting / financial reporting
- Customer feedback (e.g. Patient Complaints)
- Risk Assessment (including risk registers and an assurance framework)
- Internal and External Audit
- Executive Leads with clear work portfolios
- Programme Management Office
- Public and Patient Involvement and Engagement
- Third Party Assurance mechanisms (Service Auditor reports / NHS England – EPRR / Business Continuity etc.)

The CCG can confirm that these quality assurance processes are used across our business critical areas as appropriate.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit & Integrated Governance Committee, which aims to provide a reasonable level of assurance subject to any inherent limitations.

The Head of Internal Audit opinion provided includes opinion on the Assurance Framework, and the risk based audit assignments across the critical business systems to inform the Annual Governance Statement.

The CCG has also conducted an assurance mapping exercise to identify the CCG's assurance landscape and this continues to be further developed as systems, processes and partner relationships continue to evolve and embed.

The Head of Internal Audit Opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its Annual Governance Statement.

Data Security

The CCG has submitted a satisfactory level of compliance with the Information Governance toolkit assessment following completion of actions from the internal audit report. Further work required is highlighted in the Audit Group/Information Governance section of this statement. North Lincolnshire CCG had no lapses of data security during 2015/16.

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 Membership Body 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 North Lincolnshire 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.

Conclusion

The third year of establishment (2015/16) for North Lincolnshire CCG has proved rewarding and challenging. 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.

I look forward to our continued progress in 2016/17

Liane Langdon
Accountable Officer
26 May 2016

Appendix 1

Membership & Attendance at CCG Committees & Sub Committees 2015/16

APPENDIX 1

Governing Body Attendance

Date of meetings	Faisal Baig	Caroline Briggs	Allison Cooke	Frances Cunning	Paul Evans	Robert Jaggs-Fowler	Andy Lee	John Mayberry	James Mbugua	Ian Reekie	Margaret Sanderson	Nick Stewart	Catherine Wylie	Therese Paskell	Liane Langdon	Kieran Lappin	Overall % attended per meeting
09.04.15	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes			**93%**
14.05.15	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No			**71%**
11.06.15	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes			**86%**
09.07.15	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes			**86%**
13.08.15	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes			**86%**
10.09.15	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes			**86%**
08.10.15	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes			**86%**
12.11.15	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes			**79%**
10.12.15	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No				**85%**
31.12.15	Yes	No	No	Yes	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes				**62%**
14.01.16	Yes	Yes		No	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes		Yes		**77%**
11.02.16	Yes	No			Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	**85%**
10.03.16	Yes	No			Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	**92%**
% Attended in Year	**100%**	**62%**	**62%**	**69%**	**85%**	**77%**	**92%**	**77%**	**85%**	**92%**	**77%**	**77%**	**77%**	**54%**	**100%**	**100%**	

Engine Room Attendance

Date of meetings	Faisal Baig	Caroline Briggs	Allison Cooke	Frances Cunning	James Mbugua	Robert Jaggs-Fowler	Andy Lee	Margaret Sanderson	Nick Stewart	Catherine Wylie	Therese Paskell	Liane Langdon	Kieran Lappin	Overall % attended per meeting
02.04.15	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes			**73%**
16.04.15	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes			**82%**
30.04.15	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes			**73%**
07.05.15	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No			**82%**
04.06.15	No	Yes	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes			**55%**
18.06.15	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes			**73%**
02.07.15	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes			**64%**
16.07.15	Yes	Yes	No	No	Yes	No	Yes	Yes	Yes	Yes	Yes			**64%**
06.08.15	Yes	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No			**55%**
20.08.15	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes			**82%**
03.09.15	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes			**82%**
17.09.15	No	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes			**55%**
15.10.15	Yes	Yes	No	No	Yes	Yes	No	No	Yes	No	Yes			**45%**
01.11.15	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes			**64%**
19.11.15	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes			**82%**
03.12.15	Yes	Yes	No	Yes	Yes	Yes	No	Yes	No	Yes				**70%**
17.12.15	No	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes				**70%**
07.01.16	Yes	Yes		No	No	Yes	Yes	Yes	Yes	Yes				**70%**
21.01.16	cancelled			cancelled		cancelled		cancelled						**0%**
04.02.16	Yes	No		Yes	Yes	Yes	No	Yes	Yes	Yes			Yes	**73%**
18.02.16	No	Yes			Yes	No		no	Yes	No			Yes	**44%**
03.03.16	Yes	Yes			No	Yes	YES	yes	Yes	Yes			Yes	**89%**
17.03.16	No	No			Yes	No	Yes	Yes	No	Yes			Yes	**56%**
% Attended in Year	**70%**	**65%**	**43%**	**61%**	**83%**	**74%**	**48%**	**83%**	**70%**	**78%**	**0%**	**0%**	**133%**	

Left employment		
Allison Cooke		**31.12.2015**
Therese Paskell		**30.11.2015**
Frances Cunning		**12.02.2016**

Joined		
Liane Langdon		**01.01.2016**
Kieran Lappin		**01.02.2016**

Audit Group

Date of meetings	Paul Evans	Tehnmina Mubarika	Satpal Shekhawat	Ian Reekie	Overall % attended per meeting
21.04.15	Yes	No	Yes	Yes	75%
27.05.15	Yes	Yes	Yes	No	75%
25.08.15	Yes	Yes	No	Yes	75%
11.11.15	Yes	Yes	No	Yes	75%
13.01.16	Yes	No	Yes	Yes	75%
09.03.16	Yes	No	Yes	Yes	75%
% Attended in Year	100%	50%	67%	83%	

Remuneration Committee

Date of meetings	Paul Evans	James Mbugua	Nick Stewart	Ian Reekie	Overall % attended per meeting
30.04.15	Yes	Yes	No	Yes	75%
10.12.15	Yes	Yes	Yes	Yes	100%
25.02.16	Yes	No	No	Yes	50%
% Attended in Year	100%	67%	33%	100%	

Quality Group

Date of meetings	Robert J-Fowler	John Pougher	Anita Kapoor	Ian Reekie	Faisel Baig	Catherine Wylie	Overall % attended per meeting
23.04.15	Yes	Yes	Yes	Yes	Yes	Yes	100%
28.05.15	No	Yes	Yes	No	Yes	Yes	67%
25.06.15	Yes	Yes	Yes	Yes	No	Yes	83%
23.07.15	No	Yes	Yes	Yes	Yes	Yes	83%
27.08.15	Yes	Yes	No	Yes	Yes	Yes	83%
22.10.15	Yes	Yes	Yes	Yes	No	Yes	83%
26.11.15	No	Yes	Yes	No	Yes	No	50%
28.01.16	Yes	Yes	Yes	No	Yes	Yes	83%
25.02.16	Yes	No	Yes	Yes	Yes	Yes	83%
24.03.16	Yes	Yes	Yes	Yes	Yes	No	83%
% Attended in Year	70%	90%	90%	70%	80%	80%	

Council of Members

					AGM							
Practice	23-Apr	25-Jun	23-Jul	27-Aug	10-Sep	24-Sep	22-Oct	26-Nov	28-Jan	26-Feb	24-Mar	Overall % attended per meeting
Ancora	Yes	Yes	Yes	Apols	Apols	Yes	Yes	Yes	Yes	Yes	Yes	82%
Ashby Turn	Yes	Yes	Yes	Yes	Yes	Apols	Yes	Yes	Apols	Yes	Apols	73%
Barnetby Dr Ahmed	Apols	Yes	Yes	Apols	Yes	Yes	Apols	Apols	Yes	Yes	Apols	55%
Bridge St	Yes	Apols	Yes	Yes	Yes	Yes	Yes	Apols	Yes	Yes	Yes	82%
Cambridge Ave	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Apols	91%
Cedars	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	100%
Central	Yes	Yes	Yes	Apols	Yes	Yes	Yes	Yes	Yes	Yes	Yes	91%
Church Lane	Yes	Apols	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Apols	Yes	82%
Market Hill	Apols	Yes	Apols	Yes	Apols	Yes		Apols				27%
Oswald Rd	Apols	Yes	Apols	Yes	Yes	Yes	Yes	Yes	Apols	Apols	Yes	64%
Riverside	Yes	Yes	Apols	Yes	Yes	Yes	Yes	Yes	Yes	Yes	PM	82%
South Axholme	Apols	Apols	Yes	Apols	Yes	Apols	Yes	Yes	Yes		Yes	55%
South Killingholme	Apols	Yes	Yes	Apols	Yes	Yes	Yes	Yes	Yes	Yes	Yes	82%
The Birches	Apols	Apols	Yes	Apols	Yes	Apols	Yes	Yes	Yes		Yes	55%
Traingate	Yes	Yes	Yes	Apols	Apols	Yes	Apols	Yes	Yes	Yes	Yes	73%
Trent View	Yes	Yes	Yes	Yes	Apols	Yes	Yes	Yes	Yes	Yes	Yes	91%
WCL	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Apols	91%
West Town	Apols	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	82%
Winterton	Yes	Yes	Yes	Apols	Yes	Yes	Apols	Yes	Yes	Yes	Yes	82%

Joint Commissioning Committee

Date of meetings	Paul Evans	Caroline Briggs	John Mayberry	Ian Reekie	Andy Lee	Margaret Sanderson	Catherine Wylie	Francis Cunning	John Pougher	Therese Paskell	Allison Cooke	Liane Langdon	Kieran Lappin	Overall % attended per meeting
09.04.15	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes			**91%**
11.06.15	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes			**91%**
13.08.15	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No			**91%**
08.10.15	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes			**82%**
14.01.16	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes			No		**70%**
10.03.16	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes			No	No	**70%**
% Attended in Year	**100%**	**83%**	**100%**	**100%**	**83%**	**50%**	**83%**	**67%**	**100%**	**67%**	**50%**	**0%**	**0%**	

Left employment		
Allison Cooke		**31.12.2015**
Therese Paskell		**30.11.2015**
Frances Cunning		**12.02.2016**

Joined		
Liane Langdon		**01.01.2016**
Kieran Lappin		**01.02.2016**

2.1.4 Managing Public Money

The Accountable Officer & Governing body has:

- Reviewed its own processes and practices, informed by the views of its audit committee on the organisation's assurance arrangements;
- Received and acted upon insight into the organisation's performance from internal audit, including an audit opinion on the quality of the systems of governance, management and risk control;
- Obtained feedback from stakeholder organisations about its business, its use of resources, its responses to risks, the extent to which in year budgets and other targets have been met, and other internal accountability mechanisms; including:
  - bottom-up information and assessments to generate a full appreciation of performance and risks as they are perceived from within the organisation;
  - end-to-end assessments of processes, since it is possible to neglect interdependent and compounded risks if only the components are considered;
  - high level overview of the organisation's business so that systemic risks can be considered in the round.

2.2 Remuneration and Staff Report

2.2.1. 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.

2.2.2. Remuneration Committee Membership & Attendance (Not Subject to Audit)

For details of membership & attendance please see Appendix 1 of the Annual Governance statement, which can be found at section 1.2.3. of this report.

2.2.3. The Remuneration of Senior & Very Senior Managers (Not Subject To Audit)

The CCG does not have a local remuneration policy or performance related pay framework for Very Senior Managers, and instead normally follows national guidance with no variation for the pay of Very Senior and Senior Managers.

Senior Manager pay is normally set strictly in line with national Agenda for Change (AfC) agreements, which are announced each year. The CCG also follows national guidance in relation to the remuneration of its Very Senior Managers (VSMs), by using the Remuneration Committee, made up of lay members and a GP, to determine the appropriate remuneration for VSMs including any reference to performance targets.

The Remuneration Committee invariably makes reference to, and links, the annual VSM pay award to the average pay award made for Senior Managers under Agenda for Change terms and conditions. However, in 2015/16 for the first time in recent year, the national Agenda for Change pay award agreement set a differential pay award for staff – depending on their scale point. In brief, this meant that all CCG staff below AfC Band 8C were awarded a 1% consolidated (i.e. pensionable) pay award, and those staff paid in accordance with AfC Band 8C and above were awarded nothing.

Therefore, for 2015/16 the Remuneration Committee resolved in the interests of equity and fairness, to award all staff, regardless of grade, a 1% consolidated pay award, if not already awarded this increase automatically through AfC. This affected 4 Very Senior Managers, and two further Senior Managers within the CCG. A number of other NHS organisations took a similar approach, as disclosed in the employers' side submission to the 2016/2017 AfC pay proposals.

It is expected that the Remuneration Committee will revert to "normal" practice in determining 2016/17 practices in terms of agreeing staff salary increases, in the light of the employers Agenda for Change agreement for 2016/17 pay wards.

2.2.4. Salaries and Allowances (Subject To Audit)

Details of Salaries and Allowances are shown in Table 1 over leaf.

Table 1a) contains details the details for 2015/16 with comparative figures for 2014/15 shown in Table 1b.

TABLE 1A) SALARIES & ALLOWANCES 2015/16

Name	Title	Period In Office	Salary & Fees (bands of £5000)	Taxable Expense payments (Rounded to the nearest £00)	Performance pay and 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 2015- 31 March 2016	75-80	0	0	0	17.5-20	90-95
Dr Faisel Baig	CCG GP Member	1 April 2015- 31 March 2016	45-50	0	0	0	157.5-160	205-210
Dr Robert Jaggs-Fowler *	CCG GP Member	1 April 2015- 31 March 2016	100-105	0	0	0	0	100-105
Dr Andrew Lee	CCG GP Member	1 April 2015- 31 March 2016	50-55	0	0	0	0	50-55
Dr James Mbugua	CCG GP Member	1 April 2015- 31 March 2016	30-35	0	0	0	12.5-15	45-50
Dr Nicholas Stewart	CCG GP Member	1 April 2015- 31 March 2016	45-50	0	0	0	10-12.5	55-60
Paul Evans	Lay Member NLCCG	1 April 2015- 31 March 2016	5-10	0	0	0	0	5-10
Ian Reekie	Lay Member NLCCG	1 April 2015- 31 March 2016	5-10	0	0	0	0	5-10
Allison Cooke	Chief Officer	1 April 2015- 31 December 2015	85-90	0	0	0	17.5-20	105-110
Liane Langdon	Chief Officer	1 January 2016 - 31 March 2016	25-30	0	0	0	20-22.5	45-50
Therese Paskell	Chief Finance Officer & Business Support	1 April 2015- 30 November 2016	45-50	0	0	0	12.5-15	60-65
Kieran Lappin **	Interim Chief Finance Officer & Business Support	1 February 2016 - 31 March 2016	15-20	0	0	0	0	15-20
Catherine Wyle	Director of Quality & Risk Assurance & Executive Nurse	1 April 2015- 31 March 2016	75-80	0	0	0	20-22.5	95-100
Caroline Briggs	Director of Commissioning	1 April 2015- 31 March 2016	80-85	0	0	0	32.5-35	110-115
Professor John Mayberry	Secondary Care Doctor	1 April 2015- 31 March 2016	5-10	0	0	0	0	5-10

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

** Kieran Lappin is remunerated via an off-payroll engagement which is disclosed elsewhere in this report.

*** Comparative audited figures for 2014-15 are shown in the next Table.

TABLE 1b: 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.

2.2.5. Pension Benefits (Subject to Audit)

Details of Pension benefits are shown in Table 2 over leaf.

Table 2a) contains details the details for 2015/16 with comparative figures for 2014/15 shown in Table 2b.

For understanding the information supplied in these Tables, it is important to note the meaning of both “Cash Equivalent Transfer Values” (CETV) and real increases in CETV.

In brief, 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 (or other allowable beneficiary’s) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

In addition, a real Increase in CETV 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.

TABLE 2A) PENSION BENEFITS 2015/16

Name	Title	Period In Office	Real Increase in pension at pension age(bands of £2500) £000	Real increase in pension lump sum at pension age (bands of £2500)	Total accrued pension at pension age at 31 March 2016 (bands of £5000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5000)	Cash Equivalent transfer value at 1 April 2015	Real increase in Cash Equivalent transfer value	Cash equivalent Transfer value at 31 March 2016	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 2015- 31 March 2016	0-2.5	0-2.5	10-15	35-40	235	19	257	0
Dr Faisel Baig	CCG GP Member	1 April 2015- 31 March 2016	5-7.5	20-22.5	10-15	30-35	47	78	126	0
Dr Robert Jaggs-Fowler	CCG GP Member	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0
Dr Andrew Lee	CCG GP Member	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0
Dr James Mbugua	CCG GP Member	1 April 2015- 31 March 2016	0-2.5	0-2.5	5-10	25-30	135	8	144	0
Dr Nicholas Stewart	CCG GP Member	1 April 2015- 31 March 2016	0-2.5	0-2.5	10-15	30-35	173	9	185	0
Paul Evans	Lay Member NLCCG	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0
Ian Reekie	Lay Member NLCCG	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0
Allison Cooke	Chief Officer	1 April 2015- 31 December 2015	0-2.5	2.5-5	55-60	175-180	1,305	0	0	0
Liane Langdon	Chief Officer	1 January 2016 - 31 March 2016	0-2.5	2.5-5	10-15	40-45	174	7	184	0
Therese Paskell	Chief Finance Officer & Business Support	1 April 2015- 30 November 2016	0-2.5	0-2.5	15-20	55-60	282	7	293	0
Kieran Lappin	Interim Chief Finance Officer & Business Support	1 February 2016 - 31 March 2016	0	0	0	0	0	0	0	0
Catherine Wyle	Director of Quality & Risk Assurance & Executive Nurse	1 April 2015- 31 March 2016	0-2.5	2.5-5	30-35	100-105	623	23	653	0
Caroline Briggs	Director of Commissioning	1 April 2015- 31 March 2016	0-2.5	2.5-5	30-35	100-105	555	21	583	0
Professor John Mayberry	Secondary Care Doctor	1 April 2015- 31 March 2016	0	0	0	0	0	0	0	0

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

** Comparative audited figures for 2014/15 are shown in the next Table overleaf.

*** No CETV figures for March 2016 are being shown for the former Chief Officer (Allison Cooke) as she has taken her retirement benefits from 1st January 2016.

TABLE 2b: 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 2014	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value (CETV) at 31st March 2015	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	237	(9)	235	0
Dr James Mbugua	CCG GP Member	1 April 2014- 31 March 2015	0-2.5	2.5-5	40-45	20-25	113	19	135	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	178	(10)	173	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	1,233	38	1,305	0
Therese Paskell	Chief Finance Officer & Business Support	1 April 2014- 31 March 2015	0-2.5	0-2.5	15-20	50-55	262	14	282	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	546	61	623	0
Caroline Briggs ****	Director of Commissioning	1 April 2014- 31 March 2015	0-2.5	0-2.5	30-35	95-100	522	19	555	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.

**** Please note that the CETV for the Director of Commissioning (Caroline Briggs) at 31st March 2015 was incorrectly rounded to £5,550k rather than £555k.

2.2.6 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 2015-16 was £225k to £230k (2014/15 was £165k-£170k). The mid-point of this range is 6.24 times (2014/15 2.93) the median remuneration of the workforce which was £36,462 (2014/15 £57,070).

No employees received remuneration in excess of the highest paid Director, which is the same situation as in 2014/15, and remuneration ranged upwards from £7.88k compared to £5.38k in 2014/15.

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, the Chief Officer's salary details have also been shown for comparative purposes only.

In contrast to last year there has been significant movement in the highest paid Director's salary compared to the median for several reasons, namely:

- The need to obtain a senior experienced Chief Finance Officer in the final quarter of the financial year, to assist with the delivery of the CCG's final accounts.

- The significant increase in staff numbers from a headcount of 25 in 2014/15 to 65 in 2015/16 following the decision by the CCG to bring a number of services and the associated staff teams back in-house. This decision was then confirmed by the failure of Humber and Yorkshire CSU to acquire a place on the Local Provider Framework, and its inability to provide support services to the CCG beyond 2015/16.

2015-16 Pay Multiple Calculation	Director's Salary (Bands Of £5k)	Annualised Remuneration (Bands Of £5k)
Highest Paid Director: Chief Finance Officer.	15-20	**225-230 Mid-Point £227.500k**
Chief Officer	25-30	**100-105 Mid Point £102.500k**
Median Salary in £s		**£36,462**
Pay Multiple Ratio		**6.24**

Please note the actual level of pay which the Highest Paid Director and Chief Officer received is shown in the first column, based on the hours of work performed during the financial year.

2.2.7 Off Payroll Engagements (Subject To Audit)

Number of Off-payroll engagements of board members, and /or senior officers with significant financial responsibility , during 2015-16.	1*
Total number of individuals on payroll and off-payroll that have been deemed board members, and /or senior officials with significant responsibility, during 2015-16.	15
• This off-payroll engagement relates to Kieran Lappin, Interim Chief Financial Officer (CFO) and Business Support. This engagement has occurred due to difficulties encountered in recruiting a CFO in time for the year end accounts, with sufficient experience. The engagement began in February 2016 and will cease in July 2016, following the appointment of a substantive Chief Financial Officer.	

2.2.8 Exit Packages and Severance Payments (Subject to Audit)

There was one compulsory redundancy made in 2015/16 which was conducted and paid in accordance with the relevant national Agenda for Change terms & conditions, at a cost of £ 3,067.

2.3 Audit Opinion & Report

See overleaf for details of the external auditors independent report and opinion on the CCG's 2015/16 Accounts.

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

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

This report is made solely to the Members of the Governing Body of NHS North Lincolnshire CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view and is also responsible for the regularity of expenditure and income. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

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

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

Scope of the audit of the financial statements

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

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

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

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

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

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2016 and of its net operating expenditure for the year then ended; and

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

Opinion on regularity

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

Opinion on other matters

In our opinion:

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

- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

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

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

Certificate

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

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

Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

Date: 26 May 2016

Section 3

Financial Statements

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31-March-2016

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	1,553	1,185
Operating Expenses	5	223,801	211,924
Other operating revenue	2	(6,621)	(3,437)
Net operating expenditure before interest		**218,733**	**209,672**
Investment Revenue		0	0
Other (gains)/losses		0	0
Finance costs		0	0
Net operating expenditure for the financial year		**218,733**	**209,672**
Net (gain)/loss on transfers by absorption		0	0
Total Net Expenditure for the year		**218,733**	**209,672**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	1,144	1,016
Operating Expenses	5	2,615	3,159
Other operating revenue	2	(4)	(6)
Net administration costs before interest		**3,754**	**4,169**
Programme Income and Expenditure			
Employee benefits	4.1.1	409	169
Operating Expenses	5	221,186	208,765
Other operating revenue	2	(6,617)	(3,431)
Net programme expenditure before interest		**214,978**	**205,503**

Other Comprehensive Net Expenditure	2015-16 £000	2014-15 £000
Impairments and reversals	0	0
Net gain/(loss) on revaluation of property, plant & equipment	0	0
Net gain/(loss) on revaluation of intangibles	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Movements in other reserves	0	0
Net gain/(loss) on available for sale financial assets	0	0
Net gain/(loss) on assets held for sale	0	0
Net actuarial gain/(loss) on pension schemes	0	0
Share of (profit)/loss of associates and joint ventures	0	0
Reclassification Adjustments		
On disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year	**218,733**	**209,672**

The notes on pages 110 to 137 form part of this statement

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	8	14	19
Intangible assets		0	0
Investment property		0	0
Trade and other receivables		0	0
Other financial assets		0	0
Total non-current assets		14	19
Current assets:			
Inventories		0	0
Trade and other receivables	9	2,821	3,227
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	10	71	77
Total current assets		**2,892**	3,304
Non-current assets held for sale		0	0
Total current assets		**2,892**	3,304
Total assets		**2,906**	3,323
Current liabilities			
Trade and other payables	11	(12,382)	(13,170)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions		0	0
Total current liabilities		**(12,382)**	(13,170)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(9,476)**	(9,847)
Non-current liabilities			
Trade and other payables		0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions		0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(9,476)**	(9,847)
Financed by Taxpayers' Equity			
General fund		(9,476)	(9,847)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(9,476)**	(9,847)

The notes on pages 109 to 136 form part of this statement

The financial statements on pages 105 to 108 were approved by the Audit Group, on behalf of the Governing Body on 25-05-2016

Liane Langdon
Chief Accountable Officer
26/05/2016

Statement of Changes In Taxpayers Equity for the year ended 31-March-2016

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(9,846)	0	0	**(9,846)**
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 2015	**(9,846)**	**0**	**0**	**(9,846)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(218,733)			(218,733)
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	**(228,578)**	**0**	**0**	**(228,578)**
Net funding	219,102	0	0	219,102
Balance at 31 March 2016	**(9,476)**	**0**	**0**	**(9,476)**

	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 of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Commissioning Board balance at 1 April 2014	**(11,217)**	**0**	**0**	**(11,217)**
Changes in NHS Commissioning Board taxpayers' equity for 2014-15				
Net operating costs 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 Commissioning Board Expenditure for the Financial Year	**(220,890)**	**0**	**0**	**(220,890)**
Net funding	211,044	0	0	211,044
Balance at 31 March 2015	**(9,846)**	**0**	**0**	**(9,846)**

The notes on pages 110 to 137 form part of this statement

Statement of Cash Flows for the year ended 31-March-2016

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(218,733)	(209,673)
Depreciation and amortisation	5	5	6
Impairments and reversals		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	9	406	(2,517)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	(787)	1,012
Increase/(decrease) in other current liabilities		0	0
Provisions utilised		0	0
Increase/(decrease) in provisions		0	0
Net Cash Inflow (Outflow) from Operating Activities		**(219,109)**	(211,172)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(219,109)**	(211,172)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		219,102	211,044
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		**219,102**	211,044
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(6)**	(128)
Cash & Cash Equivalents at the Beginning of the Financial Year		**77**	205
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		**71**	77

The notes on pages 110 to 137 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 2015-16* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to 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 (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a 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 (N/A in 2015-16)

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:

Notes to 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:

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 2015-16 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 rolling annual trend
- reduce the projection by a further proportion that is reflective of current delays in assessments and other factors in line with the excess accruals in previous years (estimated to be no more than 6%).

Further adjustments required were:
- Provisional packages are recorded when an application for a patient to receive CHC funding is made. Approximately only circa 6%-12% of these packages become eligible for full NHS CHC funding and therefore a reduction is required to reflect this, based on historic trends.
- Checklist patients are put on a paid for package on discharge from hospital, however based on trend analysis up to 25% of checklist patients are subsequently found to be ineligible for CHC following full assessment 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 is therefore calculated using the forecast in the NHS BSA PMD prescribing reports and any relevant local intelligence.

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.

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 (N/A in 2015-16)**

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.

Notes to the financial statements

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the 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.

1.11.2 **Valuation**

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

Land and buildings used for the 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 current value in existing use.

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

1.11.3 **Subsequent Expenditure (N/A in 2015-16)**

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

1.12 **Intangible Assets (N/A in 2015-16)**

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.

Notes to the financial statements

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

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

1.12.2 **Measurement**

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

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

1.13 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the 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.

1.14 **Donated Assets (N/A in 2015-16)**

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

1.15 **Government Grants (N/A in 2015-16)**

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

1.16 **Non-current Assets Held For Sale (N/A in 2015-16)**

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

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

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.
The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.
Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 **Leases**

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

Notes to the financial statements

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 (N/A in 2015-16)**

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 (N/A in 2015-16)**

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.

Notes to the financial statements

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.

1.19 **Inventories (N/A in 2015-16)**
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 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

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

A restructuring provision is recognised when the 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 was 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 (N/A in 2015-16)**

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.

Notes to the financial statements

1.26 **Contingencies (N/A in 2015-16)**

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.

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 (N/A in 2015-16)**
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 (N/A in 2015-16)**
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 (N/A in 2015-16)**
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.

Notes to the financial statements

1.28.1 **Financial Guarantee Contract Liabilities (N/A in 2015-16)**
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 (N/A in 2015-16)**
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.

1.3 **Foreign Currencies (N/A in 2015-16)**
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 (N/A in 2015-16)**
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 (N/A in 2015-16)**

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 (N/A in 2015-16)**

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 (N/A in 2015-16)**

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 (N/A in 2015-16)**
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.

Notes to the financial statements

1.37 **Research & Development**

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

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

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

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

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

2 Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Recoveries in respect of employee benefits	133	0	133	92
Patient transport services	0	0	0	0
Prescription fees and charges	238	0	238	34
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	3,404	0	3,404	3,253
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	2,846	4	2,842	58
Total other operating revenue	**6,621**	**4**	**6,617**	**3,437**

Explanatory Note

Better Care Fund Income of £2,759k is included within Other Revenue Programme for 2015-16 (£nil 2014-15).

3 Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
From rendering of services	6,621	4	6,617	3,437
From sale of goods	0	0	0	0
Total	**6,621**	**4**	**6,617**	**3,437**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	2015-16	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	1,274	1,213	61	935	898	36	340	315	25
Social security costs	114	114	0	88	88	0	26	26	0
Employer Contributions to NHS Pension scheme	162	162	0	121	121	0	41	41	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	3	3	0	0	0	0	3	3	0
Gross employee benefits expenditure	**1,553**	**1,492**	**61**	**1,144**	**1,107**	**36**	**409**	**384**	**25**
Less recoveries in respect of employee benefits (note 4.1.2)	(133)	(133)	0	0	0	0	(133)	(133)	0
Total - Net admin employee benefits including capitalised costs	**1,420**	**1,359**	**61**	**1,144**	**1,107**	**36**	**276**	**251**	**25**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**1,420**	**1,359**	**61**	**1,144**	**1,107**	**36**	**276**	**251**	**25**

Employee benefits have increased in 2015-16 due to staff transferring from the Commissioning Support Unit before its closure on 31 March 2016.

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**

4.1.2 Recoveries in respect of employee benefits	2015-16			2014-15
	Total £000	Permanent Employees £000	Other £000	Total £000
Employee Benefits - Revenue				
Salaries and wages	(133)	(133)	0	(92)
Social security costs	0	0	0	0
Employer contributions to the NHS Pension Scheme	0	0	0	0
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**(133)**	**(133)**	**0**	**(92)**

4.2 Average number of people employed

	2015-16 Total Number	2015-16 Permanently employed Number	2015-16 Other Number	2014-15 Total Number
Total	**28**	**27**	**1**	17
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

During 2015-16, the number of staff employed by the Clinical Commissioning Group increased due to staff transferring from the Commissioning Support Unit before its closure on 31 March 2016.

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	20	184
Total Staff Years	21	19
Average working Days Lost	**1**	**9.7**

	2015-16 Number	2014-15 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

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	3,067	0	0	1	3,067
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**1**	**3,067**	**0**	**0**	**1**	**3,067**

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2015-16 Departures where special payments have been made		2014-15 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

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

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures has been recognised in full in 2015-16.

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change, NHS Terms and Conditions of Service Handbook, Amendment number 35.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

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

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2015-16, employers' contributions of £161,618 were payable to the NHS Pensions Scheme (2014-15: £123,501) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.1.

5. Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	1,098	689	409	697
Executive governing body members	455	455	0	489
Total gross employee benefits	**1,553**	**1,144**	**409**	**1,186**
Other costs				
Services from other CCGs and NHS England	3,072	1,817	1,255	3,824
Services from foundation trusts	128,766	25	128,741	126,154
Services from other NHS trusts	19,834	0	19,834	19,473
Services from other NHS bodies	0	0	0	2
Purchase of healthcare from non-NHS bodies	32,920	0	32,920	25,485
Chair and Non Executive Members	443	443	0	392
Supplies and services – clinical	78	0	78	79
Supplies and services – general	4,463	43	4,421	4,215
Consultancy services	4	0	4	30
Establishment	173	132	41	113
Transport	1	1	0	0
Premises	157	66	91	243
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	5	5	0	6
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				
· 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	54	54	0	72
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	31,124	0	31,124	29,949
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	1,292	0	1,292	1,546
Other professional fees excl. audit	5	2	3	16
Grants to other public bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	2	2	0	0
Education and training	24	25	(1)	21
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions	1,384	0	1,384	302
Other expenditure	0	0	0	0
Total other costs	**223,801**	**2,615**	**221,186**	**211,922**
Total operating expenses	**225,354**	**3,759**	**221,595**	**213,108**

Explanatory Note

Services from foundation trusts admin expenditure of £25k is for Internal Audit Services.

Services from foundation trusts programme expenditure includes gross Better Care Fund expenditure of £6,300k.

Purchase of healthcare form non-NHS bodies programme expenditure includes gross Better Care Fund expenditure of £7,224k.

6.1 Better Payment Practice Code

Measure of compliance	**2015-16 Number**	**2015-16 £000**	2014-15 **Number**	2014-15 **£000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	8,614	42,309	7,579	36,735
Total Non-NHS Trade Invoices paid within target	8,303	41,078	7,228	34,046
Percentage of Non-NHS Trade invoices paid within target	**96%**	**97%**	**95%**	**93%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,118	157,352	2,007	150,000
Total NHS Trade Invoices Paid within target	2,075	157,224	1,853	149,192
Percentage of NHS Trade Invoices paid within target	**98%**	**99%**	**92%**	**99%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2015-16 £000**	2014-15 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7. Operating Leases

7.1 As lessee

North Lincolnshire Clinical Commissioning Group has lease arrangements with NHS Property Services for the buildings it occupies.

7.1.1 Payments recognised as an Expense

	2015-16				2014-15			
	Land £000	**Buildings £000**	**Other £000**	**Total £000**	**Land £000**	**Buildings £000**	**Other £000**	**Total £000**
Payments recognised as an expense								
Minimum lease payments	0	151	0	**151**	0	243	9	**252**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**151**	**0**	**151**	**0**	**243**	**9**	**252**

Whilst our arrangement with NHS Property Services Limited falls 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.

7.2 As lessor

North Lincolnshire Clinical Commissioning Group holds no leases as a lessor (2014-15 None).

8 Property, plant and equipment

2015-16	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 01-April-2015	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-2016	**0**	**0**	**0**	**0**	**0**	**0**	**25**	**0**	**25**
Depreciation 01-April-2015	0	0	0	0	0	0	6	0	6
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	5	0	5
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-2016	**0**	**0**	**0**	**0**	**0**	**0**	**11**	**0**	**11**
Net Book Value at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**0**	**14**
Purchased	0	0	0	0	0	0	14	0	14
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-2016	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**0**	**14**
Asset financing:									
Owned	0	0	0	0	0	0	14	0	14
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-2016	**0**	**0**	**0**	**0**	**0**	**0**	**14**	**0**	**14**

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 01-April-2015	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-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

8 Property, plant and equipment cont'd

8.1 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

9 Trade and other receivables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	1,723	0	2,318	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	582	0	626	0
NHS accrued income	27	0	0	0
Non-NHS receivables: Revenue	188	0	230	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	10	0	53	0
Non-NHS accrued income	274	0	0	0
Provision for the impairment of receivables	0	0	0	0
VAT	17	0	0	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	0	0
Total Trade & other receivables	**2,821**	**0**	**3,227**	**0**
Total current and non current	**2,821**		**3,227**	
Included above:				
Prepaid pensions contributions	0		0	

9.1 Receivables past their due date but not impaired	**2015-16 £000**	2014-15 £000
By up to three months	122	7
By three to six months	0	12
By more than six months	0	144
Total	**122**	**163**

£63k of the amount above has subsequently been recovered post the statement of financial position date.

10 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	77	205
Net change in year	(6)	(128)
Balance at 31-March-2016	**71**	**77**
Made up of:		
Cash with the Government Banking Service	71	77
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	**71**	**77**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31-March-2016	**71**	**77**
Patients' money held by the clinical commissioning group, not included above	0	0

11 Trade and other payables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	730	0	752	0
NHS payables: capital	0	0	0	0
NHS accruals	954	0	1,666	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	1,946	0	1,527	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals	8,468	0	8,717	0
Non-NHS deferred income	0	0	0	0
Social security costs	30	0	17	0
VAT	0	0	0	0
Tax	33	0	25	0
Payments received on account	0	0	0	0
Other payables	221	0	466	0
Total Trade & Other Payables	**12,382**	**0**	**13,170**	**0**
Total current and non-current	**12,382**		**13,170**	

Other payables include £40.5k outstanding pension contributions at 31 March 2016 (31 March 2015: £23.3k). The increase in 2015-16 is due to the transfer of staff to the CCG before the closure of the Commissioning Support Unit on 31 March 2016.

12 Financial instruments

12.1 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.

12.1.1 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.

12.1.2 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.

12.1.3 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.

12.1.3 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.

12 Financial instruments cont'd

12.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	**Loans and Receivables 2015-16 £000**	**Available for Sale 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,750	0	1,750
· Non-NHS	0	462	0	462
Cash at bank and in hand	0	71	0	71
Other financial assets	0	0	0	0
Total at 31-March-2016	**0**	**2,283**	**0**	**2,283**

	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-2016	**0**	**2,625**	**0**	**2,625**

12.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	**Other 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	1,684	1,684
· Non-NHS	0	10,635	10,635
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2016	**0**	**12,319**	**12,319**

	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-2016	**0**	**13,128**	**13,128**

13 Operating segments

North Lincolnshire Clinical Commissioning Group had no operating segments to report at 31 March 2016 as was the case for 2014-15, however in the 2014-15 Annual Accounts the CCG was reported in full as an operating segment.

14 Pooled budgets

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

	2015-16	2014-15
	£000	£000
Income	2,759	14,250
Expenditure	(26,320) *	(14,790)

Income and expenditure for 2015-16 include transactions for the Better Care Fund (2014-15 £Nil).

		North Lincolnshire CCG	
*** Analysis of Pool Budget Expenditure**	**Total Pool Expenditure**	**%**	**£'000**
Mental Health Pool	(14,571)	83.4%	(12,155)
Learning Disability Pool	(7,647)	5.4%	(410)
Better Care Fund	(13,755)	100.0%	(13,755)
Total	**(35,973)**		**(26,320)**

Mental Health Pool Budget

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 2015 to 31 March 2016

	M12 2015/16	M12 2014/15
	£'000	£000
Gross Funding		
NHS North Lincolnshire CCG	11,890	12,066
North Lincolnshire Council	2,360	2,184
	14,250	14,250
Expenditure		
Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust	11,616	11,901
North Lincolnshire Council Adult Mental Health Services	2,680	2,579
Contribution to North Lincolnshire Council Social Care Services (Sandfield)	119	119
Challenge Fund	83	83
Contingency	0	35
MIND	73	73
	14,571	14,790
Total Expenditure		
Net Underspend/(Overspend)	(321)	(540)

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 £410k in 2015/16 to the Learning Disability pool (£416k in 2014-15).

14 Pooled budgets cont'd

Better Care Fund

The Better Care Fund is a government plan to integrate health and social care across the country by 2020.

Locally, North Lincolnshire Clinical Commissioning Group have implemented the Better Care Fund via a Section 75 Pooled Budget agreement with North Lincolnshire Council. The actual contractual arrangements did not result in joint control being established, therefore under '*IAS 18 Revenue Recognition'* the CCG has accounted for its transactions on a gross accounting basis.

Memorandum Account for the Better Care Fund Poooled Budget for the Period 1 April 2015 to 31 March 2016

	M 12 2015-16 £'000	M 12 2014-15 £'000
INCOME *		
Northern Lincolnshire & Goole NHS Foundation Trust	**2,759**	0
EXPENDITURE		
Health Services	2,554	0
Social Care	7,224	0
Expenditure on Non Elective Activity	3,977	0
Total Revenue Expenditure	**13,755**	0
NET EXPENDITURE	**10,996**	0
FINANCIAL TARGET	**11,006**	0
UNDER OR (OVERSPEND)	**10**	0

* Income paid by NLAG in compensation for Non Elective Activity savings which were not made by the BCF schemes in 2015-16.

15 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
Dr M L Sanderson - Chair				
CCG Chair				
Partner in Trent View Medical Practice	2,237	1	0	0
Husband is a Consultant employed by Northern Lincolnshire & Goole Hospitals NHS Foundation Trust.	108,570	2,784	402	1,495
Mrs A Cooke				
Chief Officer (*Ieft December 2015*)				
Partner Governor for Rotherham, Doncaster & South Humber NHS Foundation Trust	14,010	0	433	0
Mrs T Paskell				
Chief Finance Officer & Business Support *(left November 2015)*				
Husband is Deputy Director of Finance at Doncaster and Bassetlaw Hospitals NHS Foundation Trust.	3,366	0	97	0
Governor of Sheffield Teaching Hospitals FT	1,282	0	28	0
Mrs C Wylie				
Director of Quality & Risk Assurance and Nurse Member				
Partner Governor for Rotherham, Doncaster & South Humber NHS Foundation Trust	14,010	0	433	0
Dr A Lee				
GP Member				
Partner of West Common Lane Teaching Practice, Scunthorpe	1,106	0	0	0
Dr F Baig				
GP Member				
Salaried GP with Birches Medical Practice	1,079	1	0	0
Dr R M Jaggs-Fowler				
GP Member/Medical Director				
Senior Partner in Dr Jaggs-Fowler & Partners, Barton on Humber.	3,112	0	0	0
Dr J Mbugua				
GP Member				
Partner in Trent View Medical Practice, Scunthorpe	2,237	1	0	0
Work in Dermatology at Northern Lincolnshire & Goole NHS Foundation Trust	108,570	2,784	402	1,495
Wife works at Northern Lincolnshire & Goole NHS Foundation Trust	108,570	2,784	402	1,495
Dr N Stewart				
GP Member				
Wife works as a Community Staff nurse for Northern Lincolnshire & Goole NHS Foundation Trust	108,570	2,784	402	1,495
Mr I Reekie - Vice Chair				
Lay Member				
Wife works as a receptionist at the private Spire - Hull & East Riding Hospital.	811	0	60	0
Mrs C Briggs				
Director of Commissioning				
Partner Governor of Northern Lincolnshire & Goole NHS Foundation Trust	108,570	2,784	402	1,495

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.

15 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

16 Events after the end of the reporting period

During 2015-16 the Yorkshire and Humber Commissioning Support (Y&HCS) was not successful in securing a place on the NHS England Lead Provider Framework and as a result the organisation was closed on 31 March 2016. The services they provided to the Humber Clinical Commissioning Groups were put out to tender as 2 Lots, and contracts were awarded to eMBED and North of England Commissioning Support Unit.

The contract awarded to eMBED commenced on 1 April 2016 and has a total contract value of £2,759k over the 4 year term.

17 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:

	2015-16 Target £'000	**2015-16 Performance £'000**	2014-15 Target £'000	2014-15 Performance £'000
Expenditure not to exceed income	227,563	225,354	217,755	213,109
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	220,942	218,733	214,319	209,673
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	4,083	3,754	4,371	4,169

18 Provisions

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2016 is £724k (31 March 2015 is £724k).