NHS
North Tyneside
Clinical Commissioning Group


# Annual report 2014/15

Working together to maximise the health and wellbeing of
North Tyneside communities by making the best use of resources

# Contents

# 1. Foreword

Welcome to NHS North Tyneside Clinical Commissioning Group's (CCG) 2014/15 annual report.

We are responsible for commissioning the planning and buying of the majority of health services for people across North Tyneside.

As a clinically-led membership organisation, made up of the 29 GP practices in North Tyneside, we are in a unique position to understand the needs of our patients and to drive improvement in the delivery of high-quality services.

Improving healthcare in the borough is a complex task and we have faced many challenges throughout the year. Despite this, we have made positive steps in streamlining services, and providing safe, effective and responsive health services for the people of North Tyneside.

On a national level, funding for health is not increasing in proportion to the needs of the growing population. Locally, we have seen a significant increase in the number of people needing urgent and hospital-based care, which has outstripped the resources that we have available to pay for them. Despite close monitoring and measures to manage the financial pressure, our year-end positon is deficit of £6.4 million, which represents 2.1% of our overall budget.

A clear plan is in place to manage the significant budget pressures, and the changes that we are implementing will bring about cost savings in a number of areas. Our programme in-year will step up the delivery of savings through QIPP (Quality, Innovation, Productivity and Prevention) from around 1% of our budget to approximately 3% of our budget, in order to more than offset increases in secondary care activity. We have plans in place to better manage demand and work with our partners to deliver whole system change. These changes will take some time, but we are confident that over a three year period the budget will be balanced again. We will continue to commission high quality, affordable health care.

Despite the financial pressures, North Tyneside CCG remains a dynamic and vibrant organisation that has accomplished much over the last year. Throughout the year we have worked closely with our partners and stakeholders to develop a sustainable healthcare system. We have gained invaluable insights into the most effective ways to approach our challenges and priorities, and we are confident that we will continue to progress in 2015/16.

We have been working with clinical leaders and partners across North Tyneside to develop our New Models of Care programme, to change the way in which services work together to supporting patients with the highest needs.

We have also engaged closely with patients and carers to gain insight into what is important to them for older people's mental health services. This will allow us to redesign the services to better meet patient needs, whilst integrating care across health and social care.

We have taken great strides in developing a new urgent care strategy to ensure that people with urgent, but non-life threatening, needs should receive a responsive and effective service in the most appropriate setting. Much has already been done on this demanding piece of work, and it will continue to be one of the CCG's priorities in 2015/16.

As a CCG, we are committed to commissioning services that meet the needs of our population, and this wouldn't be possible without the hard work of our staff, the commitment of our partner organisations, and the enthusiasm of our patients. Thank you all for your work throughout what has been a very challenging, but ultimately successful, year.

Going forward, your support will be invaluable and we look forward to working in partnership with you over the coming year.

Dr John Matthews
Clinical Chair

Maurya Cushlow
Chief Officer

# 2. Strategic report

## 2.1. Introduction

The purpose of the strategic report is to give details of how the members of the clinical commissioning group (CCG) and the Governing Body have performed in promoting the success of the CCG.

This report provides a fair review of the CCG's business and a description of the principal risks and uncertainties facing the clinical commissioning group and how these are addressed.

## 2.2. Preparation of the CCG accounts

The accounts have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended).

The accounts have been prepared on the basis that the CCG is a 'going concern', despite the issue in February 2015 of a report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998 for the anticipated breach of financial duties, as indicated in the notes to the accounts.

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 the inclusion of financial provision for that service in public documents. The financial allocations for 2015/16 have been approved by parliament and there is no reason to believe that future approvals will not be forthcoming.

## 2.3. CCG discharge of duties

The clinical commissioning group has discharged its duties under the National Health Service Act 2006 (as amended), as required by the CCG Assurance Framework.

The CCG is subject to the NHS England CCG assurance process, including the completion and submission of the Assurance Framework Delivery Dashboard. The CCG has regular dialogue with the NHS England Area Team and participates in the formal quarterly assurance process. The outcome of this is reported to the Governing Body.

# 2.4. Certification

We certify that the clinical commissioning group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended) except as disclosed.

Maurya Cushlow
Chief Officer (Accountable Officer)
NHS North Tyneside Clinical Commissioning Group
27 May 2015

# 2.5. Context

## 2.5.1. The nature, objectives, and strategies of the CCG

NHS North Tyneside Clinical Commissioning Group was licenced without conditions from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the NHS Act 2006. The CCG comprises 29 GP practices and is mirrored with North Tyneside Council.

The CCG has overall responsibility for the development and planning of regional healthcare services. All of the CCG healthcare professionals are up-to-date with clinical best practice and care programmes are backed up by thorough research, for the benefit of patients.

The vision of the CCG is:

***"Working together to maximise the health and wellbeing of North Tyneside communities by making the best possible use of resources"***

The CCG's strategic principles are:

- High quality care that is safe, effective and focused on patient experience
- Services coordinated around the needs and preferences of our patients, carers and their families
- Transformation in the delivery of health and wellbeing services provided jointly with the local authority, other public sector organisations and the private and voluntary sector
- Best value for taxpayers' money and using resources responsibly and fairly
- Right services in the right place delivering the right outcomes

We have agreed ambitious plans to change the way that care is delivered by 2018, working together with our partners to deliver our strategic priorities for:

- Keeping healthy, self care
- Caring for people locally
- Hospital when it is appropriate

The CCG commissioning priorities for 2015/16 are designed to improve the quality of care for patients, modernise the local NHS system and tackle our financial deficit. They will focus on three key areas:

- **High quality affordable health care** offering the best care but reducing waste and duplication
- **Care for older people** which will focus on integrating pathways across health and social care
- **Urgent care** offering hospital based care and primary and community based care based on the level of need

## 2.5.2. Overview of North Tyneside's population

North Tyneside is located on the north-east coast and includes the coastal areas of Whitley Bay, Cullercoats, and Tynemouth, and the towns of North Shields and Wallsend and Wideopen, and agricultural areas such as Backworth and Earsdon. Many of the communities have a history of industrial development including shipbuilding, fishing, and coal mining.

The population of North Tyneside is 215,602 (population figures as at October 2013) and is expected to grow by 9.8% by 2030 with an increasingly ageing population. It is forecast that the number of people aged 65 years and over will increase by 35%, from 37,836 in 2013 to 51,000 in 2030.

It is estimated that the number of people aged 85 and over will increase by 100% between 2013 and 2030 to 7,000 creating additional demand for social care, housing and health services. The number of children and young people is projected to grow by 9.4% by the year 2030, with the biggest increase in 4-19 age group.

The health of people in North Tyneside is varied compared with the England average. Deprivation is higher than the England average and about 20% (7,100) children live in poverty. Life expectancy for both men and women is lower than the England average; with average life expectancy for North Tyneside is 79 years (77 years for males and 81 for females). Overall, however, the borough of North Tyneside as a whole is now one of the least deprived areas in North East England.

## 2.5.3. Health and wellbeing

The CCG is a key member of the health and wellbeing board in the borough and has key statutory duties and powers to encourage integrated work of both commissioners and providers to improve the health and wellbeing of the local population, reduce inequalities, and improve the quality and experience of services for the local population.

The objectives of the health and wellbeing strategy are:

- To continually seek and develop new opportunities to improve the health and wellbeing of the population
- To reduce the difference in life expectancy and healthy life expectancy between the most affluent and most deprived areas of the borough
- To shift investment to focus on evidence based prevention and early intervention wherever possible
- To engage with and listen to local communities on a regular basis to ensure that their needs are considered and wherever possible addressed
- To build resilience in local communities through focussed interventions and ownership of local initiatives to improve health and wellbeing
- To integrate services where there is an opportunity for better outcomes for the public and better use of public money
- To focus on outcomes for the population in terms of measurable improvements in health and wellbeing

The CCG is represented on the Health and Wellbeing Board by Dr John Matthews, the CCG Clinical Chair and Maurya Cushlow, the CCG Chief Officer.

## 2.5.4. Clinical leadership

The CCG Clinical Chair is Dr John Matthews, who chairs the Council of Practices and the Governing Body. The CCG Council of Practices comprises a GP from each of the 29 member practices, giving the CCG a strong mandate from the clinical leaders.

The CCG has a GP Medical Director, three GP Clinical Directors and a team of GP clinical leads working on a sessional basis to lead specific service improvement work. The CCG Executive Nurse is the Executive Director of Nursing and Transformation. In addition to his role on the Governing Body, the secondary care specialist doctor is a member of the quality and safety committee. The Council of Practices has made nominations to committees of the CCG; a GP to the Audit Committee, a GP to the Quality and Safety Committee, a Practice Manager to the Quality and Safety Committee and a Practice Manager to the Clinical Executive Committee. Clinical leadership is embedded in the day-to-day work of the organisation is integral to the success of the CCG.

## 2.5.5. Securing continuous improvement in the quality and safety of healthcare services

The CCG has a duty to secure continuous improvement in the quality of services and is committed to this in all aspects of its work.

The Medical Director and Executive Director of Nursing and Transformation are responsible for providing advice and assurance to the Governing Body and Clinical Executive on the quality and safety of commissioned services, with particular responsibility for the five domains of the NHS Outcomes Framework.

The Quality and Safety Committee has delegated responsibility to secure continuous improvement in the quality of services, improve the quality of primary medical services and promote research and the use of research to improve the delivery of care. It provides assurance to the Governing Body about the quality, safety and risks of the services being commissioned and has responsibility for oversight of the CCG's arrangements for the discharge of its duties in respect of safeguarding adults and safeguarding children and young people.

The Governing Body has delegated responsibility for monitoring and assuring safeguarding to the Quality and Safety Committee. The Executive Director of Nursing and Transformation is the lead officer for safeguarding, supported by the CCG employed Designated Nurse (Safeguarding Children), the Designated Doctor and the Safeguarding Adults Lead Nurse, the named GP for safeguarding children and named GP for safeguarding adults. In addition to regular and detailed reports to the Quality and Safety Committee, reports are provided to the CCG Governing Body in private session.

The CCG is an active member of the Safeguarding Adults Board and the Local Safeguarding Children's Board.

NHS England's '*Mental Capacity Act 2005 A Guide for Clinical Commissioning Groups and other commissioners of healthcare services on Commissioning for Compliance'* sets out our duty to ensure that the legislation, guidance and policy relating to the MCA are delivered by service providers thereby assuring CCGs and NHS England that the rights of patients are being recognised and protected and in North Tyneside we use the framework for tendering, contracting and monitoring and ongoing assurance.

Quality Review Groups are in place for all Foundation Trusts and local private hospital providers. They focus on a triangulation of data from soft intelligence systems, mortality indices, patient surveys including the Friends and Family Test, staff surveys, serious incidents and complaints. Quality monitoring is also in place in partnership with the local authority for nursing homes. The CCG is an active member of the local Quality Surveillance Group at which information and intelligence is shared. This is then

communicated to the Quality and Safety Committee and Governing Body as part of the assurance process. The CCG Serious Incident Panel, working on behalf of the Quality and Safety Committee reviews all serious incidents in detail.

# 2.6. Financial performance

## 2.6.1. Key financial performance indicators 2014/15

At the close of 2014/15, North Tyneside CCG has not met the statutory requirement to ensure expenditure in a financial year does not exceed its allocated resource. The deficit for the CCG for 2014/15 was £6.4m, against the allocated revenue resource limit, as reported in full in the annual accounts.

The CCG total revenue resource allocation for 2014/15 was £300.7m and total spend was £307.1m. This represents around 2.1% of the CCG's overall budget and follows a small surplus recorded in 2013/14.

The CCG warned in-year that despite close monitoring and measures to manage financial pressures, it was forecasting a deficit in excess of £6m for the 2014/15 financial year.

**Table 1: Key financial performance indicator 2014/15**

| | £m |
|---|---|
| Allocated resource to the CCG 2014/15 | 300.7 |
| Total expenditure for 2014/15 | 307.1 |
| Surplus / (Deficit) as at 31 March 2015 | (6.4) |

## 2.6.2. Financial performance targets

Financial performance targets are reported in note 42 of the annual accounts. Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended). North Tyneside CCG's performance against those duties was as follows:

**Table 2: Financial performance targets**

| | 2014/15 |
|---|---|
| Expenditure not to exceed income | × Not Achieved |
| Revenue resource use does not exceed the amount specified in Directions | × Not Achieved |
| Revenue administration resource use does not exceed the amount specified in Directions | ✔ Achieved |

## 2.6.3. CCG commissioning budget 2014/15

On 26 March 2014 the CCG Council of Practices approved the CCG 2014/15 annual commissioning programme budget of £287.7m. The CCG subsequently received additional allocations in-year of £7.1m to give an overall annual commissioning budget of £294.8m.

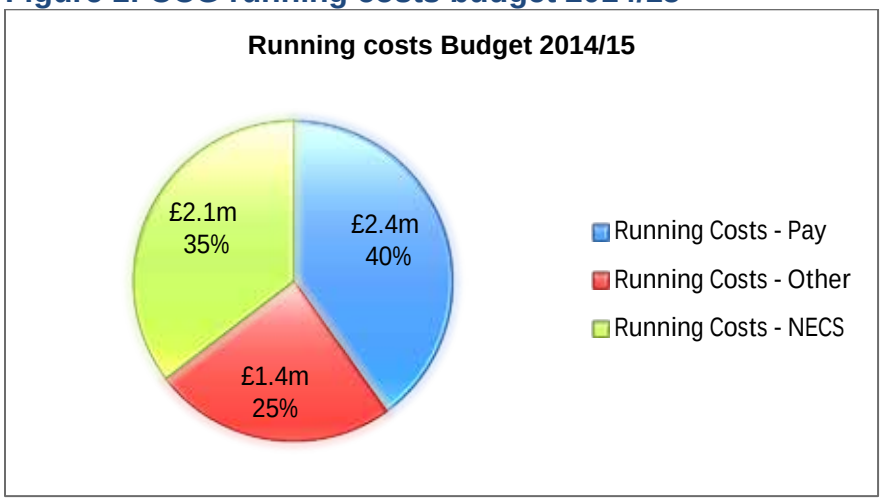
## 2.6.4. CCG running costs budget 2014/15

In addition to the commissioning budget the CCG had an initial annual running costs budget of £5.2m in 2014/15. This was budgeted across pay, other running costs and the Service Level Agreement with North of England Commissioning Support (NECS). During the year there was an additional allocation of £0.7m to this budget.

The CCG operates small office premises in North Shields leased from NHS Property Services.

The breakdown of the CCG running costs budget is shown in figure 1.

**Figure 1: CCG running costs budget 2014/15**



# 2.6.5. Financial outturn 2014/15

The CCG 2014/15 annual accounts are provided in full as part of the annual report. During the year, the CCG commissioned healthcare services to the value of £301.9m and incurred expenditure of £5.2m in respect of running costs. The overall closing position of the CCG was a deficit of £6.4m, as summarised in the table below.

### Table 3: CCG 2014/15 budget and outturn

| | Budget<br>£m | Outturn<br>£m | Surplus/ (Deficit)<br>£m |
|---|---|---|---|
| Acute health services | 176.6 | 180.7 | (4.1) |
| Mental health services | 26.8 | 24.7 | 2.1 |
| Community health services | 27.5 | 28.0 | (0.5) |
| Continuing health care | 21.3 | 23.7 | (2.4) |
| Primary care | 41.7 | 41.8 | (0.1) |
| Other programme costs | 0.9 | 3.0 | (2.1) |
| | | | |
| **Total Programme (commissioning) budget / costs** | **294.8** | **301.9** | **(7.1)** |
| | | | |
| **Total Running budget / costs** | **5.9** | **5.2** | **0.7** |
| | | | |
| **Total** | **300.7** | **307.1** | **(6.4)** |

The majority of the CCG's expenditure, £225.7m, was spent with NHS organisations, purchasing healthcare for the benefit of North Tyneside residents. A further £38.9m was used to purchase healthcare from non NHS bodies, as indicated in note 5 to the accounts. That included:

- £24.0m on continuing health care (mainly in nursing homes and on care at home)
- £7.3m on Local Authority services
- £3.5m on voluntary and not-for-profit organisations
- £3.6m on services from the independent sector organisations

## 2.6.6. Context of the reported financial outturn 2014/15

In 2013/14 a small surplus of £163k was recorded, despite an underlying deficit position driven by over-activity. The effects of this activity in 2013/14 were off-set by risk share arrangements and non-recurrent year-end adjustments. The underlying deficit of £4.8m impacted 2014/15. The 2014/15 budgets showed a balanced position but required the delivery of an ambitious £8m QIPP (Quality, Innovation, Productivity and Prevention) savings programme.

The CCG Council of Practices, Governing Body and Audit Committee received regular reports on the CCG financial position at each meeting throughout the year.

The causes of deficit in 2014/15 were mainly due to continued overspend and activity against plan particularly in ambulatory care, other non-elective activity and spend on high cost drugs. Other causes include the under-delivery of QIPP and contract activity reductions over the past two years, particularly during 2014/15 and high costs of continuing health care.

During the course of the year the CCG has recognised the need to take urgent action at scale to redress the situation. The CCG has taken external expert advice and has worked in partnership with healthcare providers, NHS England and North Tyneside Council to develop a Financial Recovery Plan. Full implementation of this challenging plan will lead to recurring financial balance for the CCG in 2016/17.

Steps have been taken to put in place measures for the resources and governance to deliver the Finance Recovery Plan:

- The Finance Committee was established in January 2015 as a committee of the Governing Body, chaired by CCG lay member
- An experienced Turnaround Director came into post in March 2015, for a 6 month period
- A Project Management Office has been established and will be embedded into the normal working of the CCG, together with additional staff from the Commissioning Support Unit and increased capacity in the CCG finance function.
- CCG Clinical Directors have redefined roles to combine a corporate portfolio with specific clinical leadership responsibility for each locality to ensure a clear line of sight between members and the Executive functions of the CCG

# 2.6.7. Financial plans 2015/16

The headline 2015/16 CCG budgets were approved by the Council of Practices on 25 March 2015.

### Table 4: CCG budgets 2015/16

| | 2015/16 £m |
|---|---|
| **Revenue resource limit** | **296.1** |
| | |
| **Income and expenditure** | |
| Acute health services | 175.4 |
| Mental health services | 26.5 |
| Community health services | 28.5 |
| Continuing health care | 23.0 |
| Primary care | 41.2 |
| Other programmes | 11.1 |
| | |
| **Total Programme Costs** | 305.7 |
| | |
| Running costs | 4.7 |
| | |
| **Total Costs** | **310.4** |
| | |
| **Planned Deficit** | **(14.3)** |

The CCG's Financial Recovery Plan reflects several proactive steps to ensure effective focus on:

- Managing the increased demands for healthcare
- Delivery of QIPP savings programmes
- Whole system change
- Commissioning external support to challenge and test the rigour of our plans and ability to deliver

As a result of these steps:

- We have a refreshed and refocused CCG-owned QIPP savings programme with detailed individual plans which include finance and quality information and robust Key Performance Indicators (KPIs)
- QIPP savings programmes have been developed to deliver a good part of the deficit position and there is an ongoing process to develop further detailed QIPP plans in response to the benchmarking findings
- We have and continue to develop a pipeline of opportunities that will be used to address any QIPP slippage in 2015/16 and produce savings in subsequent years

### 2.6.8. Better Payment Practice Code

The Better Payment Practice Code requires all CCGs to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. North Tyneside CCG has met the requirements of the code, as reported in the annual accounts and indicated in note 6.1 of the accounts.

## 2.7. Performance against targets

### 2.7.1. Performance targets

Under the Health and Social Care Act 2012, the CCG has a duty to continuously improve the quality of services commissioned and the outcomes achieved. The NHS England Planning Guidance 'Everybody Counts: Planning for patients 2014/15 - 2018/19, published in December 2013, required the CCG to:

- Continue to meet the rights and pledges set out in the NHS Constitution
- Deliver the NHS Mandate requirements by improving performance against seven nationally selected outcome measures across the five domains of the NHS Outcome Framework, and make improvements against indicators in the CCG Outcomes Indicator Set
- Deliver the five national and one local measures of the Quality Premium

These measures were considered as part of the CCG's overall performance management framework and triangulated against a wider range of quality, workforce, financial and activity measures to ensure high quality and safe services were commissioned for the population of North Tyneside. These measures were incorporated

into the CCG's performance framework and associated governance arrangements, to ensure that the appropriate reporting of progress was in place in 2014/15.

## 2.7.2. CCG performance: NHS Constitution

The NHS Constitution brings together in one place details of what staff, patients and the public can expect from the National Health Service. It also explains what everyone can do to help support the NHS, help it work effectively, and help ensure that its resources are used responsibly. The NHS Constitution sets out the rights of an NHS patient. These rights cover how patients access health services, the quality of care, the treatments and programmes available, confidentiality, information and the right to complain if things go wrong.

One of the primary aims of the NHS Constitution is to set out clearly what patients, the public and staff can expect from the NHS and what the NHS expects from them in return.

The rights and pledges as set out in the NHS Constitution are summarised in the NHS England Planning Guidance for CCGs, which specifies the thresholds against which the CCG's performance will be assessed by the NHS England. North Tyneside CCG has met all the required performance measures, as summarised in the table below.

**Table 5: Performance on NHS Constitution - summary**

| Constitution Measures | NTCCG Performance |
|---|---|
| Referral to treatment access times | ✓ |
| Diagnostic waits | ✓ |
| A&E waits | ✓ |
| Cancer waits | ✓ |
| Category A ambulance | ✓ |
| Mixed sex accommodation | ✓ |
| Cancelled operations | ✓ |
| Care Programme Approach | ✓ |
| **NHS Constitution** | ✓ |

**Based on the data we have for 2014/15 to date, we expect to achieve all of the measures in the NHS Constitution**

# 2.7.3. CCG performance: NHS Health Outcomes Framework 2014/15

The NHS Health Outcomes Framework forms part of NHS England's systematic approach to promoting quality improvement. Its aim is to support CCGs and health and wellbeing partners in improving health outcomes by providing comparative information on the quality of health services commissioned and the associated health outcomes. The indicator set supports CCGs and wellbeing boards to identify priorities for improvement.

Seven strategic ambitions were identified nationally against the five domains of the NHS Outcome Framework and five year improvement trajectories set by the CCG within our Five Year Strategic plan 2014/15 to 2018/19.

Published data for 2014/15 is currently unavailable for the seven selected outcome ambitions but the table below gives a high level overview of our progress towards achievement of these measures.

### Table 6: Performance on health outcome measures – summary

| Strategic plan Outcome Measures | | NTCCG performance | | | | |
|---|---|---|---|---|---|---|
| | | | Previous data | | Latest published data | |
| **Outcome measure 1** | Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (adults and children) | ✗ | 2012 | 2,024 | 2013 | 2,120 |
| **Outcome measure 2** | Health related quality of life for people with long term conditions (Average EQ-5D score for people reporting having one or more long-term condition) | ✓ | 2012/13 | 69.5 | 2013/14 | 70.7 |
| **Outcome measure 3** | Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside hospital (Emergency admissions composite indicator) | ✓ | 2012/13 | 2,772 | 2013/14 | 2,479 |
| **Outcome measure 4** | Increasing the proportion of older people living independently at home following discharge from hospital. | Data not yet available | | | | |
| **Outcome measure 5** | Increase the proportion of people having a positive experience of hospital care (The proportion of people reporting poor patient experience of inpatient care) | ✓ | 2012/13 | 84.2 | 2013/14 | 79.2 |
| **Outcome measure 6** | Increase the number of people having a positive experience of care outside hospital, in general practice and the community (The proportion of people reporting poor experience of General Practice and Out-of-hours Services) | ✗ | 2012/13 | 3.4 | 2013/14 | 3.7 |
| **Outcome measure 7** | Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care | Data not yet available | | | | |

## 2.7.4. CCG performance: Quality Premium 2013/14

Final performance data for the 2013/14 Quality Premium was published in October 2014. This showed that North Tyneside CCG successfully achieved four out of seven measures resulting in a Quality Premium payment to the CCG of £0.7 million.

This funding was reinvested in the following areas by the CCG:

- To provide tailored packages of support and care centred on the needs of the nursing home residents
- A prescribing engagement scheme to improve the quality of prescribing in primary care and address areas of prescribing variation by sharing successful practice across the CCG
- Engagement and education events with GP practices

## 2.7.5. CCG performance: Quality Premium 2014/15

This Quality Premium is intended to reward CCGs for improvements in the quality of commissioned services and for associated improvements in health outcomes and reducing inequalities. For 2014/15 the total amount potentially payable for achievement of the quality premium would be £5 per head of population, which equates to just over £1m for North Tyneside CCG, if all targets were met.

There are five national and one local measure. The local measure was developed by the CCG and considered by the local Health and Wellbeing Board. The percentage award for each measure is 15%, with a higher weighting of 25% against the management of emergency admissions.

North Tyneside CCG has focused on these actions and has made improvement across all areas. It has:

- Fully supported the roll out of the Friends and Family test in our local health economy in 2014/15 and showed improvement in patient experience of inpatient care at our local hospitals
- Improved the reporting of medication-related safety incidents within General Practice in 2014/15

- Improving Access to Psychological Therapies (IAPT) access levels in 2014/15 were 16.9% of the estimated number of people who have depression and/or anxiety disorders. This was above the CCG trajectory for the year of 15.5%

At the year-end performance was unfortunately, below trajectory for the following measures:

- Avoidable emergency admissions increased by an estimated 27% in 2014/15 compared to levels in 2013/14. A large proportion of this increase in reported admissions was due to a reclassification of ambulatory care patients from outpatients to emergency admissions
- Estimated levels of dementia diagnosis in the community were 66.0% in 2014/15. Although this fell just short of the CCG's trajectory of 66.7% there was strong improvement of 9% for this measure in 2014/15

The only measure that cannot be reported here is the potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people' measure as the information will not be available until October 2015.

In accordance with NHS England guidance, a CCG will not qualify for the payment of the Quality Premium if the CCG incurs an unplanned deficit in 2014/15. This means that North Tyneside CCG will not qualify for a Quality Premium payment despite some measures being successfully achieved.

## 2.7.6. CCG performance: summary

The CCG met the majority of the performance targets as indicated in the NHS England Planning Guidance for 2014/15 onwards, published in December 2013, which required the CCG to:

- Continue to meet the rights and pledges set out in the **NHS Constitution**
- Deliver the **NHS Mandate** requirements by improving performance against seven nationally selected outcome measures across the 5 domains of the NHS Outcome Framework.
- Deliver the five national and one local measures of the **Quality Premium**

### 2.7.7. CCG planned performance 2015/16

The CCG is entering the second year of a two year operational plan and a five year strategic plan, in conjunction with key partners including the North Tyneside Council, the Health and Wellbeing Board and key providers of healthcare services, including NHS providers and the community and voluntary sector. The plans set out the ambitions of the CCG and give details of the trajectories.

## 2.8. Assurance

### 2.8.1. The resources available to the CCG

The financial resources available to the CCG are described in paragraph 2.6.5 above. The CCG does not have access to capital funds. The CCG has no charitable funds.

The CCG has few employees, as it commissions support services from a range of third party suppliers, including North of England Commissioning Support. This outsourced arrangement is managed through a service level agreement, which was subject to review during 2014/15.

### 2.8.2. Principal risks to the CCG

The CCG has a robust process for the identification and management of its principal risks. This is set out in the Risk Management Policy and includes mechanisms for identifying and assessing risks, taking mitigating action, re-coding and reviewing the risk and escalating the risk as necessary.

The Governing Body, supported by the Clinical Executive Committee, Audit Committee, Finance Committee and Quality and Safety Committee maintained an oversight of the risks to the CCG throughout the 12 month period to March 2015 and to the time of reporting. Key risks are recorded on the risk assurance framework. The position has remained under review throughout the year, with attention paid to eliminating and mitigating those risks and ensuring emerging risks were identified and managed.

In addition to the directors of the CCG taking a strong lead in risk management, each committee has delegated responsibility for reviewing the risks to specified corporate objectives:

- Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution – *risks reviewed by the Quality and Safety Committee*
- Develop and grow North Tyneside CCG as a patient focused, clinically led commissioning organisation – *risks reviewed by the Clinical Executive Committee*
- Work collaboratively with partners and stakeholders to be responsive to the population of North Tyneside – *risks reviewed by the Clinical Executive Committee*
- Lead and influence the development of health and social care fit for the future – *risks reviewed by the Clinical Executive Committee*
- Deliver financial balance – *risks reviewed by the Audit Committee (and latterly by the Finance committee)*

The compressive risk management arrangements are given in detail in the Annual Governance Statement.

# 2.9. Local relationships

Over the past year, the CCG has continued to develop its local relationships with patients, the public, the borough of North Tyneside and other key stakeholders. The CCG works with a range of partners including:

- NHS England
- NHS providers of healthcare – Northumbria Healthcare NHS Foundation Trust, Northumberland, Tyne and Wear Mental Health NHS Foundation Trust, North East Ambulance Service NHS Foundation Trust, Newcastle upon Tyne NHS Foundation Trust, and GP practices
- Other providers of NHS healthcare – independent sector, community and voluntary sector
- North Tyneside Council – in particular working with adult social care, housing and public health
- North Tyneside Health and Wellbeing Board
- North Tyneside HealthWatch
- Neighbouring CCGs

- The community and voluntary sector
- Local MPs
- Local schools

Each year a national 360 degree stakeholder survey is completed to provide an analysis of the key partners of the CCG. Some of the highlights from the most recent survey include:

- 85% of stakeholders have a good working relationship with the CCG
- 85% of stakeholders felt engaged with the CCG
- 75% of stakeholders feel confident in the CCG to commission high quality services
- 93% of stakeholders had knowledge of plans and priorities of the CCG

Overall, partners feel that have contributed to the wider discussions with the CCGs through various means and in particular the urgent care working groups.

# 2.10. Patient and public engagement

Public and patient engagement is an integral part of the work of the CCG. The CCG aspires to really embrace the public and patient voice within the organisation, going further than is required in the Health and Social Act 2012.

The CCG public engagement and communications strategy meets the requirements set out in the 'transforming participation' guidance and 'Everyone Counts'. The CCG are an active Health and Wellbeing Board member driving the integration agenda in order to support the ambitions of the borough, underpinned by patient and community participation to ensure high quality sustainable responsive services for local people.

The CCG has a proactive patient and public engagement approach ensuring that patients and local communities help to shape the commissioning intensions and the future of care delivery for the residents of North Tyneside. Working with key partners, the CCG ensure that the patient and public voice is heard and actively engage them in service transformation and development programmes. Adopting systematic approaches such as *MY NHS* which is a sophisticated customer management tool also allows us to recruit patient and community members aligned against their own particular areas of interest.

The CCG actively seek ongoing feedback on NHS commissioned services and have a proactive approach to ensure that local voices are heard.  This then informs ongoing service and system improvement.

Ensuring the delivery of person centred care is a core feature of ongoing developments across primary and secondary care. Working with the patient forum and community members will raise the awareness of the importance of shared decision making and help local people to get the most from their contacts with health professionals.

Some of the key activity this year around public and patient engagement includes:

- The use of NHS England's transforming participation gap analysis to develop the CCG's public and patient insight
- Decision made on the maternity consultation
- Review of services for people with muscle, bone or joint problems, including back pain
- Older people's mental healthcare
- Talking Therapies procurement
- New models of care

## 2.10.1. North Tyneside CCG Patient Forum

The Patient Forum is a subcommittee of the Governing Body and its membership is drawn from the GP Practice Patient Participation Groups (PPGs). It has had a clear work plan in place throughout the year.

The work of the patient forum is aligned to the CCG strategic priorities and it delivers against a programme of work:

- Commenting on draft commissioning intentions and our strategic plans
- Participating in the development work for New Models of Care
- Supporting the older peoples work programme
- Proving advice about self-care focusing on eczema

### Transforming participation

We have also taken time to consider 'Transforming Participation' published by NHS England. The main aspects are how to improve individual participation, public participation and patient insight.

### Mental health

A social prescribing contract has been put in place, jointly commissioned with public health, and the CCG is collaborating closely with Age UK North Tyneside, Tyneside MIND and the Percy Hedley Foundation. The joint aim is to give patients with low mood or anxiety issues the opportunity to be prescribed well-being activities in the community, rather than using medication as a solution in the first instance.

### Get well, stay well

The self-care working group has engaged with patients across the borough on a number of programmes. This has included:

- The 'Keep Calm' winter campaign, helping to highlight ways of accessing healthcare solutions in the right way, at the right time, within the right service
- A children's skin care drop-in session, providing parents the opportunity to discuss eczema treatments and their correct usage
- A back pain workshop, helping those who have presented to their GPs with low level symptoms to manage their symptoms effectively at home, without medical intervention

### Talking Therapies

The CCG continues to engage with service users on possible new models of care for Talking Therapies services.

People who have experiences of low level mental health issues such as anxiety and depression have been encouraged to share their experiences and tell the CCG what is important to them, so that it can develop a new service specification that reflects the issues that patients feel strongly about.

### Older people's mental health

The CCG has delivered comprehensive engagement with stakeholders to inform the development of a joint commissioning vision of older people's mental health working in conjunction with North Tyneside Council.

Engagement activity has been designed to provide clear patient and carer insights about what is important to them for older people's mental health. This will allow the CCG to develop a model of care that meets the needs of the local population and continues to develop older people's mental health services as an integral part of the healthcare system.

## 2.10.2. Winter planning and promoting good health

Throughout the year, the CCG have been promoting good health by focusing on providing information to people about how they can look after themselves, under a campaign, 'keep calm and look after yourself'. Also national campaigns such as encouraging people to have flu injections and to keep warm this winter have been localised across North Tyneside.

The main focus of the campaign ties in with the national self-care week, developed from the patient forum in North Tyneside. The campaign lasted six weeks and used a variety

of media with a reach of 1.9 million, which equates to 73% of the north-east population having seen or heard the campaign.

## 2.10.3. Urgent care strategy

During the winter period there were significant pressures being experiences across all services. The North Tyneside urgent care group oversaw the local distribution of the centrally allocated winter monies, with an additional £2.6 million being allocated to the two acute hospital trusts and £131,000 to the mental health trust.

In December 2014, the CCG was advised that an additional £185,000 was available for primary care operational resilience and this resulted in three GP practices opening over the festive season from Boxing Day to Sunday 28 December 2014, when historically they would have been closed. Patient and staff feedback was very positive and hospital trusts appreciated the efforts to reduce demand on their services.

Our Urgent and Emergency Care Strategy, 2014-2018 sets out the strategic vision for the development of North Tyneside's urgent and emergency care system for the next five years. It describes the national and local context, the need for change and the approach that will be adopted to transform and improve urgent and emergency care services to address current issues and future needs and it ensures that every person in North Tyneside has access to the right treatment in the right place at the right time.

Our strategy has been strongly influenced by the vision from NHS England (2013), 'Transforming urgent and emergency care services in England - Urgent and Emergency Care Review' report which defines five key elements for future urgent and emergency care services in England. We have used this as a high level 'blue print' for a transformed urgent and emergency care system in North Tyneside.

Alignment with the broader health and social care economy will be secured through the Health and Wellbeing Board, and the Integration Board will lead the delivery of the strategy and its integration with other work programmes within its portfolio.

Our Urgent Care Working Group (now System Resilience Group) implemented robust evaluation and lessons learned processes from winter 2013/14 which identified gaps in services highlighting possible risks to operational resilience. This allowed targeted investment into resilience funding initiatives. The investments we made in 2014 were planned to pump prime the initiatives outlined within our Better Care Fund Plan which will realise contribution to financial recovery during 2015/16.

For 2015/16 operational resilience and assurance, we will follow the previous year's processes. We will evaluate winter 2014/15 and ensure ongoing liaison with providers around examples of good practice and any bottle necks in provision so that lessons are

learned. We will undertake demand and capacity planning for the coming year in real time and across the whole system of providers.

## 2.10.4. Children and young people

In 2014, the Children and Young People's Plan was developed to facilitate the development of innovative approaches to improve the lives of children, young people and their families. The plan was developed through the North Tyneside Children, Young People and Learning Partnership, which is led by North Tyneside Council. The plan has identified three priorities and the outcomes:

- 0-5 years: ready for school
    - A healthy early childhood
    - Children are ready to start school
- 6-19/25 years: ready for work and life
    - Narrow the gap in educational outcomes
    - Ready for employment
    - Reduce risk taking behaviour
- All age phases: safe, supported and cared for
    - The most vulnerable children and young people are protected
    - Improved outcomes for looked after children
    - The right support for children and young people with disabilities and additional needs

## 2.10.5. Maternity services

During December 2013 and March 2014, there was a public consultation in the borough on future arrangements for maternity care, including extensive public consultation. It was decided that services would move from North Tyneside General Hospital to the new Northumbria Specialist Emergency Care Hospital when that opens on 2015. Some key issues emerged during the consultation around post-natal care and transport to the new hospital.

Further work was carried out in 2014/15 to address these concerns and can be summarised as:

- The postnatal offer with be enhanced with the addition of new healthcare assistant roles to support the community midwives with dedicated health visitor and family health partners support for the breastfeeding peer supporters

- Improved integrated teams
- Progress being made towards UK Baby Friendly Initiative

## 2.11. Integration programme

North Tyneside has responded early to the approach of integrating health and social care by creating its own Health and Social Care Integration Programme including the CCG, North Tyneside Council and statutory providers including the community and voluntary sector. It was agreed that the integration programme would lead to greater integration of health and social care services with the focus on the priorities in North Tyneside Health and Wellbeing Strategy and the commissioning intelligence about the needs of the borough.

The priorities have evolved around six key areas (urgent care, older people, integrated disability and additional needs, integrated commissioning for adults with a learning disability, creating a health living service) which have since expanded to include mental health and better care fund.

## 2.12. The Better Care Fund

In June 2013, the Government announced a national £3.8 billion pooled budget for health and social care services. The Better Care Fund (BCF) has been created to ensure a transformation in integrated health and social care. It is a single pooled budget supporting health and social services to work more closely together. Local areas have been required to develop plans accordingly, overseen by Health and Wellbeing Boards.

The total value of the Better Care Fund is North Tyneside for 2015/16 is £16.597m.

We have developed plans jointly with North Tyneside Council, in consultation with other stakeholders including acute healthcare providers and healthwatch. The plans build on existing joint working, for example re-enablement and service transformation.

## 2.13. New models of care

The CCG is working with clinical leaders and partners from across North Tyneside to develop and implement improvements to the way NHS services work together to support patients with the highest needs. Often these patients therefore use over half the NHS resources.

The development will provide proactive care planning and coordinated care, wrapped around the patient with a single point of access, with the service fundamentally orientated towards supporting patients to have the confidence and knowledge to manage their own conditions. The service will be provided by a multi-disciplinary team who are able to provide specialist care in a locality setting to support patients with complex needs.

The 'new models of care' is an innovative model, building upon previous work carried out, including, for example, the High Risk Patient Programme where high risk frail patients were selected and managed via GP, community, reablement and geriatric services. The ultimate aim is to support people to 'age well' and to direct services to people who need them in the best way possible.

## 2.14. Co-commissioning of Primary Care services

CCGs have been offered the opportunity to become involved in commissioning primary care. The CCG has had approval to develop a joint commissioning arrangement from April 2015 whereby the CCG and NHS England will make decisions together, with a view to progress to delegated commissioning arrangements during 2015/16.

This will mean that the CCG and NHS England will work together to combine the CCG's local insight into the health needs of the borough's population with the present knowledge and resources held by NHS England to commission primary care. With the CCG taking a greater role in primary care commissioning, as a joint commissioner, this will help to enable the development of new models of care which the CCG has been leading on throughout 2014/15.

## 2.15. Promoting research

The CCG has increased its research activity this year. During 2014/15 patients in North Tyneside have had the opportunity to be recruited into 35 different studies either at or through the GP practices.  New studies are continually being assessed and we anticipate that research will continue to grow bringing benefits to patients and practitioners across North Tyneside during 2015/16.

# 2.16. Best practice

The CCG has a number of successes with practices and services across the health economy including a national award for engagement, shortlisted for a bright ideas award and a leadership award.

One of the CCGs biggest achievements has been the engagement, mapping and analysis of the North Tyneside older person's pathway which involved more than 800 people and over 40 services across primary, community, acute, voluntary and the private sector.

Over the past 12 months, the CCG has taken a more collaborative role in its projects which has produced savings of nearly £300,000 this year.

Some of the initiatives include the introduction of the electronic prescription service, working with GP practices to improve their processes and to avoid any waste or duplication,

The CCG was also shortlisted in the Health Awards 2014 with a toolkit being developed to help develop and sustain quality improvement by bringing together service improvement tools and techniques, project management tools, quality, patient and staff indicators.

The winter campaign,' keep calm' won the best healthcare campaign in the Chartered Institute of Public Relations Pride awards, where the idea was developed by the patient forum.

# 2.17. Sustainability and the environment

The CCG's approach to sustainable development sets out the commitment to work in ways which maximise the health, social and economic benefits our activities bring to the community whilst minimising our impact on the environment.

Sustainable development requires the CCG to be mindful of the need to safeguard the future in all of our choices, decisions, and actions. Wherever possible, the CCG takes opportunities to contribute positively to the local economy and community, reduce waste and utilities consumption, and minimise any negative impact on the environment both now and for future generations.

Working in a sustainable way means rethinking a lot of what we do. It affects not only the major strategic decisions we take but also how we go about our daily business.

Getting these decisions right will not only help us save money, eliminate unnecessary waste in the system and reduce our carbon footprint; it demonstrates to partners and the public that the CCG is dedicated to enhancing individuals' well-being through our work as commissioners of high quality health services, but also by enhancing the wellbeing of the local and global community through taking seriously our corporate responsibilities.

### Travel

The CCG encourage sustainable travel wherever possible for our staff. The CCG offer a reduced cost public transport initiatives and are developing a cycle to work scheme. We offer shower facilities and cycle parking where we can. We also promote care closer to home and home working opportunities where possible.

### Waste

The CCG work hard to minimise the creation of waste and have a robust approach to recycling. Paper, cardboard, glass, metal, ink cartridges, batteries, waste electrical goods and confidential waste are all recycled.

### Workforce development

All of the CCG's staff are encouraged to work sustainably, by promoting environmental awareness, encourage low carbon travel and facilitate flexible working where possible.

### Utilities usage

Where possible, the CCG try and reduce electricity, gas and water consumption. For example, they have a policy to make sure that they switch off our lights and close down computers when they are not being used and we're looking to reduce our carbon footprint as much as possible. In summary, for 2014/15, our usage has been as follows:

**Table 7: Utilities usage for Hedley Court**

| | | Cost |
|---|---|---|
| Electricity | Usage – 62,237.63<br>Carbon emissions – 30,761.88<br>*(Conv. Factor 0.494265)* | £8,491.09 |
| Gas | Usage – 55,362.16<br>Carbon emissions – 10,240.50<br>*(Conv. Factor 0.184973)* | £2,227.98 |
| Water usage | Units – 822.85<br>*(Estimate)* | £2,104.00 |

Notes:

- Information provided by NHS Property Services
- Water consumption calculation - water consumption has been calculated from costs on the basis of using a conversion factor of £2.55696 per cubic meter. This conversion figure is an average of ten water company charges for both Fresh Water supply and Sewerage processing from 2013 and 2014 that supply NHS Property Services properties

- Electric consumption calculation - where no details are available for electric consumption the consumption figures have been estimated using a conversion factor of 12.8 pence per unit. This conversion figure is based on an average taken from a representative sample of NHS Property Services properties
- Gas consumption calculation - where no details are available for gas consumption the consumption figures have been estimated using a conversion factor of 2.4978 pence per KWh. This conversion figure is based on an average taken from a representative sample of NHS Property Services properties

# 2.18. Equality report

The CCG is committed to ensuring that equality and diversity is part of everything that the organisation does. NHS North Tyneside CCG complies with the Equality Act 2010 and the Public Sector Equality Duty. We have demonstrated our commitment to taking Equality and Human Rights into account in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work. Equality and diversity training is a mandatory requirement for CCG staff.

The work done towards advancing equality of opportunity and meeting the legal requirements has been published on our website, including the Equality Strategy, EDS and the Equality Objectives.

### Equality Delivery System

The CCG has used the Equality Delivery System (EDS) to assist in compliance with legislation. EDS ensures that those with “Protected Characteristics” are taken into account in everything we do. It also encourages a more representative workforce, ensuring staff are supported and that those at the highest level are committed to promoting Equality. The CCG has used to EDS to shape its Equality Objectives. The Governing Body has delegated responsibility to the Quality and Safety Committee to oversee the development of policy, strategy and practice and also to ensure the Equality Objectives are being met.

### Promoting equality and diversity

Staff across the CCG have access to an online and paper based copy of a multi-faith Diversity Calendar for both 2014 and 2015 designed by our Equality and Diversity manager within the commissioning support unit. This calendar highlights key dates in order to promote the positive work that can be achieved when Equality and Diversity principles are embedded within an organisation. We also receive the Diversity Matters newsletter on a quarterly basis to keep all staff up to date on current diversity issues, news and key diary dates.

## Staff gender profiles

The CCG staff gender profile is given in the table below. This reflects our gender representation on the Governing Body, Very Senior Manager (VSM) staff and all CCG staff. The CCG Very Senior Managers are CCG employees and all are members of the Governing Body, hence they are included in both sets of figures in this table.

### Table 8: North Tyneside CCG gender profile

| | Male | Female |
|---|---|---|
| Governing Body Members[1] | 5 | 7 |
| VSM | 1 | 3 |
| CCG employees | 11 | 30 |

1. This figure includes substantive voting and non-voting members of the Governing Body, as listed in the Members Report.

The CCG can demonstrate fair and equitable recruitment, workforce engagement and employment terms and conditions to ensure levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work, and work rated as of equal value, being entitled to equal pay.

## Accessibility and communications

The CCG's public buildings are accessible for people with a disability. Information for patients and the general public is available in other languages or formats such as large print or Braille and audio on request. The CCG has earned the two tick 'positive about disabled people' symbol awarded by Jobcentre Plus which demonstrates our commitment to employ, retain and develop the abilities of disabled staff.

# 3. Members report

# 3.1 Membership of the CCG

## 3.1.1. Member Practices

The CCG is made up of all the 29 GP practices in North Tyneside, as listed below:

- 49 Marine Avenue Surgery
- Appleby Surgery
- Battle Hill Health Centre
- Beaumont Park Medical Group
- Bewicke Medical Centre
- Collingwood Health Group
- Dr Smith & Partners
- Drs Preston and Austin
- Earsdon Park Medical Practice
- Forest Hall Medical Group
- Garden Park Surgery
- Lane End Surgery
- Marine Avenue Medical Centre
- Monkseaton Medical Centre
- Nelson Medical Group
- Northumberland Park Medical Group
- Park Parade Surgery
- Park Road Medical Practice
- Portugal Place Health Centre
- Priory Medical Group
- Redburn Park Medical Centre
- Spring Terrace Health Centre
- Swarland Avenue Surgery
- The Village Green Surgery
- Wellspring Medical Practice
- West Farm Surgery
- Whitley Bay Health Centre
- Wideopen Medical Centre
- Woodlands Park Health Centre

## 3.1.2. The Clinical Chair of the CCG

Dr John Matthews is the Clinical Chair of the CCG. He is a GP in Wallsend. He was in post at 1 April 2013 and remains in post.

## 3.1.3. The CCG Chief Officer

Maurya Cushlow is the Chief Officer of the CCG and she is the Accountable Officer. She was in post at 1 April 2013 and remains in post.

## 3.1.4. The CCG Council of Practices

The CCG Council of Practices comprises a nominated GP from each of the 29 GP practices that form the CCG. Its terms of reference require it to meet at least four times a year. In 2014/15, The Council of Practices met eight times. Six meetings are planned for 2014/15.

The Chair of the Council of Practices is Dr John Matthews. The Council of Practices is supported by the Clinical Executive Committee and the CCG Governing Body.

## 3.1.5. The CCG Governing Body

The membership of the CCG Governing Body is set out in the CCG constitution.

In January 2015, the Chief Finance Officer, Alison Thompson, went on secondment to a post outside the CCG and Rob Robertson took on the role of Interim Chief Finance; these arrangements remained in place to the end of period covered by this report.

The Local Authority Director of Public Health attends Governing Body meetings. In February 2015 Mrs Marietta Evans left that post and from 4 March 2015 Ms Wendy Burke was Acting Director of Public Health.

Robert Wiggins joined the CCG on 2 March 2015 as Director of CCG Turnaround.

Other than that, members of the Governing Body were in post on 1 April 2013 and remain in post.

Membership of the CCG Governing Body is summarised in the table below. Throughout 2014/15 the Governing Body had four committees, the Audit Committee, the Quality and Safety Committee, CCG Patients' Forum and the Remuneration Committee. In January 2015, the Finance Committee became a committee of the Governing Body.

**Table 9: Membership of the CCG Governing Body**

| Role | Name of post holder |
|---|---|
| Clinical Chair of the CCG | Dr John Matthews |
| Chief Officer and Accountable Officer | Maurya Cushlow |
| Deputy Lay Chair of the CCG | Mary Coyle |
| Lay Member (audit and governance) | David Willis |
| Lay Member (patient and public involvement) | Eleanor Hayward |
| Secondary Care Specialist Doctor | Mr Kyee Han |
| Executive Director of Nursing and Transformation (registered nurse) | Dr Lesley Young-Murphy |
| Medical Director | Dr Martin Wright |
| Chief Finance Officer (on secondment to an NHS Foundation Trust from 19 January 2015) | Alison Thompson |
| Interim Chief Finance Officer (from 19 January 2015) | Rob Robertson |
| **Non-voting members of the Governing Body** | |
| Director of Commissioning Development | Phil Clow |
| North Tyneside Local Authority Director of Public Health (until February 2015) | Mrs Marietta Evans |
| North Tyneside Local Authority Acting Director of Public Health (from 4 March 2015) | Ms Wendy Burke |
| Director of CCG Turnaround (from 2 March 2015) | Robert Wiggins |
| Head of Governance | Pauline Fox |

## 3.1.6. Membership of the CCG Audit Committee

**Table 10: Membership of the CCG Audit Committee**

| Role | Name of post holder |
|---|---|
| Audit committee Chair - Lay Member (audit and governance) | David Willis |
| Deputy Lay Chair of the CCG | Mary Coyle |
| GP member, nominated by the Council of Practices | Dr Richard Scott |

All members of the Audit Committee were in post on 1 April 2014 and remain in post.

More details about the work of the Governing Body and its committees are given in the Governance Statement.

## 3.1.7. The Clinical Executive Committee

The Clinical Executive committee reports directly to the Council of Practices. Its primary role is to implement and deliver the strategic priorities of the CCG, working with the Council of Practices, the Governing Body and the Chief Officer.

**Table 11: Membership of the Clinical Executive Committee**

| Role | Name of post holder |
|---|---|
| Chief Officer and Accountable Officer | Maurya Cushlow |
| Executive Director of Nursing and Transformation | Dr Lesley Young-Murphy |
| Medical Director | Dr Martin Wright |
| Chief Finance Officer | Alison Thompson (to 19 January 2015) |
| Interim Chief Finance Officer | Rob Robertson (from 19 January 2015) |
| Clinical Director | Dr Ruth Evans (GP) |
| Clinical Director | Dr Shaun Lackey (GP) |
| Clinical Director | Dr Caroline Sprake (GP) |
| Practice Manager | Philip Horsfield |
| Director of Commissioning Development | Phil Clow |
| Head of Governance | Pauline Fox |
| Director of CCG Turnaround (from 2 March 2015) | Robert Wiggins |

### 3.1.8. Profiles

Profiles of the individual members of the Governing Body, the Governing Body committees and the Clinical Executive, including the arrangements for the effective management of conflicts of interest are given in the remuneration report.

## 3.2. Relevant discloses for 2014/15

The CCG has not made or received any charitable donations in 2014/15. The CCG is committed to promoting and supporting research and development, as set out in the CCG constitution. There are no significant research and development activities to disclose.

This report provides full details of the CCG activities and financial affairs for the year 1 April 2014 to 31 March 2015. There have been no important events since the end of the financial year and the time of this report affecting the clinical commissioning group. The CCG's plans for the future are set out in the CCG Operational and Strategic Plans. There are no other likely future developments at the clinical commissioning group to be highlighted here. The CCG operates in North Tyneside, with no other branches elsewhere in the UK or outside the UK.

## 3.3. Pension liabilities

The notes to the Financial Statements and the Remuneration Report provide reference to the statements on the relevant pension scheme and indicate how pension liabilities are treated in the accounts.

## 3.4. Sickness absence data

The notes to the financial statements refer to sickness absence. The CCG has an agreed policy on the management of staff absence (policy HR02) which ensures all staff are treated fairly and equitably, with the relevant support from line managers and HR advisors. The CCG has access to occupational health services.

## 3.5. External audit

The Audit Commission appointed Mazars LLP as the CCG's external auditor for the years 2013/14 to 2016/17. The 2014/15 audit fee was £70,000 plus VAT.

The auditors did not perform any non-audit work for the CCG during the 12 month period beginning April 2014.

## 3.6. Disclosure of 'serious untoward incidents'

The Governance Statement gives the details of incidents involving data loss or confidentiality breaches. No such incidents have occurred in the CCG during 2014/15.

## 3.7. Cost allocation and setting of charges for information

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

## 3.8. Principles for Remedy

The CCG's Complaints Policy, references the Parliamentary and Health Service Ombudsman's 'Principles for Remedy' regarding best practice. The complaints policy describes the importance of customer focus and the need to be open and accountable and acting fairly to all complainants regardless of gender, age and ethnic origin. It also describes the CCG's willingness to put things right and endeavour to seek continuous improvement.

No payments have been made in 2014/15 in respect of losses and special payments or in respect of ex gratia payments.

# 3.9. Employee consultation

The CCG has taken positive steps throughout the year to maintain and develop the provision of information to, and consultation with employees, including:

- Providing employees systematically with information on matters of concern to them as employees
- Consulting employees and their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- Encouraging the involvement of employees in the CCG's performance
- Taking actions throughout the year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the CCG
- Membership of the North East Partnership Forum, where staff representatives and CCG managers from across the region meet together

The CCG have an agreed organisational development (OD) plan that has been reviewed in-year. The actions to involve and consult our employees and their representatives have included:

- A weekly 'report out' involving all staff, giving everyone the opportunity to report on work being undertaken, with specific reference to implementing the CCG operational plan
- A series of staff 'lunch and learn' sessions

# 3.10. Disabled employees

The CCG's policy in relation to disabled employees is set out in the Equality Report, above. The CCG has achieved the two tick 'positive about disabled people' symbol awarded by Jobcentre Plus which demonstrates our commitment to employ, retain and develop the abilities of disabled staff.

# 3.11. Preparedness, resilience and response

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013.

The CCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

# 3.12. 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
- 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

Maurya Cushlow
Chief Officer (Accountable Officer)
NHS North Tyneside Clinical Commissioning Group
27 May 2015

# 4. Remuneration report

## 4.1. Remuneration committee membership

The remuneration committee was established to advise the Governing Body about pay, other benefits and terms of employment for the Chief Officer and other senior staff. The committee is comprised entirely of independent members as follows:

| | |
|---|---|
| Mary Coyle | CCG Deputy Lay Chair (Chair) |
| David Willis | CCG Lay Member (Governance and Audit) |
| Eleanor Hayward | CCG Lay Member (Patient and Public Involvement) |

The remuneration committee has delegated authority from the Governing Body to make recommendations on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG.

## 4.2. Remuneration committee meetings

There have been four meetings of the remuneration committee during 2014/15. All meetings were quorate. The CCG Head of Governance attends the Remuneration Committee to assist the committee with record keeping. The Chief Officer and Head of Human Resources (from the Commissioning Support Unit) are in attendance as required.

## 4.3. Remuneration policy

The remuneration for senior managers for current and future financial years is determined in accordance with relevant guidance, best practice and national policy.

Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to any senior managers during the year and there are no plans to make such payments in future years out with the ‘Very Senior Management Pay Framework’. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health.

Contracts of employment in relation to all senior managers employed by the CCG are permanent in nature and subject to six months' notice of termination by either party. The GP leads, practice manager and practice nurse representatives are not directly employed by the CCG, with their services provided through separate agreements between the CCG and the respective GP practices.

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the NHS Pension Scheme Regulations for those who are members of the scheme. No awards have been made during the year to past senior managers.

# 4.4. Salaries and allowances

For the purpose of this remuneration report, the definition of 'senior managers' is as per the Department of Health Group Manual for Accounts (December 2014):

*Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments.*

It is considered that members of the Governing Body and the Clinical Directors are the senior managers of the CCG.

**Notes to salaries and allowances shown in the tables below:**

Comparative information for the prior year is disclosed in the tables.

The Director of Public Health is not employed by the CCG and receives no remuneration from the CCG for their role as a Governing Body member.

The following individuals are not directly employed by the CCG. The amounts here disclosed are paid to the respective GP practice as the employing organisation, to provide the services of the individuals on a sessional basis:

Dr John Matthews
Dr Martin Wright
Dr Ruth Evans
Dr Caroline Sprake
Dr Shaun Lackey

During 2014/15 Rob Robertson, Chief Finance Officer of Northumberland CCG received remuneration from Northumberland CCG for a part-time assignment as Interim CFO at North Tyneside CCG. No recharge was made by Northumberland CCG to North Tyneside CCG as services of a similar value were received by Northumberland CCG from other officers of North Tyneside CCG.

## Table 12: North Tyneside CCG remuneration report 2014/15 (this has been subjected to audit)

| Name | Title | Salary & Fees (bands of £5,000) £000 | Taxable Benefits (Rounded to the nearest £00) £00 | Annual Performance Related Bonuses (bands of £5,000) £000 | Long-term Performance Related Bonuses (bands of £5,000) £000 | All Pension Related Benefits (bands of £2,500) £000 | Total (bands of £5,000) £000 |
|---|---|---|---|---|---|---|---|
| Dr John Matthews ~ | GP & Clinical Chair | 75 - 80 | 0 | 0 | 0 | 0 | 75 - 80 |
| Maurya Cushlow * | Chief Officer | 120-125 | 64 | 0 | 0 | 0 | 130-135 |
| Mary Coyle ~ | Deputy Lay Chair | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| David Willis ~ | Lay Member (audit and governance) | 10 -15 | 0 | 0 | 0 | 0 | 10 - 15 |
| Eleanor Hayward ~ | Lay Member (patient and public involvement) | 5 - 10 | 0 | 0 | 0 | 0 | 5 - 10 |
| Kyee Han ~ | Secondary Care Doctor | 5 - 10 | 0 | 0 | 0 | 0 | 5 - 10 |
| Dr Lesley Young-Murphy | Director of Transformation and Executive Nurse | 95 - 100 | 2 | 0 | 0 | 2.5 - 5 | 100 - 105 |
| Alison Thompson ^ | Chief Finance Officer | 80 - 85 | 0 | 0 | 0 | 15 – 17.5 | 100 - 105 |
| Rob Robertson $ | Interim Chief Finance Officer | 0 | 0 | 0 | 0 | 0 | 0 |
| Dr Martin Wright ~ | GP & Medical Director | 75 - 80 | 0 | 0 | 0 | 0 | 75 - 80 |
| Phil Clow | Director of Commissioning Development | 80 - 85 | 14 | 0 | 0 | 0 – 2.5 | 80 - 85 |
| Dr Ruth Evans ~ | GP & Clinical Director | 55 - 60 | 0 | 0 | 0 | 0 | 55 - 60 |
| Dr Shaun Lackey ~ | GP & Clinical Director | 50 - 55 | 0 | 0 | 0 | 0 | 50 - 55 |
| Dr Caroline Sprake ~ | GP & Clinical Director | 25 - 30 | 0 | 0 | 0 | 0 | 25 - 30 |
| Pauline Fox ~ | Head of Governance | 45 - 50 | 0 | 0 | 0 | 7.5 - 10 | 55 - 60 |
| Robert Wiggins | Director of CCG Turnaround | 30 - 35 | 0 | 0 | 0 | 0 | 30 - 35 |

Taxable benefits are shown in £00 and all relate to lease cars.
All pensions related benefits information is provided by NHS Pensions. Clarification and confirmation of reported values has been requested from NHS Pensions
~ indicates post holders with less than a full time commitment to the CCG
* This includes a car allowance of £5k owed for 2013/14 and 2014/15, both amounts which were paid in 2014/15
^ post holder on secondment from January 2015 but remained on the CCG payroll
$ The post holder did not receive any remuneration from North Tyneside CCG for a part-time assignment as Interim CFO at North Tyneside CCG during 2014/15

## Table 13: North Tyneside CCG remuneration report 2013/14 (this has been subjected to audit)

| Name | Title | Salary & Fees (bands of £5,000) £000 | Taxable Benefits (Rounded to the nearest £00) £00 | Annual Performance Related Bonuses (bands of £5,000) £000 | Long-term Performance Related Bonuses (bands of £5,000) £000 | All Pension Related Benefits (bands of £2,500) £000 | Total (bands of £5,000) £000 |
|---|---|---|---|---|---|---|---|
| Dr John Matthews ~ | GP & Clinical Chair | 75 - 80 | 0 | 0 | 0 | 0 | 75 - 80 |
| Maurya Cushlow | Chief Officer | 110 -115 | 57 | 0 | 0 | 110 – 112.5 | 225 - 230 |
| Mary Coyle ~ | Deputy Lay Chair | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| David Willis ~ | Lay Member (audit and governance) | 10 - 15 | 0 | 0 | 0 | 0 | 10 - 15 |
| Eleanor Hayward ~ | Lay Member (patient and public involvement) | 5 - 10 | 0 | 0 | 0 | 0 | 5 - 10 |
| Kyee Han ~ | Secondary Care Doctor | 5 - 10 | 0 | 0 | 0 | 0 | 5 - 10 |
| Dr Lesley Young-Murphy | Director of Transformation and Executive Nurse | 95 - 100 | 3 | 0 | 0 | 17.5 - 20 | 115 - 120 |
| Alison Thompson | Chief Finance Officer | 80 - 85 | 0 | 0 | 0 | 17.5 - 20 | 100 - 105 |
| Dr Martin Wright ~ | GP & Medical Director | 75 - 80 | 0 | 0 | 0 | 0 | 75 - 80 |
| Phil Clow | Director of Commissioning Development | 75 - 80 | 11 | 0 | 0 | 47.5 - 50 | 125 - 130 |
| Dr Ruth Evans ~ | GP & Clinical Director | 60 - 65 | 0 | 0 | 0 | 0 | 60 - 65 |
| Dr Shaun Lackey ~ | GP & Clinical Director | 60 - 65 | 0 | 0 | 0 | 0 | 60 - 65 |
| Dr Caroline Sprake ~ | GP & Clinical Director | 25 - 30 | 0 | 0 | 0 | 0 | 25 - 30 |
| Pauline Fox ~ | Head of Governance | 45 - 50 | 0 | 0 | 0 | 67.5 - 70 | 115 - 120 |
| Robert Wiggins ^ | Director of CCG Turnaround | | | | | | |

~ indicates post holders with less than a full time commitment to the CCG
^ post holder not in post at North Tyneside CCG in 2013/14

## Table 14: North Tyneside CCG senior officers pension benefits 2014/15 (this has been subjected to audit)

| Name and Title | Real increase in pension at age 60 (bands of £2,500) £000 | Real increase in Pension Lump Sum at aged 60 (bands of £2,500) £000 | Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £000 | Lump Sum at aged 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 31 March 2014 £000 | Cash Equivalent Transfer Value at 31 March 2015 £000 | Real increase in cash equivalent transfer value £000 | Employer's contribution to partnership pension £000 |
|---|---|---|---|---|---|---|---|---|
| Maurya Cushlow Chief Officer | 0 - 2.5 | 0 – 2.5 | 45 – 50 | 135 – 140 | 749 | 797 | 28 | 16 |
| Phil Clow Director of Commissioning Development | 0 – 2.5 | 0 – 2.5 | 15 – 20 | 50 – 55 | 205 | 224 | 13 | 11 |
| Pauline Fox Head of Governance | 0 – 2.5 | 0 – 2.5 | 20 – 25 | 60 – 65 | 359 | 391 | 22 | 7 |
| Alison Thompson Chief Finance Officer | 0 – 2.5 | 0 – 2.5 | 0 – 5 | 0 | 17 | 34 | 16 | 12 |
| Lesley Young-Murphy Director of Transformation and Change | 0 – 2.5 | 0 – 2.5 | 20 – 25 | 60 – 65 | 364 | 399 | 25 | 14 |

## Table 15: North Tyneside CCG senior officers pension benefits 2013/14 (this has been subjected to audit)

| Name and Title | Real increase in pension at age 60 (bands of £2,500) £000 | Real increase in Pension Lump Sum at aged 60 (bands of £2,500) £000 | Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000 | Lump Sum at aged 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 31 March 2013 £000 | Cash Equivalent Transfer Value at 31 March 2014 £000 | Real increase in cash equivalent transfer value £000 | Employer's contribution to partnership pension £000 |
|---|---|---|---|---|---|---|---|---|
| Maurya Cushlow Chief Officer | 5 – 7.5 | 15 – 17.5 | 40 – 45 | 130 – 135 | 625 | 749 | 111 | 16 |
| Phil Clow Director of Commissioning Development | 0 – 2.5 | 5 – 7.5 | 15 – 20 | 45 – 50 | 164 | 205 | 37 | 11 |
| Pauline Fox Head of Governance | 2.5 – 5 | 7.5 – 10 | 20 – 25 | 60 – 65 | 287 | 359 | 66 | 7 |
| Alison Thompson Chief Finance Officer | 0 – 2.5 | 0 | 0 – 5 | 0 | 1 | 17 | 16 | 12 |
| Lesley Young-Murphy Director of Transformation and Change | 0 – 2.5 | 2.5 – 5 | 15 – 20 | 55 – 60 | 322 | 364 | 35 | 14 |

# 4.5. Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

# 4.6. Real increase in cash equivalent transfer values

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

# 4.7. Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in North Tyneside CCG in the financial year 2014/15 was £130 – 135k (2013/14 £120 – 125k). This was 3.4 times (2013/14, 3.5) the median remuneration of the workforce, which was £38,586 (2013/14, £34,530).

In 2014/15, no employee received a full time equivalent remuneration in excess of the highest paid director. Full time equivalent remuneration for employees ranged from £15,013 to £98,610 (2013/14 £15,850 to £98,753).

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

**Table 16: Pay multiples (this has been subjected to audit)**

| | 2014/15 | 2013/14 |
|---|---|---|
| Band of Highest Paid Director's Total Remuneration (£'000) | 130 - 135 | 120 - 125 |
| Median Total Remuneration (£) | 38,586 | 34,530 |
| Ratio | 3.4 | 3.5 |

# 4.8. Off-payroll engagements as of 31 March 2015

As at 31 March 2015, the CCG off-payroll engagements, for more than £220 per day and that have lasted longer than six months are indicated in the table below. The majority of these individuals are GPs.

**Table 17: Off payroll engagement**

| | Number |
|---|---|
| Number of existing arrangements as of 31 March 2015 | 21 |
| *Of which the number that have existed:* | |
| · For less than one year at the time of reporting | 3 |
| · For between one and two years at the time of reporting | 18 |
| · For between 2 and 3 years at the time of reporting | 0 |
| · For between 3 and 4 years at the time of reporting | 0 |
| · For 4 or more years at the time of reporting | 0 |

Off-payroll engagements, as outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought, as indicated in table below.

**Table 18: New off-payroll engagements between 1 April 2014 and 31 March 2015, for more than £220 per day and that last longer than 6 months**

| | Number |
|---|---|
| Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015 | 3 |
| Number of the above which included contractual clauses giving North Tyneside CCG the right to request assurance in relation to Income Tax and National Insurance obligations | 3 |
| Number for whom assurance has been requested | 3 |
| *Of which:* | |
| · assurance has been received | 0 |
| · assurance has not been received | 3 |
| · engagements terminated as a result of assurance not being received | 0 |

The CCG had off-payroll engagements with some Governing Body members and/or senior officials with significant financial responsibilities between 1 April 2014 and 31 March 2015, as reported in the table below.

**Table 19: On payroll and off-payroll arrangements**

| | Number |
|---|---|
| Number of off-payroll engagement of Governing Body members and of senior officers with a significant financial responsibility during the financial year | 6 |
| Number of individuals that have been deemed to be Governing Body members and of senior officers with a significant financial responsibility during the financial year (this figure includes both off-payroll and on-payroll engagements) | 14 |

The figures in this table include all substantive members of the CCG Governing Body and the Clinical Directors, as listed in the Members Report. The local authority Director of Public Health and the Interim Chief Finance Officer received no remuneration from the CCG and are not included in these figures.

# 4.9. Governing body and Clinical Director profiles

## 4.9.1. Council of Practices

The CCG Council of Practices is the membership body of the CCG. It comprises a GP representative from each of the 29 Member Practices, acting on behalf of the practice in dealings with the CCG and to representing the Member Practice at meetings of the Council of Practices. The Council of Practices is chaired by Dr John Matthews.

## 4.9.2. Clinical Chair of the CCG

### Dr John Matthews, GP & Clinical Chair

John is senior partner and a GP trainer in Park Road Medical Practice, Wallsend where he has worked for the past 24 years. He has previously been Practice Based Commissioning Clinical Director and has a postgraduate certificate in Public Sector Commissioning. As the Clinical Chair, he is the senior clinical voice of the CCG and is committed to developing the CCG as a member led organisation that works effectively with local partners. John chairs the CCG Council of Practices and the CCG Governing Body. Externally he represents the CCG on the North Tyneside Health and Wellbeing Board. His contractual commitment to the CCG is five sessions per week, which is the equivalent of five half-days.

# 4.9.3. Chief Officer of the CCG

### Maurya Cushlow, Chief Officer

Maurya is a registered nurse, with a clinical and managerial background spanning over 30 years in the North East and the West Midlands. Her qualifications include RGN, BA (Hons), MBA and a postgraduate certificate in business and executive coaching. She has held a variety of senior positions contributing locally and nationally to policy development. Maurya is the CCG Accountable Officer, responsible for making sure that the CCG carries out its statutory duties as outlined in the NHS Health and Social Care Act 2012. She is a member of the CCG Governing Body and the Finance Committee and the Chair of the CCG Clinical Executive Committee. She is a member of the North Tyneside Health and Wellbeing Board, she chairs the North Tyneside Integration Board and she is a member of the North East Clinical Senate. Maurya is a full time employee of the CCG.

# 4.9.4. Governing Body members

The Governing Body members were all in post ready for the start of the CCG on 1 April 2013 and all remained in post throughout 2014/15, except as reported here.

### Mary Coyle MBE, DL, Deputy Lay Chair

Formerly chair of North Tyneside Primary Care Trust and Vice Chair of NHS North of Tyne, Mary is a freelance leadership consultant who moved to Tyneside from Northern Ireland over 40 years ago. Mary is the Deputy Chair of the Governing Body, the Chair of the Quality and Safety Committee and the Chair of the Remuneration Committee. Mary is a member of the Audit Committee. Mary's contractual commitment to the CCG is a minimum of one day per week.

### David Willis, Lay Member (audit and governance)

David is an accountant by profession and works as a senior manager at Department of Work and Pensions. He was the Audit Chair for the North Tyneside Primary Care Trust and for NHS North of Tyne Joint Board prior to being appointed as the Lay Member for Audit and Governance at North Tyneside CCG. David is the Chair of the Audit Committee and a member of the Finance Committee and the Remuneration Committee. David's contractual commitment to the CCG is a minimum of two days per month.

### Eleanor Hayward, Lay Member (Patient and Public Involvement)

Eleanor Hayward lives in Tynemouth and has had a long and varied career in the NHS and local government mainly in the field of human resources and development. She has considerable experience in organisational development in the UK and developing countries and has been involved in various projects to encourage public involvement in the provision of public services. Eleanor is the Chair of the Patients

Forum, the Chair of the Finance Committee and a member of the Remuneration committee. Eleanor's contractual commitment to the CCG is a minimum of one and a half days per month.

### Kyee Han, Secondary Care Doctor

Kyee has worked as a Consultant in Accident and Emergency Medicine at Middlesbrough General and the James Cook University Hospital for the past 24 years and has also been employed by the North East Ambulance Service NHS Foundation Trust as Medical Director (part-time) since 2010. He brings a wealth of knowledge and a secondary care perspective to the CCG and is keen to promote patient-centred care combined with efficient use of NHS resources. Kyee is a member of the Quality and Safety Committee. Kyee's contractual commitment to the CCG is two sessions per month, which is the equivalent of two half-days.

### Dr Martin Wright, GP & Medical Director

Martin is a senior partner at Portugal Place Heath Centre, Wallsend, where he has worked for over 20 years. He is particularly interested in service improvement and transformation, especially in General Practice. His main responsibilities in the CCG are the quality of commissioned services, medicines optimisation, individual funding requests and primary care quality and development. Martin is a member of the Governing Body, the Quality and Safety Committee and the Clinical Executive Committee. He chairs the Northumbria Healthcare NHS Foundation Trust quality review group and the regional medicines use and guidelines group. Martin's contractual commitment to the CCG is five sessions per week, which is the equivalent of five half-days.

### Dr Lesley Young-Murphy, Director of Transformation and Change and Executive Nurse

Lesley is a nurse, midwife, health visitor, organisational development practitioner and manager with over 35 years' experience working in the UK and Saudi Arabia. She has held a number of clinical and managerial roles in relation to community and hospital care as well as organisational development. She has a PhD and is a visiting research fellow at Northumbria University. Lesley is a member of the Quality and Safety Committee and a member of the Clinical Executive Committee. Lesley is a full time employee of the CCG

### Alison Thompson, Chief Finance Officer

Alison has 20 years of experience in senior roles in the public sector in finance, HR, governance and IT across the Department of Work and Pensions and the Department for Environment, Food and Rural Affairs. She joined the NHS in February 2013 as Chief Finance Officer for the newly formed CCG and is responsible for the financial management and performance of the CCG ensuring taxpayers' money is spent appropriately and effectively for North Tyneside residents. She is a Fellow of the Institute of Chartered Accountants in England and Wales. Alison is a member of the CCG Governing Body and the Clinical Executive. She is a full time employee of the CCG.

### Rob Robertson, Interim Chief Finance Officer (from 19 January 2015)

Rob has over 14 years' experience of working in finance posts in the NHS, in both primary and secondary care. Rob also continues to be the Chief Finance Officer at Northumberland CCG.

## 4.9.5. Non-voting members of the Governing Body

### Phil Clow, Director of Commissioning Development

Phil joined the NHS in 2008 bringing over 10 years of experience as a manager in the public sector. Phil worked with a local NHS Community Provider before taking up a commissioning role. Phil is responsible for commissioning and improving services to meet local need within North Tyneside CCG's budget. Phil attends the Governing Body as a non-voting member and he is a member of the Clinical Executive Committee. Phil is a full time employee of the CCG.

### Marietta Evans, Director of Public Health

Marietta Evans was the Director of Public Health (DPH) for North Tyneside until February 2015. The DPH is a statutory Chief Officer of the Council with responsibility to maximise the health and wellbeing of the population of North Tyneside. Marietta was previously the DPH for North Tyneside Primary Care Trust/North Tyneside Council and prior to that was the DPH for South Tyneside, with a career in the NHS spanning over 25 years. Marietta is a fellow of the Faculty of Public Health and is on the UK Public Health Register.

### Wendy Burke, Acting Director of Public Health

Wendy is an experienced registered public health specialist and Fellow of the Faculty of Public Health. She has had a career in the NHS spanning 27 years as a nurse, health visitor and clinical manager, and from 4 March 2015 she was the Acting Director of Public Health of North Tyneside Council. Wendy works in close partnership with the CCG.

### Pauline Fox, Head of Governance

Pauline's NHS career spans 30 years, including national and local roles in acute, mental health and community services. Her qualifications include an MBA, MA, a postgraduate certificate in Commissioning and an advanced certificate in Health Service Governance. Pauline attends the Governing Body, the Audit Committee and the Remuneration committee and she is a member of the Quality and Safety committee and the Clinical Executive Committee. Pauline's contractual commitment to the CCG is 30 hours per week.

### Robert Wiggins, Interim Turnaround Director

Robert joined the CCG and Interim Turnaround Director on 2 March 2015. He has over 20 years' experience in organisation financial turnaround, including significant

experience of NHS commissioning organisation turnaround. He is a Director of the Institute for Turnaround.

## 4.9.6. Clinical Directors

The Clinical Directors were all in post from April 2013 and all remain in post.

### Dr Ruth Evans, GP and Clinical Director

Ruth has over 20 years' experience as a GP in Wallsend, always with a passion for service re-design. Ruth is currently responsible for mental health, children and young people, families and maternity, as well as health improving services and public satisfaction. Ruth is a member of the Clinical Executive Committee, with a contractual commitment to the CCG of four sessions per week, which is the equivalent of four half-days.

### Dr Shaun Lackey, GP and Clinical Director

Shaun has been a GP partner at Woodlands Park Health Centre at Wideopen for nine years. He is interested in applying system and process thinking to improve patient care. As a Clinical Director for the CCG, he is responsible for urgent and planned care and is the clinical lead for the secondary care and community services contracts. Shaun is a member of the Clinical Executive committee. Shaun's contractual commitment to the CCG is four sessions per week, which is the equivalent of four half-days.

### Dr Caroline Sprake, GP and Clinical Director

Caroline has been a GP partner at Lane End Surgery in Benton for 23 years. She has a commitment to improve the quality of care for patients with long-term conditions such as diabetes and Chronic Obstructive Pulmonary Disease (COPD), to ensure greater patient involvement in their own care and support the training of the workforce to complement this approach. She leads on long-term conditions at the CCG. She is an Associate Sub-Dean for Community and Primary Care at Newcastle University and a GP Respiratory Advisor on COPD Programme at Northumbria Healthcare NHS Foundation Trust. Caroline is a member of the Clinical Executive Committee. Caroline's contractual commitment to the CCG is two sessions per week, which is the equivalent of two half-days. Caroline has decided to stand down from her post as Clinical Director from April 2015 but will remain involved with the CCG.

# 4.9.7. Registers of interests

The CCG has as duty under the Health and Social Care Act 2012 to manage conflicts of interest, as reflected in CCG constitution. The effective management of conflicts of interests is a key issue in the management of risk in the CCG.

The CCG registers of interests for the Governing Body, the CCG Committees, the CCG staff and the Register of Member Practice Interests are all in place. The registers are actively reviewed by the Deputy Lay Chair and Head of Governance at least quarterly. This includes assessing each declaration as either 'no risk', 'potential risk' or 'actual risk' and taking steps as required. If necessary, further information is obtained. The registers are posted on the CCG website, refreshed as a result of the oversight with the date of the posted register is clearly shown.

In December 2014, on receipt of revised national guidance on effective management of conflicts of interest, the CCG's policies and processes were reviewed. This particularly took into account the forthcoming changes in the CCG role in Primary Care co-commissioning.

The Governing Body and Clinical Directors register of interest as at 31 March 2015 is given below in full, with a note of significant changes in year.

Maurya Cushlow
Chief Officer (Accountable Officer)
NHS North Tyneside Clinical Commissioning Group
27 May 2015

## Table 20: Register of interests - Governing Body and Clinical Directors (as at 31 March 2015)

| Position held on | Surname | Forename | Self/Status | Company/Organisation | Brief Details of Interest | Significant changes notes in year |
|---|---|---|---|---|---|---|
| Clinical Chair | Matthews | John | Self | Park Road Medical Practice<br>Wallsend Memorial Hall and People's Café<br>TyneHealth Ltd (North Tyneside GP Federation) | Partner<br>Trustee (Provider and Community Facilitator)<br>Partner in a GP Practice that is a shareholder of TyneHealth | No longer a member of CIC<br>Practice is no longer minority shareholder in Freeman Clinics (from January 2015) |
| | | | Wife | Newcastle Upon Tyne Hospitals NHS FT | Consultant in Palliative Care Medicine | |
| Deputy Lay Chair | Coyle | Mary | Self | Newcastle University Pension Trustee Limited<br>Tyne Gateway Trust<br>Lionra (network to foster North East/Irish collaboration)<br>Northumbrian Water Forum<br>Gentoo Group Board | Trustee member<br><br>Member of Advisory Board<br>Committee member<br><br>Board member<br>Non-Executive board member | No longer a Director and trustee of Tyne & Wear Archives & Museums Development Trust |
| Secondary Care Doctor | Han | Kyee | Self | North East Ambulance Services NHS FT<br>Great North Air Ambulance Service<br>South Tees Hospitals NHS FT | Medical Director (p/t)<br><br>Trustee<br><br>A&E consultant (Part time) | |
| Lay Member | Hayward | Eleanor | Self | Northumbria Police Commissioner/Chief Constable | Lay Member, Joint Audit Committee | Stood down from role Magistrate in 2014 |
| | | | Daughter | North Tyneside Council | Business Advisor, HR | |
| Lay Member | Willis | David | Self | Nothing to declare | | |
| Chief Officer | Cushlow | Maurya | Self | Marden High School | Community Governor | |
| Chief Finance Officer | Thompson | Alison | self | Nothing to declare | Associate Director of Finance | On secondment to Hartlepool and North Tees Hospitals NHS Foundation Trust (from 19 January 2015) |

| Position held on | Surname | Forename | Self/Status | Company/Organisation | Brief Details of Interest | Significant changes notes in year |
|---|---|---|---|---|---|---|
| Interim Chief Finance Officer | Robertson | Rob | Self | Northumberland CCG | Chief Finance Officer | Interim CFO at North Tyneside CCG from 19 January 2015 |
| Registered Nurse - Director of Transformation and Change | Young Murphy | Lesley | Self | University of Northumbria at Newcastle | Visiting fellow | |
| Medical Director | Wright | Martin | Self | Portugal Place Health Centre<br>Slaters Bridge Group<br><br>TyneHealth Ltd (North Tyneside GP Federation) | Partner<br>Director - advisory body (not fee earning)<br>Partner in a GP Practice that is a shareholder of TyneHealth<br>Practice Manager is a Director | Practice is no longer minority shareholder in Freeman Clinics (from January 2015) |
| | | | Wife | NHS Improving Quality | Director | |
| | | | Sister in Law | Newcastle Hospitals NHS FT | Consultant - Palliative Care | |
| | | | Friend | Connect Physical Therapy | CEO | |
| Director of Commissioning Development | Clow | Phil | Wife | Securicare (Private healthcare provider) | Employed as a nurse | |
| Director of Public Health | Evans | Marietta | | | | Stood down from post at North Tyneside Council in February 2015; no longer a member of the CCG Governing Body |
| Acting Director of Public Health | Burke | Wendy | Self | North Tyneside Council | Employed as Consultant in Public Health | Acting Director of Public Health from 4 March 2015 |
| Head of Governance | Fox | Pauline | | Nothing to declare | | |

| Position held on | Surname | Forename | Self/Status | Company/Organisation | Brief Details of Interest | Significant changes notes in year |
|---|---|---|---|---|---|---|
| Director of Turnaround | Bob | Wiggins | Self | Hertford Partners Limited<br>Hertford Partners (North) Limited<br>Institute for Turnaround<br>Kings Langley Management Company<br>Give a Kidney - One's enough | Director<br>Director<br><br>Director<br>Director<br><br>Charity Trustee | Joined the CCG on 2 March 2015 |
| Clinical Director | Evans | Ruth | Self | Taking Part Workshop CIC<br>Village Green Surgery<br>Action Foundation<br>TyneHealth Ltd (North Tyneside GP Federation) | Director (CIC) (paid employment)<br>Partner<br>Director – unpaid<br>Partner in a GP Practice that is a shareholder of TyneHealth | Practice is no longer minority shareholder in Freeman Clinics (from January 2015)<br>Norprime subsumed into TyneHealth ltd. |
| Clinical Director | Lackey | Shaun | Self | Woodlands Park Health Centre<br>TyneHealth Ltd (North Tyneside GP Federation) | Partner<br>Partner in a GP Practice that is a shareholder of TyneHealth; Practice Manager is a Director | |
| | | | Wife | Woodlands Park Health Centre | Salaried GP | |
| Clinical Director | Sprake | Caroline | Self | Lane End Surgery<br>Newcastle University<br>Northumbria Healthcare FT<br>TyneHealth Ltd (North Tyneside GP Federation) | Partner<br>Associate sub-dean for community and primary care<br>GP respiratory advisor on COPD programme<br>Partner in a GP Practice that is a shareholder of TyneHealth | |

# 5. Statement by the Accountable Officer

The NHS Act 2006 (as amended) states that each clinical commissioning group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of the clinical commissioning group.

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the 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 NHS 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 Government Financial Reporting Manual and in particular to:

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

Maurya Cushlow
Chief Officer (Accountable Officer)
NHS North Tyneside Clinical Commissioning Group
27 May 2015

# 6. Governance statement by the Chief Officer as the Accountable Officer of NHS North Tyneside Clinical Commissioning Group

## 6.1. Introduction and context

NHS North Tyneside Clinical Commissioning Group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006. As at 1 April 2014, the clinical commissioning group continued to be licensed without conditions.

The CCG comprises 29 GP practices and is co-terminus with North Tyneside Council.

## 6.2. Scope of responsibility

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

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

## 6.3. UK Corporate Governance Code

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

# 6.4. The NHS North Tyneside Clinical Commissioning Group Governance Framework

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

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

This section of the governance statement includes information about the CCG governance arrangements, including describing the composition and work of the Governing Body and other committees of the CCG.

## 6.4.1. CCG Constitution

The CCG had a fully compliant constitution at the time of authorisation, endorsed by the member practices and approved by NHS England. The terms of office for CCG lay members, the Clinical Chair and the Secondary Care Specialist Doctor are set out in the Constitution.

During the course of 2014/15 the CCG Constitution has been reviewed. Application was made to NHS England in December 2014 for some minor changes to be made. The proposed changes were approved by NHS England in January 2015. A further application was made to NHS England in January 2015 for changes to be made to the CCG Constitution in respect of co-commissioning primary care services, to take effect from April 2015. These changes were approved by NHS England in March 2015. The revised Constitution was posted on the CCG website with effect from 1 April 2015. The CCG Constitution is a public document.

The CCG governance structure is described in detail in the CCG Constitution.

## 6.4.2. Council of Practices

The 29 nominated member practice representatives meet together as the Council of Practices. The responsibilities of the Council of Practices are set out in the CCG Constitution and there are agreed terms of reference. It sets the strategy and enables practices to influence the strategic direction and priorities of the group.

The Council of Practices is chaired by the Clinical Chair of the CCG, who is also chair of the Governing Body. The Medical Director, Clinical Directors and GP Practice Managers attend the Council of Practices but are not voting members. The

Council of Practices has considered the advantages of identifying a Vice Chair and in March 2015 Dr James Lunn was elected by the members to this role from April 2015.

The Council of Practices is required by its terms of reference to meet no less than four times a year. It has met eight times in the 12 month period starting 1 April 2014. The Council of Practices undertook a self-assessment in February 2015 and the results were reported back to the membership in March 2015.

During 2014/15, discussions at meetings of the Council of Practices included:

- *Commissioning for quality* – the CCG commissioning plan, urgent care, planned care, winter planning, benchmarking of the commissioning of services of low clinical value, nominating a GP to sit on the CCG Quality and Safety Committee
- *Finance and performance* – budget updates, updates on the financial recovery plan, Quality, Innovation, Productivity and Prevention (QIPP), performance updates and 2015/16 budget for approval.
- *Strategy* – development of 2015/16 commissioning priorities and plans, the development of New Models of Care, urgent care, primary care co-commissioning (with NHS England)
- *Governance and assurance* – proposed changes to the CCG constitution, effective management of conflicts of interest, and arrangements for the Governing Body members whose term of office were due to expire.
- *Development* – key development issues have included the development of locality working, the development of New Models of Care and clinical ownership of the CCG finance recovery plans.
    - The four localities - Wallsend, Whitley Bay, North Shields and North West - are now an established way of working, with a clinical and managerial lead, agreed work plans and formal links into the Clinical Executive.
    - New Models of Care – in addition to the discussions at Council of Practice meetings, there has been strong GP participation in the New Models of Care development workshops and ‘blue printing’ events
    - Financial recovery plans – in addition to the regular discussions at Council of Practice meetings, there has been GP participation in the focussed workshops and strong clinical leadership in the CCG QIPP work.

## 6.4.3. Clinical Executive Committee

The Clinical Executive Committee reports directly to the Council of Practices. The responsibilities of the Clinical Executive are set out in the CCG Constitution and there are agreed terms of reference. Its primary role is to implement and deliver the strategic priorities of the CCG, working with the Council of Practices and the Governing Body. It is chaired by the Chief Officer. The Clinical Executive

membership comprises the Chief Officer, Medical Director, three (GP) Clinical Directors, a nominated Practice Manager, the three CCG Directors and the CCG Head of Governance. It meets twice a month.

The Clinical Executive Committee has met 22 times in the 12 month period starting 1 April 2014. Main items of business have included:

- Commissioning for quality – managing elective healthcare, winter planning, urgent care, 2015/16 commissioning intentions, reviewing, effective management of prescribing, current and future arrangements for community contracts, developing plans for the Better Care Fund, 2015/16 contracts.
- Finance and performance – the CCG monthly performance report, with a focus on actions to address on areas where the CCG is an outlier, financial position, continuing financial pressures and the CCG financial recovery plan, QIPP and preparation for and feedback from the CCG assurance meetings with NHS England Area Team.
- Strategy – primary care co-commissioning, progress on the North Tyneside Health and Social Care Integration Programme, the development and implementation of the IM&T strategy, mental health service transformation, the development of New Models of Care
- Governance and assurance – risk management and risk registers and the effective management of conflicts of interest

## 6.4.4. CCG Governing Body

The Governing Body is constituted in line with the Health and Social Care Act 2012, and associated CCG regulations. The membership of the NHS North Tyneside CCG Governing Body is set out in the CCG Constitution. Throughout the year beginning 1 April 2014 and up to the point of this report, the membership has comprised:

Voting members:

- Dr John Matthews, Clinical Chair
- Mary Coyle, Deputy Lay Chair
- David Willis, Lay Member for governance and audit
- Eleanor Hayward, Lay Member for Patient and Public Involvement
- Mr Kyee Han, Secondary Care Specialist Doctor
- Maurya Cushlow, Chief Officer
- Dr Martin Wright, Medical Director
- Alison Thompson, Chief Finance Officer (on secondment to an NHS Foundation Trust from 18 January 2015)
- Rob Robertson, Interim Chief Finance Officer (from 19 January 2015)

- Dr Lesley Young-Murphy, Executive Director of Nursing and Transformation

Non-voting members:

- Phil Clow, Director of Commissioning Development
- Marietta Evans, local authority Director of Public Health (DPH) (to February 2015)
- Wendy Burke, local authority Acting DPH (from 4 March 2015)
- Robert Wiggins, Director of CCG Turn-around (from 9 March 2015)
- Pauline Fox, Head of Governance

The Governing Body has a key role to play in the CCG; it assures the decision making process of the CCG and oversees the delivery of the duties of the CCG.

The Standing Orders state that the Governing Body will meet no less than four times per year. During the year beginning 1 April 2014, the CCG Governing Body has met seven times, six times in public with papers posted in public in advance of the meeting and notices placed inviting public attendance. On each of those occasions, members of the public have attended.

The 2013/14 Annual Accounts and Annual Report were presented in public at the CCG Annual Public Meeting on 22 July 2014.

Throughout the year the CCG Governing Body was supported by four Committees, each chaired by a lay member of the Governing Body: the Audit Committee, the Remuneration Committee, the Quality and Safety Committee and the Patient Forum. The Finance Committee was formally established as a committee of the Governing Body in January 2015.

The CCG Governing Body receives regular reports from the committees of the Governing Body on quality of commissioned services and on finance and performance. Other items of business discussed in 2014/15 have included:

- Commissioning for quality –regular reports from the Quality and Safety Committee, oversight of the CCG's work in response to the Department of Health report, 'Transforming care: A national response to Winterbourne View hospital,' oversight of the CCG's response to the Francis report, and the opportunities and challenges presented by the panned opening of the Northumbria Specialist Emergency Care Hospital
- Finance and performance – reports of CCG performance against plan, including NHS Constitution measures, NHS Outcomes Framework and Quality Premium standards, receipt and assurance of the 2014/15 CCG budget and the 2015/16 CCG budget. Oversight has included the wider CCG's financial position, continuing financial pressures and, in January 2015, the sanctioning of the CCG declaring a deficit position for 2014/15 following discussions with the NHS Area Team. The Governing Body endorsed the

development of the CCG financial recovery plan, strengthened with the formation of the Finance Committee in January 2015.

- Strategy – the CCG operational and strategic planning priorities for 2014/15, the development of New Models of Care, urgent care, system resilience and winter planning, health and social care integration, Better Care Fund plans, the CCG membership and participation in the North Tyneside Health and Wellbeing Board and co-commissioning of primary care services.
- Governance and assurance – oversight of the CCG risk assurance framework, the development of the CCG Constitution, oversight of the effective management of conflicts of interest, approval of the revised Standards of Business Conduct policy, approval of the revised complaints policy, approval of the CCG Equality Objectives and the review of the Terms of Reference for all Governing Body committees.
- Development – in addition to the formal meetings held during the year, there has been a development programme including four Governing Body development sessions. In these sessions members have considered: the Governing Body self-assessment and development (June 2014), the Prevent agenda and adult safeguarding (October 2014), detailed discussion of finance and performance reporting (December 2014) and CCG Financial Recovery Plan and New Models of Care (February 2015).

## 6.4.5. Audit Committee

The Audit Committee is a committee of the Governing Body. It was in operation throughout the 12 month period starting 1 April 2014 and has continued to operate since the period end. The objective of the committee is:

- To provide assurance to the Governing Body and to me through an independent and objective view of internal control.

The Audit Committee has agreed terms of reference. The committee is comprised entirely of independent members, as follows:

- David Willis, CCG Lay Member for Governance and Audit (Chair)
- Mary Coyle MBE, CCG Deputy Lay Chair
- Dr Richard Scott, GP nominee of the CCG Council of Practices

All members have been in post continuously from 1 April 2014 and remain in post.

The CCG Internal and External Auditors, Chief Finance Officer, Head of Finance and Head of Governance routinely attend the Audit Committee; the Chief Officer attends at least annually and the Counter Fraud Officer has a standing invitation.

In accordance with the Terms of Reference, the Audit Committee meets not less than five times per financial year. In 2014/15 the Audit Committee met seven times. On each occasion, Audit Committee members meet privately and then with the

internal and external auditors prior to the CCG officers joining the meeting. The Audit Committee Chair provides a written briefing to all members of the CCG Governing Body after each meeting of the Audit Committee.

The Audit Committee's main activities throughout the 12 month period starting 1 April 2014 have been:

- Finance and performance – receiving regular reports form the CFO on the CCG's financial position, reports on the CCG financial recovery plan, receipt of independent review of the CCG financial recovery plan, in-depth review of consultant to consultant referrals and of the increasing costs of maternity services and receipt of a report on the Better Care Fund.
- Governance and assurance:
  - Overseeing the risk management processes across the CCG;
  - Seeking assurances over all high risk areas and their mitigation plans, including the review of the CCG conflicts of interests policy to embed the December 2014 NHS England revised guidance;
  - Oversight of the CCG Prescribing Engagement Scheme;
  - Approval of the Practice Activity Scheme
  - Taking assurances on quality and safety
  - Receiving audit reports in-year and
  - Reviewing the annual report and annual accounts for the Governing Body.
- Development – members of the Audit Committee participated in a half day training session in September 2014, covering auditor's assessment of Value for Money.

The Audit Committee completed a self-assessment of its operation and effectiveness during 2014/15. In December 2014 a detailed on-line questionnaire (based on the new NHS Audit Committee handbook) was circulated to all members and attendees of the CCG Audit Committee. The collated responses were discussed in detail at the January 2015 meeting of the Audit Committee. An action plan was drawn up and presented to the Audit Committee at its March meeting.

## 6.4.6. Remuneration Committee

The Remuneration Committee was in operation throughout the 12 month period starting 1 April 2014 and has continued to operate since the period end. The roles and responsibilities of the committee are set out in the CCG Constitution. The Remuneration Committee has agreed terms of reference. The remit is to:

- Make recommendations to the CCG Governing Body on the approach to pay and remuneration for employees of the CCG and people who provide services to the CCG and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

The committee is comprised entirely of lay members, as follows:

- Mary Coyle MBE, CCG Deputy Lay Chair (Chair)
- David Willis, CCG Lay Member for Governance and Audit
- Eleanor Hayward, CCG Lay Member for Patient and Public Involvement

All members were in post at the time of CCG authorisation, all have been in post continuously from 1 April 2014 and remain in post.

The CCG Head of Governance attends the Remuneration Committee and the Chief Officer and Head of Human Resources (from the Commissioning Support Unit) are in attendance as required.

When an individual is the subject matter of discussion at any time during the committee meeting, that individual is excluded from the meeting. The Quoracy for the meeting is two members. As there are three members the committee remains quorate even when a member is excluded.

The terms of reference require that the Remuneration Committee will meet at least annually, with no more than 15 months between meetings. The Remuneration Committee has met four times in the period from 1 April 2014 to the time of this report. The principal items of business were:

- Consideration and approval of the CCG 2013/14 remuneration report (part of the CCG annual report)
- Remuneration of CCG Chief Officer, Chief Finance Officer and CCG Very Senior Managers (VSMs), in line with national guidance
- Remuneration of Secondary Care Specialist Doctor, Clinical Chair, Medical Director, Clinical Directors, Clinical Leads and Practice Managers who undertake sessional work for the CCG, for which there is currently no national guidance
- Remuneration of CCG lay members in line with national guidance
- Arrangements for the reimbursement of expenses for CCG lay members, Clinical Chair, Medical Director, Clinical Director and Clinical Leads
- Arrangements for review of the terms of office that would expire on 31 March 2015

## 6.4.7. Quality and Safety Committee

The Quality and Safety Committee was in operation throughout the 12 month period starting 1 April 2014 and has continued to operate since the period end. The roles and responsibilities of the committee are set out in the CCG Constitution. The objective of the committee is:

- To be responsible for ensuring the appropriate governance systems and processes are in place to commission, monitor and ensure the delivery of high quality safe patient care in commissioned services.

The Quality and Safety Committee has agreed terms of reference. The Committee comprises:

- Mary Coyle, Deputy Lay Chair (Chair of the Committee)
- Mr Kyee Han, Secondary Care Specialist Doctor
- Dr Martin Wright, Medical Director
- Dr Lesley Young Murphy, CCG Registered Nurse and Director of Transformation and Change
- Maurya Cushlow, Chief Officer
- Alice Southern, Practice Manager nominated by the Council of Practices
- Pauline Fox, Head of Governance
- Sharon Haggerty, Head of Quality and Patient Safety
- Dr James Lunn, GP nominee of the CCG Council of Practices (from January 2015)

The Quality and Safety Committee has met a total of 10 times in the year from 1 April 2014 to 31 March 2015. On one occasion the committee was not quorate, and consequently all decisions required were deferred to the next meeting. The Quality and Safety Committee undertook a self-assessment in May 2014 and this was repeated in March 2015, with the results fed-back and discussed at the April 2015 meeting.

The Quality and Safety Committee's main activities throughout the period starting 1 April 2014 have been:

- Commissioning for quality, including review of CCG performance
    - The development, monitoring and review the CCG's vision for commissioning services that are safe, high quality and clinically effective;
    - The receipt of reports on the quality of commissioned services, the review of risks arising and monitoring progress in implementing recommendations and action plans;
    - The receipt of reports on clinical risks, incident reporting, serious incidents, 'Never Events', complaints, claims and safety alerts; and the monitoring of progress in the implementation of recommendations and action plans;
    - Oversight of the CCG's detailed work across the health economy on the implementation of national reports including the Francis report, the Savile Inquiry and the Keogh report;
    - Oversight of the CCG's detailed work on the Winterbourne report;

- Monitor ratings and any other relevant sources of external assurance;
- The receipt and scrutiny of independent investigation reports relating to patient safety issues;
- Receipt and review of the Quality Accounts of NHS Foundation Trusts;
- The receipt of reports on the management of infection control performance, especially health care acquired infections;
- The receipt of reports to ensure that appropriate strategies and training plans are in place for safeguarding of children and vulnerable adults, pertaining to the CCG's safeguarding duties;
- The review of the role of the CCG in assuring quality in primary care, working in conjunction with NHS England whilst recognising the CCG's strengthened role;
- The receipt of reports regarding research and the use of research.

· Strategy – the provision of advice and assurance to the Governing Body on the development of policy, strategy and practice in respect of equality, diversity and human rights (supported through the Equality Delivery System), including the Equality Diversity and Human Rights Annual Report to ensure the statutory and legal obligations of the CCG are met

· Governance and assurance – oversight of the relevant risk registers, receipt and approval of policies and action plans for the identification, assessment and prioritisation of potential risk (including quality and patient safety, financial risk including regarding health and safety, emergency preparedness, business continuity and information governance), oversight of Information Governance (IG), including the completion of the IG toolkit

· Development – at the Quality and Safety Committee meeting in February 2015 an inclusive approach to a committee self-assessment of effectiveness was agreed. It was conducted during March and reported to the April 2015 meeting of the committee.

## 6.4.8. Patient Forum

The Patient Forum was in operation throughout the 12 month period starting 1 April 2014 and has continued to operate since the period end. There have been seven meetings of the patient forum in the 12 month period starting April 2014. Eleanor Hayward, CCG Lay Member and Chair of the Patient Forum has attended all seven meetings.

The Patient Forum assists the CCG in its duty to secure public involvement in the planning, development and operation of commissioning arrangements, providing a clear patient and carer voice direct to the Governing Body.

The Patient Forum is chaired by the CCG Lay Member for Public and Patient Involvement and facilitated by the North Tyneside Community and Health Care

Forum. It aims to have membership from each of the 29 GP Practices in North Tyneside. Agenda items for the Forum are a mix of CCG areas for discussion and member led issues. The Patient Forum is strong, robust and acts as a critical friend to the CCG and its Governing Body. Members are encouraged to challenge and debate throughout all engagement processes. The strength of the Forum is the dedication and commitment within the membership as well as their passion for local health services.

The Patient Forum has been involved in a range of activities including:

- Development Session to establish the Member Work Plan in line with their areas of special interest as well as CCG commissioning intentions and priorities
- Northumberland Tyne & Wear Mental Health Foundation Trust-presentation to inform and discuss service changes
- Draft Continuing Healthcare document-content and implications presented to Members for discussion and feedback
- Members heard of the next steps for New Models of Care and members attended some/all of the four NMC development sessions
- CCG Five Year Plan - Members received and (with a patient emphasis) discussed the document
- Members discussed National Breastfeeding Week and what we could do in North Tyneside with a Public Health Specialist
- Parking difficulties at North Tyneside General Hospital were discussed with an Estates Manager from Northumbria Healthcare Foundation Trust
- An interesting information exchange on generic prescribing with the Medicines Optimisation Pharmacist

### Patient Forum Working Groups

There are currently five Working Groups, all chaired by Clinicians or senior personnel. The Working Groups topics were decided by Forum Members and are compatible with CCG Strategic Plan and Priorities:

- Self Care Working Group
- Older People Working Group
- End of Life Care Working Group
- Mental Health and Social Prescribing Working Group
- Health and Wellbeing Working Group

The Patient Forum has a programme of work planned throughout 2015/16.

# 6.4.9. Finance Committee

The Finance Committee was established in January 2015 and remains in place. The terms of reference for the committee were formally approved by the Governing Body in March 2015. The remit of the committee is to:

- Oversee the current and projected financial position of the CCG and work on the financial recovery plan in relation to this to provide assurance to the Governing Body.
- The duties of the committee are driven by the priorities identified by the CCG and the associated risks. The committee shall;
  - Review the latest financial position to seek assurance that the planned outturn is deliverable
  - Perform deep dives into the main parts of the recovery plan on a rolling basis
  - Assess the impact of any current schemes on the next financial year and advise if more action is necessary to mitigate financial risks (such as but not limited to the current risk share schemes)
  - Recommend whether the actions in the CCG assurance framework are sufficient to mitigate risk
  - Provide assurance to the CCG and its Governing Body and Audit Committee as necessary

The committee membership is as follows:

- Eleanor Hayward, CCG Lay Member for Patient and Public Involvement (Chair)
- David Willis, CCG Lay Member for Governance and Audit
- Maurya Cushlow, Chief Officer,
- Rob Robertson, Interim Chief Finance Officer
- Primary Care representative

The terms of reference require that the Finance Committee will meet monthly. The committee has met five times during the period January to March 2015 and continues to meet. The principle items of business were the CCG Financial Recovery Plan (FRP), deep dives into key pressure areas (including continuing health care, prescribing costs and all QIPP projects) and the reports from external consultants on the development and implementation of the FRP.

# 6.4.10. Attendance records for CCG Governing Body and committees

The attendance records for the Council of Practices, Governing Body and associated committees for 2014/15 are given in the following tables: .

**Table 21: Council of Practices attendance records 2014/15**

| Name/practice | Total (out of 8) |
|---|---|
| Dr John Matthews, Clinical Chair and Chair of Council of Practices | 8 |
| 49 Marine Avenue | 7 |
| Appleby Surgery | 7 |
| Battle Hill Health Centre | 7 |
| Beaumont Park | 6 |
| Bewicke Medical Centre | 8 |
| Collingwood Health Group | 6 |
| Dr Smith & Partners | 5 |
| Drs Preston and Austin | 8 |
| Earsdon Park Medical Practice | 6 |
| Forest Hall Medical Group | 6 |
| Garden Park Surgery | 6 |
| Lane End Surgery | 7 |
| Marine Avenue Medical Centre | 8 |
| Monkseaton Medical Centre | 8 |
| Nelson Medical Group | 5 |
| Northumberland Park Medical Group | 8 |
| Park Parade Surgery | 8 |
| Park Road Medical Practice | 8 |
| Portugal Place Health Centre | 7 |
| Priory Medical Group | 6 |
| Redburn Park Medical Centre | 8 |
| Spring Terrace Health Centre | 8 |
| Swarland Avenue Surgery | 7 |
| The Village Green Surgery | 5 |
| Wellspring Medical Practice | 8 |
| West Farm Surgery | 8 |
| Whitley Road Health Centre | 8 |
| Wideopen Medical Centre | 7 |
| Woodlands Park Health Centre | 7 |

## Table 22: Governing Body and Committee attendance records 2014/15

| Name | Post Held | Governing Body<br>Actual attendances<br>Possible attendance | Clinical Executive<br>Actual attendances<br>Possible attendance | Audit Committee<br>Actual attendances<br>Possible attendance | Q&S committee<br>Actual attendances<br>Possible attendance | Remuneration Committee<br>Actual attendances<br>Possible attendance | Finance Committee<br>Actual attendances<br>Possible attendance |
|---|---|---|---|---|---|---|---|
| Dr John Matthews [1] | Clinical Chair | 7 / 7 | | | | | |
| Mary Coyle [2] | Deputy Lay Chair | 7 / 7 | | 5 / 7 | 10 / 10 | 4 / 4 | |
| Maurya Cushlow [3] | Chief Officer | 7 / 7 | 20 / 22 | 2 | 2 / 10 | | 4 / 5 |
| David Willis [4] | Lay Member (audit) | 7 / 7 | | 7 / 7 | | 4 / 4 | 5 / 5 |
| Eleanor Hayward [5] | Lay Member (PPI) | 7 / 7 | | | | 3 / 4 | 5 / 5 |
| Kyee Han | Secondary Care Doctor | 4 / 7 | | | 7 / 10 | | |
| Alison Thompson | Chief Finance Officer | 4 / 5 | 15 / 17 | 5 / 5 | | | |
| Rob Robertson | Interim Chief Finance Officer | 2 / 2 | 5 / 5 | 0 / 2 | | | 5 / 5 |
| Lesley Young Murphy | Director of Transformation & Executive Nurse | 7 / 7 | 18 / 22 | | 10 / 10 | | |
| Dr Martin Wright | Medical Director | 6 / 7 | 19 / 22 | | 9 / 10 | | 2 / 5 |
| Phil Clow | Director of Commissioning Development | 6 / 7 | 18 / 22 | | | | |
| Marietta Evans | North Tyneside Council DPH | 4 / 6 | | | | | |
| Wendy Burke | North Tyneside Council Acting DPH | 1 / 1 | | | | | |
| Robert Wiggins | Director of CCG Turn-around | 1 / 1 | 2 / 2 | | | | |

[1] Chair of Governing Body
[2] Chair of Quality and Safety Committee and Chair of Remuneration Committee
[3] Chair of Clinical Executive: as Chief Officer, required to attend Audit Committee at least once per year
[4] Chair of Audit Committee
[5] Chair of Patient Forum and Chair of Finance Committee

| Name | Post Held | Governing Body<br>Actual attendances<br>Possible attendance | Clinical Executive<br>Actual attendances<br>Possible attendance | Audit Committee<br>Actual attendances<br>Possible attendance | Q&S committee<br>Actual attendances<br>Possible attendance | Remuneration Committee<br>Actual attendances<br>Possible attendance | Finance Committee<br>Actual attendances<br>Possible attendance |
|---|---|---|---|---|---|---|---|
| Pauline Fox[6] | Head of Governance | 7 / 7 | 18 / 22 | 6 / 7 | 9 / 10 | 4 / 4 | |
| Dr Ruth Evans | Clinical Director | | 19 / 22 | | | | |
| Dr Caroline Sprake | Clinical Director | | 13 / 22 | | | | |
| Dr Shaun Lackey | Clinical Director | | 18 / 22 | | | | |
| Philip Horsfield | Practice Manager, Clinical Executive Member | | 19 / 22 | | | | |
| Dr Richard Scott | GP, Audit Committee member | | | 6 / 7 | | | |
| Dr James Lunn | GP, Q&S Committee member | | | | 3 / 3 | | |
| Sharon Haggerty | Head of Quality and Patient Safety, Q&S committee member | | | | 9 / 10 | | |
| Alice Southern | Practice Manager Q&S Committee Member | | | | 2 / 10 | | |

[6] Member of Clinical Executive and Quality and Safety Committee; in attendance at Governing Body, Audit Committee and Remuneration Committee.

### 6.4.11. Conclusion of the review of the Governance Framework

The CCG Governance Arrangements were subject to an internal audit in 2013, with an outcome of 'significant assurance' reported to the Audit Committee in November 2013. This indicated that no significant issues were identified by the auditors to bring to the attention of the CCG managers, Audit Committee, Governing Body or me, in my role as Accountable Officer.

The Head of Internal Audit Opinion for 2014/15 noted that in a number of areas information was not flowing through the organisation in a consistent way, or as envisaged in committee terms of reference and differences between the information reported to different committees or groups, particularly in the early part of the financial year. As the Head of Internal Audit observed that the CCG has taken action to address the issues, including clarification about the committee structures to ensure accurate and timely reporting.

This review of the CCG Governance Framework, including information about the CCG governance arrangements describing the composition and work of the Governing Body and other committees of the CCG and the observations of the Head of Internal Audit, has indicated that the CCG has appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

## 6.5. The Clinical Commissioning Group risk management framework

### 6.5.1. Embedding risk management

Risk management is embedded in the work of the CCG, with the aim of preventing risks where possible and taking mitigating action to minimise the occurrence of risks that are unpreventable. This is done through:

- The Risk Management Policy and supporting procedures
- The committee structures described earlier in this report
- The effective management of conflicts of interests
- Management processes, including, for example, the maintenance of effective risk registers
- The Risk Assurance Framework

- The CCG programme of statutory and mandatory training
- The commissioning of effective commissioning support services, including, for example, information governance support and advice
- Building a counter fraud culture

## 6.5.2. CCG risk management policy

The key elements of the CCG Risk Management Policy are designed to identify and control risks, including potential risks to finance, reputation, compliance, health and safety including risks of an operational or strategic nature. The CCG risk management policy was approved by the CCG Governing Body in January 2014.

The aims of the Risk Management Policy are summarised as follows:

- To ensure that risks to the achievement of the CCG's objectives are understood and effectively managed
- To ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed
- To assure the public, patients, staff and partner organisations that the CCG is committed to managing risk appropriately
- To protect the services, staff, reputation and finances of the CCG through the process of early identification of risk, risk assessment, risk control and elimination

This policy applies to all employees and contractors of the CCG. All staff at every level of the organisation are required to recognise that risk management is their personal responsibility.

## 6.5.3. Risk identification

Risks are systematically identified. Risk management is discussed at departmental team meetings. The CCG quality and safety officer, who administers the risk register, meets with Directors and/or attends departmental meetings regularly to discuss risks, to assist in the recording of risks and to support colleagues in identifying and effectively managing risks.

Risks are highlighted in committee papers and committee discussions. The Head of Governance attends the Council of Practices, the Governing Body, committees of the Governing Body and the Clinical Executive. She has as key role in identifying risks to the achievement of corporate objectives, supporting colleagues in effective risk management and advising on the escalation of risks in line with the risk management policy.

## 6.5.4. Risk appetite

Risk appetite is the organisation's unique attitude towards risk taking that in turn dictates the amount of risk considered acceptable. It is the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time. The Governing Body has a responsibility to maintain a strategic view of the organisation's risk appetite, as set out in the Risk Management Policy.

The CCG Governing Body has noted that effective risk management is integral to the work of the CCG in delivering against its corporate objectives and in its stewardship of public funds. It has agreed that more time needs to be spent on risk appetite and suggested that it should be further discussed in a Governing Body development session in May 2015.

## 6.5.5. Risk assessment

In order to ensure that appropriate controls are put in place to eliminate the risk or mitigate its effect a standard risk matrix is used across the CCG, based on current national guidance provided by the National Patient Safety Agency.

## 6.5.6. Risk grading and risk registers

The risk management policy sets out the responsibilities of the CCG Committees, lead officers and staff members in respect of identification and management of risks.. The risk management policy sets out the arrangements for the escalation of risk.

## 6.5.7. Risk Assurance Framework

The Risk Assurance Framework is predicated on risks to the achievement of the CCG corporate objectives. The Assurance Framework was considered by the CCG Governing Body Committees throughout the year, with risks and the management of those risks actively reviewed. The CCG Governing Body considered the Assurance Framework in public session in September 2014 and January 2015 and March 2015.

## 6.5.8. Working with stakeholders and partners

The CCG works in partnership with a wide range of key partners, including with the Council of the Borough of North Tyneside, providers of health care (including NHS Foundation Trusts, GPs, nursing home providers and other independent sector, voluntary, community and third sector providers). The CCG also works closely with a number of stakeholder groups, such as the Community and Healthcare Forum. The CCG strives to ensure that work carried out across the health and social care

economy adheres to the CCG's principles of robust risk management. Partnerships can involve high levels of risk because of their complexity and potential lack of clarity in the roles and responsibilities of those involved. The risk management policy refers to the arrangements that are required to mitigate the risks.

### 6.5.9. Counter fraud culture

The CCG has taken positive steps to instil a counter fraud culture. There is an anti-Fraud policy in place, covering counter fraud and bribery. This is alongside the Standards of Business Conduct Policy. The Audit Committee has approved the Counter Fraud plan and received progress reports on this. Counter fraud publicity information is publically displayed in the CCG premises.

There has been no fraud issues reported in the CCG during the period 1 April 2014 to the date of this report.

## 6.6. The Clinical Commissioning Group internal control framework

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

- A Governing Body that ensures that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance
- An approved CCG constitution, incorporating Standing Orders, Scheme of Delegation and Prime Financial Policies
- A committee structure, where each committee has a vital role in contributing to the establishment of an effective governance infrastructure
- An appointed Accountable Officer who is responsible (amongst other duties) for ensuring that the clinical commissioning group fulfils its duties to exercise its functions effectively, efficiently and economically thus ensuring improvement in the quality of services and the health of the local population whilst maintaining value for money. By working closely with the chair of the Governing Body, the Accountable Officer will ensure that proper constitutional, governance and development arrangements are put in place to

assure the members (through the Governing Body) of the organisation's ongoing capability and capacity to meet its duties and responsibilities.

- An appointed Chief Finance Officer who is responsible for (amongst other duties) overseeing robust audit and governance arrangements leading to propriety in the use of the CCG's resources
- Staff members are responsible for reporting problems of operations, monitoring and improving their performance, and monitoring non-compliance with the corporate policies and various professional codes, or violations of policies, standards, practices and procedures.

## 6.6.1. Internal audit service

One important feature of the system of internal control is the work of the Internal Audit service. Through a systematic programme of work Internal Audit provide assurance on key systems of control. The Head of Internal Audit reports to the Audit Committee and has direct access to the Audit Committee Chair as required.

## 6.6.2. Assurances from outsourced support services

The CCG relies on several external support services providers, including the NHS Shared Business Service (SBS), Electronic Staff Records (ESR) (McKesson) and the NHS Business Services Authority (BSA). These organisations traditionally provide service auditor reports as part of the evidence of assurance required by their customers. These reports have just been issued and no issues of concern have been highlighted to the CCG during the period 1 April 2014 to 31 March 2015 and up to the time of this report.

The Head of Internal Audit has taken the third party assurances into account when forming her opinion. She has advised that the CCG should independently consider what assurance can be taken from the reports and what, if any, weaknesses should be included in this governance statement.

Payroll services are provided by the Payroll Bureau hosted by Northumbria Healthcare NHS Foundation Trust. NHS North Tyneside CCG is a member of the Payroll consortium and attends consortia meetings and no concerns have been reported at those meetings during 2014/15. Through its membership of the Payroll Consortium, the CCG receives an annual assurance letter setting out the results of the internal audit work carried out during the year. This letter was issues on 29 April 2015, confirming that there have been no concerns identified during the period 1 April 2014 to 31 March 2015.

The CCG has outsourced a range of support services to the North of England Commissioning Support Unit (NECS), hosted by NHS England. Assurances on the operation of these services during 2014/15 are provided by NHS England's internal

auditors, Deloitte LLP, via means of two IASE 3402 reports covering the period 1 April 2014 to 31 March 2015. The first report, covering 6 months from 1 April 2014, was issued in December 2014. The second report, covering the period 1 October 2014 to 31 March 2015 was issued in May 2015. There were some minor weaknesses in the operation of controls identified in the report, none were considered significant.

At the Audit Committee meetings in January and May 2015, the Audit Committee concluded that the reported weaknesses were not sufficiently material to require a formal response.

## 6.6.3. Policies

Another key feature of the system of internal control is the application of a range of policies and procedures. The CCG has a suite of policies in place, including corporate policies, HR policies, and Information Governance policies. Each policy has a named director lead, their implementation has been monitored and reviews undertaken as necessary in-year.

The CCG Quality and Safety Committee received an assurance report in February 2015 on matters including statutory and mandatory training, compliance with health and safety, fire safety and first aid at work. There is commitment to Continuing Professional Development, with robust processes in place for staff supervision, training, objective setting, performance review and appraisal.

## 6.6.4. Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. Authority for managing information governance (IG) has been delegated to the CCG Quality and Safety Committee. The Chief Finance Officer is the Senior Information Risk Officer (SIRO) and the Interim CFO took on this responsibility as part of his role. The Medical Director is the Caldicott Guardian.

The CCG has a suite of information governance processes and procedures in place as reported through the information governance toolkit submission. All staff undertake annual information governance training to ensure staff are aware of their information governance roles and responsibilities. The Quality and Safety Committee

was formally advised in February 2015 that all CCG staff had completed their annual IG training for 2014/15.

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

# 6.7. Risk Assessment in relation to Governance, risk management and internal control

## 6.7.1. Risks identified in 2014/15

The Governing Body, supported by the Clinical Executive Committee, Audit Committee, Quality and Safety Committee and latterly the Finance Committee maintained an oversight of the risks to the CCG from April 2014 to the time of this report.

In addition to the directors of the CCG taking a strong lead in risk management, each committee has delegated responsibility for reviewing the risks to specified corporate objectives:

- Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution – risks reviewed by the Quality and Safety Committee
- Develop and grow North Tyneside CCG as a patient focused, clinically led commissioning organisation – risks reviewed by the Clinical Executive Committee
- Work collaboratively with partners and stakeholders to be responsive to the population of North Tyneside – risks reviewed by the Clinical Executive Committee
- Lead and influence the development of health and social care fit for the future – risks reviewed by the Clinical Executive Committee
- Deliver financial balance – risks reviewed by the Audit Committee and by the Finance Committee

The effective management of conflicts of interest is essential to the probity and transparency of CCG business and has remained under review throughout the year. The CCG registers of interests for the Governing Body, the CCG Committees, the CCG staff and the Register of Member Practice Interests are all in place. In January 2015 the Governing Body approved a revised version of the CCG's Standards of

Business Conduct Policy, which had been reviewed to reflect the most recent NHS England guidance on the management of conflicts of interest.

The key risk to the CCG during 2014/15 was achieving financial breakeven. The position has remained under review throughout the year, with attention paid to eliminating and mitigating risks and ensuring emerging risks were identified and managed. This is considered in detail in the review of economy, efficiency and effective use of resources.

## 6.7.2. Risks to compliance with the CCG licence

As at 1 April 2013, NHS North Tyneside Clinical Commissioning Group was licensed without conditions. During the course of 2014/15, there have been no issues identified that may risk the CCG's compliance.

## 6.7.3. Risk assurance at the close of 2014/15

At the January 2015 meeting of the Governing Body, the principal risks to achieving the corporate objectives and the management of those risks were formally reviewed, by way of the Assurance Framework. The Governing Body requested that further work was undertaken regarding the recoding and rating of risks to corporate objective 5, 'achieving financial balance' This work was conducted, overseen by the Audit Committee and was reported to the Governing Body in public session in April 2015.

As at 31 March 2015 the CCG Risk Assurance Framework showed a total of 11 risks rated as 'extreme' (rated between 15 and 25).

**Table 23: Summary of risks rated 'extreme' at close of 2014/15**

| | Initial risk score (Likelihood x consequences) | Residual risk score |
|---|---|---|
| **Objective 1:** Commission high quality care for patients, that is safe, value for money and in line with the NHS Constitution' | 8 | 5 |
| **Objective 2:** Develop and grow North Tyneside CCG as a patient focused, clinically led commissioning organisation | 0 | 0 |
| **Objective 3:** Work collaboratively with partners and stakeholders to be responsive to the population of North Tyneside | 3 | 2 |
| **Objective 4:** Lead and influence the development of health and social care fit for the future | 1 | 0 |
| **Objective 5:** Deliver financial balance' | 8 | 6 |

## 6.7.4. Risk assurance at the start of 2015/16

The CCG faces a number of current and future risks and has clear arrangements in place to identify and mitigate those risks.

The CCG corporate objectives have been reviewed and revised objectives for 2015/16 were approved by the Governing Body on 28 April 2015.

- Commission high quality care for patients that is safe, value for money and in line with the NHS Constitution
- Develop and grow North Tyneside CCG as a patient focused, clinically led commissioning organisation
- Deliver year 1 of the Financial Recovery Plan, leading to sustainable financial balance and delivery of the CCG's statutory financial duties
- Work collaboratively with partners and stakeholders to be responsive to the population of North Tyneside
- Lead and influence the development of health and social care fit for the future

## 6.7.5. NHS England Assurance Framework

In addition to the assurances provided by management processes, the work of the Internal Auditors and External Auditors and oversight of the Governing Body and CCG committees, the CCG is subject to the national assurance process, including

the completion and submission of the 'Assurance Framework Delivery Dashboard'. The CCG has regular dialogue with the NHS England Area Team and participates in the formal assurance process.

## 6.8. Review of economy, efficiency and effectiveness of the use of resources

North Tyneside CCG has a duty to use resources economically, efficiently and effectively. The CCG budget comprises the commissioning budget and the operating budget. The 2014/15 budget setting process was assured by the Governing Body and the budget was approved by the Council of Practices in March 2014. A similar process has been followed for the 2015/16 budget. Material changes to the CCG budget are subject to the approval of the Council of Practices.

The CCG commissioning budget is deployed to commission healthcare for the population of North Tyneside, in line with national guidance. The CCG works in close partnership with local healthcare providers. Regular contract monitoring meetings and Quality Review Group meetings are held with all the principal providers. A Quality, Innovation, Productivity and Prevention (QIPP) savings programme has been in place throughout the year.

In respect of the CCG operating budget, there is an agreed staffing structure, balancing the roles of clinical leaders, including the Chair, Medical Director, Director of Nursing, Clinical Director and Clinical Leads. CCG staff are organised into three Directorates, working to the Chief Finance Officer, the Director of Transformation and Executive Nurse and the Director of Commissioning Development. The remuneration committee sets the remuneration of Very Senior Managers and Clinical Leaders (for whom there are no national pay scales). The Senior Management Team ensures that remuneration for posts in the CCG structure is in line with national guidance, to ensure consistency between posts. The CCG operating budget remained under close scrutiny throughout the year and savings were identified to be redeployed to the commissioning budget.

As indicated in the review of risk management, governance and internal control, the duty to ensure expenditure does not exceed income was the greatest risk faced by the CCG throughout 2014/15.

**Duty to ensure expenditure does not exceed income -** In 2013/14 a small surplus of £163k was recorded, despite an underlying deficit position driven by over-activity. It was stated in the 2013/14 Annual Governance Statement that the challenging financial position was likely to continue in 2014/15, requiring continuing management attention and financial resilience. As anticipated, 2014/15 has been a challenging year financially and significant budget pressures have emerged.

The CCG warned in-year that, despite close monitoring and measures to manage financial pressures, it was forecasting a deficit in excess of £6m for the 2014/15 financial year. The closing position of the CCG was a deficit of £6.4m.

From the start of 2014/15 the Governing Body was aware of the financial challenges facing the CCG. The 2014/15 CCG budgets were approved by the Council of Practices on 26 March 2014, with the process assured by the Governing Body.

The 2014/15 budgets showed a balanced position but required the delivery of an £8m QIPP (Quality, Innovation, Productivity and Prevention) savings programme. The effects of over activity in 2013/14 were off-set by risk share arrangements and non-recurrent year-end adjustments but the underlying deficit of £4.8m impacted 2014/15.

The Council of Practices, Governing Body and its committees have all received regular reports on the CCG budget position throughout the year. The financial position of the CCG and progress against its recovery plan was discussed at every meeting of the CCG Governing Body.

In September 2014 the Chief Finance Officer reported that a 6 month financial stock-take was being conducted and advised that the CCG was heavily reliant on QIPP savings being delivered in the second half of the financial year. As a result of the stock-take, the CCG invited independent advisors (PwC) to assess the CCG's recovery plan.

Detailed discussions at the Governing Body meeting in November 2014 included consideration of several options to address the urgent financial situation. A similar discussion took place at the Council of Practices meeting the same month, building on the regular finance reports received at the committee and recognising the need to continue to build clinical engagement to address the underlying activity issues.

The independent review of the CCG's recovery plan was that 55% of the CCG QIPP planned savings were at risk of non-delivery. Based on the stock-take, the independent review and discussions with relevant partners, the CCG forecast a deficit in excess of £6m for the 2014/15 financial year. These findings were reported to the Audit Committee and Governing Body in January 2015.

The PwC review also recommended the establishment of a Programme Management Office, the establishment of a Finance Committee and the preparation of a CCG three to five year Strategic Financial Recovery Plan. The CCG is implementing the recommendations and is continuing to work with partners and stakeholders to put effective arrangements in place.
Internally, action has been taken to put in place the resources and governance structures to deliver the Financial Recovery Plan:

- The Finance Committee was established as a committee of the Governing Body, chaired by CCG lay member, with its inaugural meeting on 23 January 2015

- An experienced Turnaround Director came into post in March 2015, for a 6 month period
- A Project Management Office has been established and is being embedded into the normal working of the CCG, together with additional staff from the Commissioning Support Unit and increased capacity in the CCG finance function
- CCG Clinical Directors have been given redefined roles, to combine a corporate portfolio with specific clinical leadership responsibility for each locality to ensure a clear line of sight between members and the executive functions of the CCG

The CCG continues to work intensively with partners and stakeholders to develop and implement the CCG Financial Recovery Plan (FRP). The FRP is a detailed document describing the historical financial position, causes for the underlying deficit and CCG plans over a three year period to bring the CCG back into surplus.

The CCG has been supported by external advisors to prepare the FRP and the process has also involved a wide range of partners and has included, for example, detailed benchmarking work to identify potential areas of savings. To achieve the financial recovery plan through and with the membership, the CCG will focus on four areas:

- Managing demand - through longer term and short term measures to deliver elective and non-elective demand within identified benchmarks through active engagement with both Primary care and Secondary care providers
- Delivery of a reviewed, revised and refocused QIPP - strengthening QIPP programme management capacity and capability to provide sustainable effective, development, monitoring, reporting and support of QIPP delivery
- Provider Contract Management - engaging with providers to support QIPP delivery through strong contract management
- Whole system change - implementing at pace the agreed long term strategic solutions in particular across the older persons pathway and New Models of Primary Care.

On 13 February 2015, following the CCG forecast of a budget deficit for 2014/15, the CCG's external auditor issued a report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998 for the anticipated breach of financial duties, as indicated in the notes to the accounts.

The headline 2015/16 CCG budgets were approved by the Council of Practices on 25 March 2015.

# 6.9. Review of the effectiveness of Governance, risk management and internal control

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

## 6.9.1. Capacity to handle risk

The Risk Management Policy describes the roles and responsibilities of the CCG directors, senior management team and staff members.

- The Council of Practices has delegated responsibility to the Governing Body for establishing a scheme of governance
- The CCG Chief Officer has overall responsibility for strategic direction and operational management, including ensuring that CCG's process documents comply with all legal, statutory and good practice guidance requirements. This is delegated to senior managers as follows:
    - The Director of Transformation / Executive Nurse and the Medical Director are together responsible for providing advice and assurance to the Governing Body and Clinical Executive on the quality and safety of commissioned services, contributing to the dialogue and challenge at the Governing Body and Clinical Executive
    - The Medical Director has particular responsibility for domains 1, 2 and 3 of the NHS Outcomes Framework. The Medical Director is the Caldicott Guardian for the CCG. The Medical Director brings specific medical expertise to the commissioning of safe and sustainable services
    - The Director of Transformation and Executive Nurse brings a broader view, from her perspective as a registered nurse, on health and care issues to underpin the work of the CCG especially the contribution of nursing to patient care. She has particular responsibility for domains 4 and 5 of the NHS Outcomes Framework. She brings specific nursing expertise to the commissioning of safe and sustainable services
    - The Chief Finance Officer has responsibility for:
        - Providing professional advice to the CCG Governing Body on the effective, efficient and economic use of the CCG's financial allocation and to identify risks to the delivery of required financial targets and duties
        - Ensuring robust risk management and audit arrangements are in place to make appropriate use of the CCG's financial resources

- Ensuring appropriate arrangements are in place to identify risks and mitigating actions to the delivery of QIPP savings and resource-releasing initiatives
- Leading on the assessment and overall management of risks pertaining to Information Governance, undertaking the role of Senior Information Risk Officer
- Incorporating risk management as a management technique within the financial performance management arrangements for the organisation

o The Head of Governance is the CCG's lead for risk management and has responsibility for ensuring risk management systems are in place throughout the CCG and operating effectively

o The Senior Leads and all staff, including agency staff, have a responsibility to incorporate risk management within all aspects of their work

## 6.9.2. Review of effectiveness

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

The Assurance Framework itself provides me with evidence that the effectiveness of controls to manage the risks to the CCG achieving its objectives have been reviewed.

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

The CCG directors, senior managers and staff who have responsibility for the development and maintenance of systems of internal control provide me with assurance. In addition to the responsibility for risk management within their areas of control, the CCG directors also have corporate responsibility as members of the CCG Governing Body.

The CCG has continued to work with NHS England throughout the year, including participating in regular assurance meetings and detailed discussions about the development and implementation of the Financial Recovery Plan.

In particular, throughout the year, there are some key methods that the CCG uses to be assured that the system of internal control is effective:

- **The Audit Committee** – the Annual Internal Audit Plan, as approved by the Audit Committee, enables the CCG to be assured that key internal financial controls and other matters relating to risk are regularly reviewed. The committee has reviewed Internal and External Audit Reports and has kept the Assurance Framework under review throughout the year
- **The Quality and Safety Committee** – this committee provides assurance to the Governing Body that there are adequate controls in place to ensure the CCG is delivering on its statutory and non-statutory clinical duties and responsibilities
- **The Finance Committee** – established as a committee of the Governing Body in January 2015 to oversee the current and projected financial position of the CCG and work on the financial recovery plan to provide assurance to the Governing Body
- **Review of the CCG Constitution** – the CCG Constitution was reviewed during 2014. The proposed changes were agreed with the member Practices and approved by NHS England

Assurances from outsourced services have all been satisfactory in 2014/15, as reported in section 6.6.2 of this report.

## 6.9.3. The 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 ***limited assurance*** can be given.

*The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the CCG's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the CCG in the completion of its Annual Governance Statement.*

*My opinion is set out as follows:*

1. *Overall opinion*
2. *Basis for the opinion*
3. *Commentary*

*My **overall opinion** is **limited assurance** as inconsistent application of controls put the achievement of the organisation's objectives at risk in the areas reviewed. The key themes identified from our work across systems are weaknesses:*

- *In forecasting and reporting arrangements: we found a number of areas where reports, particularly financial reports, lacked sufficient information for readers to understand the likely realisation of the risks that the CCG was facing, or where information was not reported to enable the relevant committee to deliver on their terms of reference. We also identified significant issues around the robustness of forecasting during the year, which further undermined the effectiveness of reporting*
- *During the year, senior management within the CCG identified concerns around whether the likelihood of risk realisation was adequately recognised, with these concerns crystallising in September 2014. This resulted in the CCG taking a number of steps: commissioning the North of England Commissioning Support Unit (NECS) to carry out a stocktake of activity levels; requesting that internal and external audit carry out a review of QIPP plans; and then, before this work commenced, commissioning an independent review of the QIPP plan from an external consultant, which reported in January 2015, with this review confirming that QIPP plans would not deliver the savings required*
- *In governance arrangements: we noted a number of areas where information was not flowing through the organisation in a consistent way, or as envisaged in committee terms of reference. We also noted differences between the information reported to different committees or groups, particularly in the early part of the financial year. However, where the CCG has become aware of such issues during the year, it has taken action to address them, as noted below*
- *In project planning: around both the failure to develop and communicate formal strategies in a number of areas and the lack of robust project plans to deliver these strategies. While our work did identify that a considerable amount of work was underway within the CCG to improve patient care, the failure to formalise and report against plans undermined its effectiveness, including the ability of the CCG to identify and address areas of slippage or duplication of effort. This was compounded by the weaknesses in forecasting noted above, particularly in terms of overreliance on planned savings without necessarily recognising when projected savings were unlikely to be delivered and flexing forecasting accordingly*

*The CCG has recognised many of these issues, and action is in hand to address them. In particular, we note that the CCG has made changes to its financial reporting processes, with the reports after January 2015 containing considerably more information and with the same level of detail now being reported throughout the organisation. The CCG has also established a formal Project Management Office to address the weaknesses identified around project planning, implementation and monitoring, and has recently revised its governance arrangements around financial reporting and service developments, establishing a Finance Committee that reports to the Governing Body and whose membership includes lay members, and a Quality Assurance Committee that reports into both the Clinical Executive and newly established Finance Committee and which oversees the CCG's programmes of service planning, reform and quality improvement work, a role which includes*

*approval of new projects, reviewing the assumptions made, and monitoring progress against plan. The CCG has also revised its arrangements for medicines management, enhancing the SLA with its outsourced service provider in January 2015, implementing a business case to ensure that the service meets its needs going forward, with the new arrangements being in place from March 2015, and, from April 2015, ensuring that quarterly reports on activity are received to provide the Medicines Optimisation Committee with the information that it requires to deliver on its terms of reference.*

*The Finance Committee's inaugural meeting was in January 2015, and its terms of reference were approved at the March 2015 Governing Body meeting. The CCG has also appointed a Turnaround Director to assist in the financial recovery process. The Quality Assurance Committee first met on 3 March 2015 and is meeting weekly, and its terms of reference – currently in draft – have already been discussed by the Finance Committee and will be approved by the Clinical Executive shortly.*

***The successful implementation of these steps, together with other action being taken by the CCG, should move the CCG towards a position of significant assurance.***

*The **basis** for forming my opinion is as follows:*

1. *An assessment of the design and operation of the underpinning Assurance Framework and supporting processes*
2. *An assessment of the range of individual opinions arising from audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses*

# 6.9.4. Internal audit reports

During the 2014/15 audit year Internal Audit issued:

- Three audit reports with 'significant assurance'
- Three audit reports with 'significant assurance and one issue of note'
- Three audit reports with 'limited' assurance
- No reports with a conclusion of no assurance.

At the time of this report, there is one internal audit report in draft form with the assurance level still to be agreed.

**Internal audit reports with 'limited assurance' and the remedial action taken**

**Medicines optimisation** (draft report issued 26 November 2014 and final report issued 2 February 2015)

- A conclusion of 'limited assurance opinion' due to weaknesses in the performance reporting metrics presented to the Medicines Optimisation Committee and the slow implementation of the agreed reconfiguration of the medicines optimisation arrangements. Remedial action has been completed and has included:
    - Systematic, detailed quarterly prescribing reports being presented to the Medicines Optimisation Committee from January 2015 onwards
    - Phase 1 of the implementation of the agreed reconfiguration of the medicine optimisation arrangements being reviewed and phase 2 being approved by the Clinical Executive in March 2015 for immediate implementation

**Contract Monitoring** (draft report issued 27 March 2015 and final report issued 27 April 2015)

- A conclusion of 'limited assurance opinion' due to weaknesses in relation to reporting of expenditure on contracts to the CCG Clinical Executive and Governing Body, including understating contract expenditure and masking the financial pressure facing the CCG. Remedial action has been taken, including:
    - Establishment of the Finance Committee and the QIPP Programme Assurance Committee
    - Finance and contract performance reporting now included in the financial position report to Clinical Executive and Governing Body and both committees have confirmed that they are happy with the level detail in the reports
    - All committees receive accurate and timely information and any differences in reporting due to timing differences are highlighted and explained
    - Clear arrangements to flag, report and address breaches in activity planning assumptions

**Key Financial Controls** (draft report issued 22 April 2015 and final report not yet issued)

- A conclusion of 'limited assurance opinion' due to weaknesses in forecasting, particularly in relation to provider activity and the achievement of QIPP savings, both of which affected the reporting of year-end outturns, weaknesses in the oversight of QIPP programmes and weaknesses in the timeliness of reporting and the level of detail of financial information reported. Remedial action has been taken and the draft report notes that by March 2015 the CCG had already made significant improvements to financial reporting arrangements and has formed a new Finance Committee which includes lay members

## 6.9.5. Data quality

The CCG has a data quality policy. This policy defines data and explains data standards and the importance of data validation.

Robust data is provided to the Council of Practices, the Governing Body and other committees of the CCG. In the self-assessment the Audit Committee confirmed that the quality of data and information presented is acceptable.

## 6.9.6. Business critical models

The CCG has a Business Continuity Management Plan, approved by the Quality and Safety Committee in October 2013. The CCG does not have any business critical models.

## 6.9.7. Data security

The CCG has published the HSCIC Information Governance Toolkit, demonstrating achievement of level 2 or above in all requirements, which is a satisfactory level of compliance with the information governance toolkit assessment

During the period 1 April 2014 to the date of this report there have been no Serious Untoward Incidents in the CCG relating to data security breaches and nothing that has required the CCG to report to the Information Commissioner.

The CCG complies with its statutory duty to respond to requests for information. During the year the CCG received 239 requests under the Freedom of Information (FoI) Act 2000 and 1 request under the Data Protection Act 1998. All the requests were responded to within the statutory timescales. Four requests had exemptions applied: one under Section 12 of the FoI Act 2000 (exceeds appropriate limit), two under Section 43 of the FoI Act 2000 (commercial interests), and one under Section 22 of the FoI Act 2000 (Information intended for future publication).

## 6.9.8 Discharge of statutory functions

During establishment, the arrangements put in place by the clinical commissioning group and explained within the *Corporate Governance Framework* were developed with expert external legal input, to ensure compliance with all the relevant legislation. That legal advice also informed the matters reserved for the Council of Practices and the Governing Body decision and the scheme of delegation.

In light of the Harris review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can

confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

### Section 19 of the Audit Commission Act 1998

Under the Health and Social Care Act 2012 (amending the 2006 NHS Act), CCGs are required to ensure that their capital and revenue resource use in a financial year does not exceed the amount specified by the NHS Commissioning Board (NHS England).

In the year ending 31 March 2015 NHS North Tyneside Clinical Commissioning Group failed to meet its statutory financial target to ensure expenditure does not exceed income. The CCG total revenue resource allocation for 2014/15 was £300.7m and total spend was £307.1m, resulting in a deficit of £6.4m.

In February 2015, following the CCG forecast of a budget deficit for 2014/15, the CCG's appointed External Auditor issued a report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998 for the anticipated breach of financial duties.

# 6.10. Conclusion

The system of control described in this report has been in place in the CCG for the year ended 31 March 2015 and up to the date of the approval of the annual report and accounts.

The work undertaken in 2014/15 across the range of assurance providers to the CCG has shown that:

- The CCG failed to meet its statutory duty to ensure expenditure does not exceed income
- The Head of Internal Audit concluded an overall Opinion of 'limited assurance'

I have therefore concluded that the CCG did not have a generally sound system of internal control in place continuously throughout the year, designed to meet the organisation's objectives and that the controls are being applied consistently.

Where improvements have been recommended, the CCG has acted on them and will continue to do so, tracking progress through the Governing Body and associated committees.

Maurya Cushlow
Chief Officer / Accountable Officer
NHS North Tyneside Clinical Commissioning Group
27 May 2015

# 7. Annual accounts

## 7.1. Report by the Auditors to the members of the CCG

**INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS NORTH TYNESIDE CLINICAL COMMISSIONING GROUP (CCG)**

We have audited the financial statements of NHS North Tyneside CCG for the year ended 31 March 2015 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England.

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers on pages 44 and 45;
- the table of pension benefits of senior managers on pages 46 and 47; and
- the table of pay multiples on pages 48 and 49.

This report is made solely to the members of NHS North Tyneside CCG n accordance with Part II of the Audit Commission Act 1998 and for no other purpose.

**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 the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's (APB's) Ethical Standards for Auditors.

**Scope of the audit of the financial statements**

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Accountable Officer; and
- the overall presentation of the financial statements.

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

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

**Opinion on regularity**

As disclosed in Note 42 of its financial statements, the CCG failed to meet its statutory duties under:

- section 223H (1) of the NHS Act 2006 (as amended) to ensure expenditure did not exceed income in 2014/15; and
- section 223I (3) of the NHS Act 2006 (as amended) to ensure revenue resource use does not exceed the amount specified in Directions.

Except for the incurrence of expenditure in excess of the specified targets, in our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

**Opinion on the financial statements**

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS North Tyneside CCG as at 31 March 2015 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

**Opinion on other matters**

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we report by exception**

We report to you if:

- in our opinion the governance statement does not comply with NHS England's guidance; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

**Exception reports**

We are required to report to you if we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 13 February 2015, we issued a report to the Secretary of State for Health on 13 February 2015, under Section 19 of the Audit Commission Act 1998, for the anticipated breach of financial duties under:

- section 223H (1) of the NHS Act 2006 (as amended) to ensure expenditure did not exceed income in 2014/15; and
- section 223I (3) of the NHS Act 2006 (as amended) to ensure revenue resource use does not exceed the amount specified in Directions.

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

**Respective responsibilities of the CCG and auditor**

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

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

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

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

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

The Audit Commission determined these two criteria as those necessary for us to consider under its 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 2015.

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.

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all significant respects, NHS North Tyneside CCG did not have in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

**Basis for adverse conclusion**

In considering the CCG's arrangements for securing financial resilience, we identified weak arrangements for financial forecasting, recovery planning and Quality Innovation Productivity and Prevention (QIPP) oversight. This included an overall lack of accuracy and quality in ongoing financial reporting during the year, which did not assist Governing Body members in taking timely action to ensure the CCG secured a stable financial position.

In considering the CCG's arrangements for securing economy, efficiency and effectiveness an external review of the Financial Recovery Plan and QIPP highlighted fundamental weaknesses in the CCG's processes for developing and delivering its QIPP plan and activity reduction programme, including project management arrangements.

These weaknesses contributed to the CCG's failure to meet its statutory duty under section 223H (1) of the NHS Act 2006 (as amended) to ensure expenditure in 2014/15 did not exceed income. The CCG reported a deficit of £6.4 million for 2014/15 and is reporting further significant financial pressures in 2015/16.

**Adverse conclusion**

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, the matters reported in the basis for adverse conclusion paragraph above prevent me from being satisfied that in all significant respects NHS North Tyneside CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

**Certificate**

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

Cameron Waddell (CPFA)
for and on behalf of Mazars LLP

The Rivergreen Centre
Aykley Heads
Durham
DH1 5TS

27 May 2015

# 7.2. Appendix one: full Annual Accounts

**APPENDIX 1 - ANNUAL ACCOUNTS**

| | |
|---|---|
| Entity name: | North Tyneside CCG |
| This year | 2014-15 |
| This year ended | 31 March 2015 |
| This year commencing: | 1 April 2014 |

**CONTENTS** **Page Number**

**The Primary Statements:**

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

| | Note | 2014-15 £000 | 2013-14 £000 |
|---|---|---|---|
| **Total Income and Expenditure** | | | |
| Employee benefits | 4.1 | 2,265 | 2,040 |
| Operating expenses | 5 | 304,919 | 286,617 |
| Other operating revenue | 2 | (54) | (648) |
| **Net operating expenditure before interest** | | **307,130** | **288,009** |
| Investment revenue | 8 | 0 | 0 |
| Other (gains)/losses | 9 | 0 | 0 |
| Finance costs | 10 | 0 | 0 |
| **Total net operating expenditure for the financial year** | | **307,130** | **288,009** |
| Of which: | | | |
| **Administration Income and Expenditure** | | | |
| Employee benefits | 4.1 | 2,265 | 2,040 |
| Operating expenses | 5 | 3,008 | 1,767 |
| Other operating revenue | 2 | (54) | (502) |
| **Net administration costs before interest** | | **5,219** | **3,305** |
| **Programme Income and Expenditure** | | | |
| Employee benefits | 4.1 | 0 | 0 |
| Operating expenses | 5 | 301,911 | 284,850 |
| Other operating revenue | 2 | 0 | (146) |
| **Net programme expenditure before interest** | | **301,911** | **284,704** |

| **Other Comprehensive Net Expenditure** | 2014-15 £000 | 2013-14 £000 |
|---|---|---|
| **Total comprehensive net expenditure for the year** | **307,130** | **288,009** |

The notes on pages 7 to 12 form part of this statement.

**Statement of Financial Position as at 31 March 2015**

| | Note | 31 March 2015 £000 | 31 March 2014 £000 |
|---|---|---|---|
| **Total non-current assets** | | **0** | 0 |
| **Current assets:** | | | |
| Trade and other receivables | 17 | 5,791 | 4,464 |
| Cash and cash equivalents | 20 | 109 | 53 |
| **Total current assets** | | **5,900** | 4,517 |
| **Total assets** | | **5,900** | 4,517 |
| **Current liabilities** | | | |
| Trade and other payables | 23 | (21,995) | (15,360) |
| **Total current liabilities** | | **(21,995)** | (15,360) |
| **Total assets employed** | | **(16,095)** | (10,843) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (16,095) | (10,843) |
| **Total taxpayers' equity:** | | **(16,095)** | (10,843) |

The notes on pages 16 to 18 form part of this statement.

The financial statements on pages 1 to 4 were approved by the Governing Body on 26 May 2015 and signed on its behalf by:

Chief Accountable Officer
Maurya Cushlow

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

| | Note | General fund £000 | Revaluation reserve £000 | Other reserves £000 | Total reserves £000 |
|---|---|---|---|---|---|
| **Changes in taxpayers' equity for 2014-15** | | | | | |
| **Balance at 1 April 2014** | | **(10,843)** | **0** | **0** | **(10,843)** |
| Transfer between reserves in respect of assets transferred from closed NHS bodies | | 0 | 0 | 0 | **0** |
| **Adjusted CCG balance at 1 April 2014** | | **(10,843)** | **0** | **0** | **(10,843)** |
| **Changes in CCG taxpayers' equity for 2014-15** | | | | | |
| Net operating expenditure for the financial year | SOCNE | (307,130) | 0 | 0 | (307,130) |
| **Net Recognised CCG Expenditure for the Financial Year** | | **(307,130)** | **0** | **0** | **(307,130)** |
| Net funding | SCF | 301,878 | 0 | 0 | 301,878 |
| **Balance at 31 March 2015** | | **(16,095)** | **0** | **0** | **(16,095)** |

| | | General fund £000 | Revaluation reserve £000 | Other reserves £000 | Total reserves £000 |
|---|---|---|---|---|---|
| **Changes in taxpayers' equity for 2013-14** | | | | | |
| **Balance at 1 April 2013** | | **0** | **0** | **0** | **0** |
| Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition | | 0 | 0 | 0 | **0** |
| **Adjusted CCG balance at 1 April 2013** | | **0** | **0** | **0** | **0** |
| **Changes in CCG taxpayers' equity for 2013-14** | | | | | |
| Net operating costs for the financial year | SOCNE | (288,009) | 0 | 0 | (288,009) |
| **Net Recognised CCG Expenditure for the Financial Year** | | **(288,009)** | **0** | **0** | **(288,009)** |
| Net funding | SCF | 277,166 | 0 | 0 | 277,166 |
| **Balance at 31 March 2014** | | **(10,843)** | **0** | **0** | **(10,843)** |

The primary statements on pages 1 and 4 form part of this statement.

## Statement of Cash Flows for the year ended 31 March 2015

| | Note | 2014-15 £000 | 2013-14 £000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year | SOCNE | (307,130) | (288,009) |
| Increase in trade & other receivables | 17 | (1,327) | (4,464) |
| Increase in trade & other payables | 23 | 6,635 | 15,360 |
| **Net Cash (Outflow) from Operating Activities** | | **(301,822)** | (277,113) |
| **Cash Flows from Financing Activities** | | | |
| Grant in Aid Funding Received | | 301,878 | 277,166 |
| **Net Cash Inflow from Financing Activities** | | **301,878** | 277,166 |
| **Net Increase in Cash & Cash Equivalents** | 20 | **56** | 53 |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | 20 | **53** | 0 |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | | **109** | 53 |

The notes on pages 16 to 18 form part of this statement.

**Notes to the financial statements**

1 **Accounting Policies**

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

1.1 **Going Concern**

These accounts have been prepared on the going concern basis despite the issue of a report to the Secretary of State for Health under Section 19 of the Audit Commission Act 1998 for the anticipated or actual breach of financial duties.

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 **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.

1.4 **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.

1.4.1 *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:

· Determining whether income and expenditure should be disclosed as either administrative or programme expenditure;
· Determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets; and,
· Determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare services.

1.4.2 *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. The main estimate in 2014/15 related to prescribing expenditure.

1.5 **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.

**Notes to the financial statements**

1.6 **Employee Benefits**

1.6.1 *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.

1.6.2 *Retirement Benefit Costs*

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

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

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.

1.7 **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.

1.8 **Leases**

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

1.8.1 *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.

1.8.2 *The Clinical Commissioning Group as Lessor*

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

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

1.9 **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.

1.10 **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.

1.11 **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.

1.12 **Continuing healthcare risk pooling**

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

1.13 **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.

**2. Other Operating Revenue**

| | **2014-15 Total** | **2014-15 Admin** | **2014-15 Programme** | 2013-14 Total | 2013-14 Admin | 2013-14 Programme |
|---|---|---|---|---|---|---|
| | **£000** | **£000** | **£000** | £000 | £000 | £000 |
| Non-patient care services to other bodies | 28 | 28 | 0 | 347 | 201 | 146 |
| Other revenue | 26 | 26 | 0 | 301 | 301 | 0 |
| **Total other operating revenue** | **54** | **54** | **0** | **648** | **502** | **146** |

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the General Fund.

**3. Revenue**

| | **2014-15 Total** | **2014-15 Admin** | **2014-15 Programme** | 2013-14 Total | 2013-14 Admin | 2013-14 Programme |
|---|---|---|---|---|---|---|
| | **£000** | **£000** | **£000** | £000 | £000 | £000 |
| From rendering of services | 54 | 54 | 0 | 648 | 502 | 146 |
| **Total** | **54** | **54** | **0** | **648** | **502** | **146** |

## 4. Employee benefits and staff numbers

### 4.1. 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 | 1,959 | 1,636 | 323 | 1,959 | 1,636 | 323 | 0 | 0 | 0 |
| Social security costs | 129 | 129 | 0 | 129 | 129 | 0 | 0 | 0 | 0 |
| Employer Contributions to NHS Pension scheme | 177 | 177 | 0 | 177 | 177 | 0 | 0 | 0 | 0 |
| **Gross employee benefits expenditure** | **2,265** | **1,942** | **323** | **2,265** | **1,942** | **323** | **0** | **0** | **0** |

| 2013-14 | Total | | | Admin | | | Programme | | |
|---|---|---|---|---|---|---|---|---|---|
| | Total £000 | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 | Total £000 | Permanent Employees £000 | Other £000 |
| **Employee Benefits** | | | | | | | | | |
| Salaries and wages | **1,764** | 1,498 | 266 | **1,764** | 1,498 | 266 | 0 | 0 | 0 |
| Social security costs | **117** | 117 | 0 | **117** | 117 | 0 | 0 | 0 | 0 |
| Employer Contributions to NHS Pension scheme | **159** | 159 | 0 | **159** | 159 | 0 | 0 | 0 | 0 |
| **Gross employee benefits expenditure** | **2,040** | **1,774** | **266** | **2,040** | **1,774** | **266** | **0** | **0** | **0** |

In accordance with IAS 19 Employee Benefits, £17k has been included in staff salaries for annual leave accrued but not taken at 31 March 2015.
This Accrual includes an amount for employer's pension contributions.
Information relating to senior staff salaries and other benefits in kind is disclosed within the Remuneration Report on page 41 of the Annual Report.

*4.1.1 Recoveries in respect of employee benefits*

The clinical commissioning group had no recoveries in respect of employee benefits for the year ending 31 March 2015 and 31 March 2014.

**4.2 Average number of people employed**

| | 2014-15 | | | 2013-14 | | |
|---|---|---|---|---|---|---|
| | **Total Number** | **Permanently employed Number** | **Other Number** | Total Number | Permanently employed Number | Other Number |
| **Total** | **34** | **30** | **4** | 33 | 29 | 4 |
| Of the above: | | | | | | |
| **Number of whole time equivalent people engaged on capital projects** | **-** | **-** | **-** | - | - | - |

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

| | **2014-15 Number** | 2013-14 Number Restated |
|---|---|---|
| Total Days Lost | 320 | 82 |
| Total Staff Years | 35 | 32 |
| **Average working Days Lost** | **9.1** | **2.6** |

Sickness reporting in 2014/15 is based upon 12 months data from January 2014 to December 2014.
Sickness reporting in 2013/14 is based upon 9 months data from April 2013 to December 2013. 2013/14 information has been restated during 2014/15.

There were no ill health retirements for the year ending 31 March 2015 and 31 March 2014.

**4.4 Exit packages agreed in the financial year**

The clinical commissioning group had no exit packages agreed for the year ending 31 March 2015 and 31 March 2014.

**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 Accounting valuation*

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

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

*4.5.2 Full actuarial (funding) valuation*

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

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

*4.5.3 Scheme Provisions*

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).
Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

**4.6 Severance Payments**

The clinical commissioning group made no severance payments for the year ending 31 March 2015 and 31 March 2014.

**5. Operating expenses**

| | **2014-15 Total £000** | **2014-15 Admin £000** | **2014-15 Programme £000** | 2013-14 Total £000 | 2013-14 Admin £000 | 2013-14 Programme £000 |
|---|---|---|---|---|---|---|
| **Gross employee benefits** | | | | | | |
| Employee benefits excluding governing body members | 1,610 | 1,610 | 0 | 1,429 | 1,429 | 0 |
| Executive governing body members | 655 | 655 | 0 | 611 | 611 | 0 |
| **Total gross employee benefits** | **2,265** | **2,265** | **0** | **2,040** | **2,040** | **0** |
| | | | | | | |
| **Other costs** | | | | | | |
| Services from other CCGs and NHS England | 2,778 | 1,810 | 968 | 918 | 880 | 38 |
| Services from foundation trusts | 222,732 | 54 | 222,678 | 215,717 | 14 | 215,703 |
| Services from other NHS trusts | 247 | 0 | 247 | 279 | 0 | 279 |
| Purchase of healthcare from non-NHS bodies | 38,844 | 0 | 38,844 | 31,422 | 4 | 31,418 |
| Chair and Non Executive Members | 122 | 122 | 0 | 123 | 123 | 0 |
| Supplies and services – general | 459 | 324 | 135 | 185 | 161 | 24 |
| Consultancy services | 354 | 354 | 0 | 49 | 49 | 0 |
| Establishment | 50 | 50 | 0 | 211 | 209 | 2 |
| Transport | 14 | 14 | 0 | 13 | 13 | 0 |
| Premises | 872 | 136 | 736 | 955 | 133 | 822 |
| Audit fees | 84 | 84 | 0 | 92 | 92 | 0 |
| Other non statutory audit expenditure | | | | | | |
| · Internal audit services | 0 | 0 | 0 | 40 | 40 | 0 |
| · Other services | 0 | 0 | 0 | 0 | 0 | 0 |
| Prescribing costs | 37,032 | 0 | 37,032 | 35,598 | 0 | 35,598 |
| Pharmaceutical services | 138 | 0 | 138 | 0 | 0 | 0 |
| GPMS/APMS and PCTMS | 711 | 0 | 711 | 966 | 0 | 966 |
| Other professional fees excl. audit | 10 | 10 | 0 | 9 | 9 | 0 |
| Clinical negligence | 5 | 5 | 0 | 5 | 5 | 0 |
| Research and development (excluding staff costs) | 0 | 0 | 0 | 12 | 12 | 0 |
| Education and training | 45 | 45 | 0 | 23 | 23 | 0 |
| CHC Risk Pool contributions | 422 | 0 | 422 | 0 | 0 | 0 |
| **Total other costs** | **304,919** | **3,008** | **301,911** | **286,617** | **1,767** | **284,850** |
| | | | | | | |
| **Total operating expenses** | **307,184** | **5,273** | **301,911** | **288,657** | **3,807** | **284,850** |

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

The external auditor of the CCG is Mazars LLP. The audit fee for 2014/15 including VAT, was £84k.

**6. Better Payment Practice Code**

| **Measure of compliance** | **2014-15 Number** | **2014-15 £000** | 2013-14 Number | 2013-14 £000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS trade invoices paid in the year | 7,726 | 33,840 | 6,955 | 32,944 |
| Total Non-NHS trade invoices paid within target | 7,508 | 33,005 | 6,791 | 32,459 |
| **Percentage of Non-NHS Trade invoices paid within target** | **97.18%** | **97.53%** | **97.64%** | **98.53%** |
| | | | | |
| **NHS Payables** | | | | |
| Total NHS trade invoices paid in the year | 1,742 | 231,685 | 1,047 | 215,233 |
| Total NHS trade invoices paid within target | 1,696 | 231,442 | 1,006 | 215,021 |
| **Percentage of NHS Trade invoices paid within target** | **97.36%** | **99.90%** | **96.08%** | **99.90%** |

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

*6.1 The Late Payment of Commercial Debts (Interest) Act 1998*
The clinical commissioning group does not have any expense arising from legislation in the late payment of Commercial Debt Act 1998 as at 31st March 2015.

**7. Income Generation Activities**

The clinical commissioning group does not undertake any income generation activities.

**8. Investment revenue**

The clinical commissioning group had no investment revenue for the year ending 31 March 2015 and 31 March 2014.

**9. Other gains and losses**

The clinical commissioning group had no other gains and losses for the year ending 31 March 2015 and 31 March 2014.

**10. Finance costs**

The clinical commissioning group had no finance costs for the year ending 31 March 2015 and 31 March 2014.

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

The clinical commissioning group had no net gain/(loss) on transfer by absorption for the year ending 31 March 2015 and 31 March 2014.

**12. Operating Leases**

**12.1 As lessee**

*12.1.1 Payments recognised as an Expense*

| | **2014-15** | | | | 2013-14 | | | |
|---|---|---|---|---|---|---|---|---|
| | **Land** | **Buildings** | **Other** | **Total** | Land | Buildings | Other | Total |
| | **£000** | **£000** | **£000** | **£000** | £000 | £000 | £000 | £000 |
| **Payments recognised as an expense** | | | | | | | | |
| Minimum lease payments | 0 | 130 | 2 | **132** | 0 | 77 | 7 | 84 |
| **Total** | **0** | **130** | **2** | **132** | **0** | **77** | **7** | **84** |

*12.1.2 Future minimum lease payments*

| | **2014-15** | | | | 2013-14 | | | |
|---|---|---|---|---|---|---|---|---|
| | **Land** | **Buildings** | **Other** | **Total** | Land | Buildings | Other | Total |
| | **£000** | **£000** | **£000** | **£000** | £000 | £000 | £000 | £000 |
| **Payable:** | | | | | | | | |
| No later than one year | 0 | 0 | 1 | **1** | 0 | 77 | 6 | 83 |
| Between one and five years | 0 | 0 | 1 | **1** | 0 | 308 | 6 | 314 |
| After five years | 0 | 0 | 0 | **0** | 0 | 17 | 0 | 17 |
| **Total** | **0** | **0** | **2** | **2** | **0** | **402** | **12** | **414** |

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

**12.2 As lessor**

*12.2.1 Rental revenue*
The clinical commissioning group had no rental revenue as a lessor for the year ending 31 March 2015 and 31 March 2014.

*12.2.2 Future minimum rental value*
The clinical commissioning group had no future minimum rental values as a lessor for the year ending 31 March 2015 and 31 March 2014.

**13. Property, plant and equipment**

The clinical commissioning group had no property, plant and equipment for the year ending 31 March 2015 and 31 March 2014.

*13.1 Additions to assets under construction*
The clinical commissioning group had no assets under construction for the year ending 31 March 2015 and 31 March 2014.

*13.2 Donated assets*
The clinical commissioning group had no donated assets for the year ending 31 March 2015 and 31 March 2014.

*13.3 Government granted assets*
The clinical commissioning group had no Government granted assets for the year ending 31 March 2015 and 31 March 2014.

*13.4 Property revaluation*
The clinical commissioning group had no property revaluations for the year ending 31 March 2015 and 31 March 2014.

*13.5 Compensation from third parties*
The clinical commissioning group received no compensation in relation to assets from third parties for year ending 31 March 2015 and 31 March 2014.

*13.6 Write downs to recoverable amount*
The clinical commissioning group had no assets written down to recoverable amount for the year ending 31 March 2015 and 31 March 2014.

*13.7 Temporarily idle assets*
The clinical commissioning group had no assets that were temporary idle for the year ending 31 March 2015 and 31 March 2014.

*13.8 Cost or valuation of fully depreciated assets*
The clinical commissioning group had no fully depreciated assets for the year ending 31 March 2015 and 31 March 2014.

**14. Intangible non-current assets**

The clinical commissioning group had no intangible assets for the year ending 31 March 2015 and 31 March 2014.

*14.1 Donated assets*
The clinical commissioning group had no donated intangible assets as at 31 March 2015 and 31 March 2014.

*14.2 Government granted assets*
The clinical commissioning group had no Government granted intangible assets as at 31 March 2015 and 31 March 2014.

*14.3 Revaluation*
The clinical commissioning group had no intangible assets to revalue for the year ending 31 March 2015 and 31 March 2014.

*14.4 Compensation from third parties*
The clinical commissioning group received no compensation in relation to intangible assets from third parties for the year ending 31 March 2015 and 31 March 2014.

*14.5 Write downs to recoverable amount*
The clinical commissioning group had no intangible assets written down to recoverable amount for the year ending 31 March 2015 and 31 March 2014.

*14.6 Non-capitalised assets*
The clinical commissioning group had no non-capitalised assets for the year ending 31 March 2015 and 31 March 2014.

*14.7 Temporarily idle assets*
The clinical commissioning group had no intangible assets that were temporary idle for the year ending 31 March 2015 and 31 March 2014.

*14.8 Cost or valuation of fully amortised assets*
The clinical commissioning group had no fully amortised intangible assets for the year ending 31 March 2015 and 31 March 2014.

**15. Investment property**

The clinical commissioning group had no investment property and made no investment transactions for the year ending 31 March 2015 and 31 March 2014.

**16. Inventories**

The clinical commissioning group held no inventories for the year ending 31 March 2015 and 31 March 2014.

| **17. Trade and other receivables** | **Current 2014-15 £000** | **Non-current 2014-15 £000** | Current 2013-14 £000 | Non-current 2013-14 £000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 436 | 0 | 2,283 | 0 |
| NHS prepayments and accrued income | 3,101 | 0 | 915 | 0 |
| Non-NHS receivables: Revenue | 2,214 | 0 | 1,251 | 0 |
| Non-NHS prepayments and accrued income | 26 | 0 | 2 | 0 |
| VAT | 14 | 0 | 8 | 0 |
| Operating lease receivables | 0 | 0 | 5 | 0 |
| **Total Trade & other receivables** | **5,791** | **0** | **4,464** | **0** |
| **Total current and non current** | **5,791** | | **4,464** | |
| Included above: | | | | |
| Prepaid pensions contributions | 0 | | 0 | |

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

The clinical commissioning group did not hold any collateral receivables outstanding at 31 March 2015.

| *17.1 Receivables past their due date but not impaired* | **2014-15 £000** | 2013-14 £000 |
|---|---|---|
| By up to three months | 1,320 | 550 |
| By three to six months | 31 | 73 |
| By more than six months | 711 | 94 |
| **Total** | **2,062** | **717** |

£14,918 of the amount above has subsequently been recovered post the statement of financial position date.

*17.2 Provision for impairment of receivables*

The clinical commissioning group had no provisions for impairments of receivables for the year ending 31 March 2015 and 31 March 2014.

**18. Other financial assets**

The clinical commissioning group had no other financial assets held outside the statement of financial position for the year ending 31 March 2015 and 31 March 2014. This includes all other current, non-current and capital financial assets.

**19. Other current assets**

The clinical commissioning group had no other current assets held outside the statement of financial position for the year ending 31 March 2015 and 31 March 2014.

**20. Cash and cash equivalents**

| | **2014-15 £000** | 2013-14 £000 |
|---|---|---|
| Balance at 1 April | 53 | 0 |
| Net change in year | 56 | 53 |
| **Balance at 31 March** | **109** | **53** |
| | | |
| Made up of: | | |
| Cash with the Government Banking Service | 109 | 53 |
| **Cash and cash equivalents as in statement of financial position** | **109** | **53** |
| | | |
| **Total bank overdrafts** | **0** | **0** |
| | | |
| **Balance at 31 March** | **109** | **53** |

No patients' money was held by the clinical commissioning group as at 31 March 2015.
Cash is held with the Government Banking Services, the current providers are Citibank and Natwest.

**21. Non-current assets held for sale**

The clinical commissioning group had no non-current assets held for sale for the year ending 31 March 2015 and 31 March 2014.

**22. Analysis of impairments and reversals**

The clinical commissioning group had no impairments or reversals for the year ending 31 March 2015 and 31 March 2014.

| 23. Trade and other payables | Current 2014-15 £000 | Non-current 2014-15 £000 | Current 2013-14 £000 | Non-current 2013-14 £000 |
|---|---|---|---|---|
| NHS payables: revenue | 272 | 0 | 888 | 0 |
| NHS accruals and deferred income | 3,075 | 0 | 5,689 | 0 |
| Non-NHS payables: revenue | 6,685 | 0 | 2,883 | 0 |
| Non-NHS accruals and deferred income | 11,846 | 0 | 5,830 | 0 |
| Social security costs | 20 | 0 | 19 | 0 |
| Tax | 25 | 0 | 24 | 0 |
| Other payables | 72 | 0 | 27 | 0 |
| **Total Trade & Other Payables** | **21,995** | **0** | **15,360** | **0** |
| Total current and non-current | **21,995** | | **15,360** | |

Other payables include £32k outstanding pension contributions at 31 March 2015 (£27k as at 31 March 2014).

At 31 March 2015, the clinical commissionin group had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years.

**24. Other financial liabilities**

The clinical commissioning group had no other financial liabilities for the year ending 31 March 2015 and 31 March 2014.

**25. Other liabilities**

The clinical commissioning group had no other liabilities for the year ending 31 March 2015 and 31 March 2014.

**26. Borrowings**

The clinical commissioning group had no borrowings for the year ending 31 March 2015 and 31 March 2014, therefore there are no repayment due dates to report.

**27. Private finance initiative, LIFT and other service concession arrangements**

The clinical commissioning group had no PFI, LIFT or other service concession arrangements for the years ending 31 March 2015 and 31 March 2014. This includes any payments on or off the statement of financial position and imputed finance leases.

**28. Finance lease obligations**

The clinical commissioning group had no finance lease obligations for the year ending 31 March 2015 and 31 March 2014.

**29. Finance lease receivables**

The clinical commissioning group had no finance lease receivables for the year ending 31 March 2015 and 31 March 2014.

*29.1 Finance leases as lessor*
The clinical commissioning group had no finance leases as lessor for the year ending 31 March 2015 and 31 March 2014.

*29.2 Rental revenue*
The clinical commissioning group had no rental revenue for the year ending 31 March 2015 and 31 March 2014.

**30. Provisions**

The clinical commissioning group had no provisions to report in their statement of financial position for the year ending 31 March 2015 and 31 March 2014.

NHS England are responsible for the payment of liabilities relating to Continuing Healthcare cases relating to the period before establishment of the clinical commissioning group. The total value of 'legacy' continuing healthcare provisions carried by NHS England relating to the CCG is £3,016k as at 31 March 2015 (£2,105k as at 31 March 2014).

**31. Contingencies**

The clinical commissioning group had no contingencies for the year ending 31 March 2015 and 31 March 2014.

The clinical commissioning group is in the process of mediation with a care home provider in respect of a contract dispute with regards to fees payable for continuing healthcare. This mediation process is part of legal proceedings and following legal advice received the clinical commissioning group prudently views the claim as only having a possible prospect of succeeding and therefore not requiring provision recognition.

**32. Commitments**

The clinical commissioning group had no capital commitments or other financial commitments for the year ending 31 March 2015 and 31 March 2014.

**33. Financial instruments**

*33.1 Financial risk management*

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.
Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.
Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

*33.1.1 Currency risk*

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

*33.1.2 Interest rate risk*

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

*33.1.3 Credit risk*

Because the majority of the NHS clinical commissioning group and revenue comes from parliamentary funding, NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

*33.1.4 Liquidity risk*

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

**33. Financial instruments cont'd**

*33.2 Financial assets*

| | At 'fair value through profit and loss' 2014-15 £000 | Loans and Receivables 2014-15 £000 | Available for Sale 2014-15 £000 | Total 2014-15 £000 |
|---|---|---|---|---|
| Receivables: | | | | |
| · NHS | 0 | 436 | 0 | 436 |
| · Non-NHS | 0 | 2,214 | 0 | 2,214 |
| Cash at bank and in hand | 0 | 109 | 0 | 109 |
| **Total at 31 March 2015** | **0** | **2,759** | **0** | **2,759** |

| | At 'fair value through profit and loss' 2013-14 £000 | Loans and Receivables 2013-14 £000 | Available for Sale 2013-14 £000 | Total 2013-14 £000 |
|---|---|---|---|---|
| Receivables: | | | | |
| · NHS | 0 | 2,283 | 0 | 2,283 |
| · Non-NHS | 0 | 1,251 | 0 | 1,251 |
| Cash at bank and in hand | 0 | 53 | 0 | 53 |
| **Total at 31 March 2014** | **0** | **3,587** | **0** | **3,587** |

*33.3 Financial liabilities*

| | At 'fair value through profit and loss' 2014-15 £000 | Other 2014-15 £000 | Total 2014-15 £000 |
|---|---|---|---|
| Payables: | | | |
| · NHS | 0 | 3,347 | 3,347 |
| · Non-NHS | 0 | 18,603 | 18,603 |
| **Total at 31 March 2015** | **0** | **21,950** | **21,950** |

| | At 'fair value through profit and loss' 2013-14 £000 | Other 2013-14 Restated £000 | Total 2013-14 Restated £000 |
|---|---|---|---|
| Payables: | | | |
| · NHS | 0 | 6,577 | 6,577 |
| · Non-NHS | 0 | 8,740 | 8,740 |
| **Total at 31 March 2014** | **0** | **15,317** | **15,317** |

**34. Operating segments**

The clinical commissioning group and consolidated group consider they have only one segment: commissioning of healthcare services.

| | **Gross expenditure** | **Income** | **Net expenditure** | **Total assets** | **Total liabilities** | **Net assets** |
|---|---|---|---|---|---|---|
| | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** |
| Commissioning of Healthcare Services | 307,184 | (54) | 307,130 | 5,900 | (21,995) | (16,095) |
| **Total 2014-15** | **307,184** | **(54)** | **307,130** | **5,900** | **(21,995)** | **(16,095)** |

| | Gross expenditure | Income | Net expenditure | Total assets | Total liabilities | Net assets |
|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Commissioning of Healthcare Services | 288,657 | (648) | 288,009 | 4,517 | (15,360) | (10,843) |
| **Total 2013-14** | **288,657** | **(648)** | **288,009** | **4,517** | **(15,360)** | **(10,843)** |

*34.1 Reconciliation between Operating Segments and SoCNE*

| | **31-Mar-15** | 31-Mar-14 |
|---|---|---|
| | **£'000** | £'000 |
| Total net expenditure reported for Commissioning of Healthcare Services | 307,130 | 288,009 |
| Total net expenditure per the Statement of Comprehensive Net Expenditure | 307,130 | 288,009 |

*34.2 Reconciliation between Operating Segments and SoFP*

| | **31-Mar-15** | 31-Mar-14 |
|---|---|---|
| | **£'000** | £'000 |
| Total assets reported for Commissioning of Healthcare Services | 5,900 | 4,517 |
| Total assets per Statement of Financial Position | 5,900 | 4,517 |

| | **31-Mar-15** | 31-Mar-15 |
|---|---|---|
| | **£'000** | £'000 |
| Total liabilities reported for Commissioning of Healthcare Services | (21,995) | (15,360) |
| Total liabilities per Statement of Financial Position | (21,995) | (15,360) |

**35. Pooled budgets**

The clinical commissioning group and consolidated group had entered into a pooled budget with North Tyneside Council.
Under the arrangement funds are pooled under Section 75 of the NHS Act 2006.
The memorandum account for the pooled budget is:

| | **2014-15 £000** | 2013-14 £000 |
|---|---|---|
| Income | - | - |
| Expenditure | **1,006** | 1,038 |

This budget is used to fund a Joint Equipment Loan Service and the Cedars Care Home for North Tyneside Residents.
The Joint Equipment Loan Service provides equipment to help patients to live independently at home and covers equipment which can protect patients from accidents, assist in carrying out day to day tasks and make it easier for people to care for others. The Cedars Care Home provides accommodation with nursing and personal care giving intermediate care for people discharged from hospital, prior to returning from home.

**36. NHS Lift investments**

The clinical commissioning group had no NHS Lift Investments for the year ending 31 March 2015 and 31 March 2014.

**37. Intra-government and other balances**

| | **Current Receivables 2014-15 £000** | **Non-current Receivables 2014-15 £000** | **Current Payables 2014-15 £000** | **Non-current Payables 2014-15 £000** |
|---|---|---|---|---|
| **Balances with:** | | | | |
| · Other Central Government bodies | 52 | 0 | 98 | 0 |
| · Local Authorities | 2,062 | 0 | 7,646 | 0 |
| **Balances with NHS bodies:** | | | | |
| · NHS bodies outside the Departmental Group | 345 | 0 | 295 | 0 |
| · NHS Trusts and Foundation Trusts | 3,192 | 0 | 3,052 | 0 |
| **Total of balances with NHS bodies:** | **3,537** | **0** | **3,347** | **0** |
| · Public corporations and trading funds | 0 | 0 | 0 | 0 |
| · Bodies external to Government | 140 | 0 | 10,904 | 0 |
| **Total balances at 31 March 2015** | **5,791** | **0** | **21,995** | **0** |

| | Current Receivables 2013-14 £000 | Non-current Receivables 2013-14 £000 | Current Payables 2013-14 £000 | Non-current Payables 2013-14 £000 |
|---|---|---|---|---|
| **Balances with:** | | | | |
| · Other Central Government bodies | 8 | 0 | 186 | 0 |
| · Local Authorities | 1,193 | 0 | 1,083 | 0 |
| **Balances with NHS bodies:** | | | | |
| · NHS bodies outside the Departmental Group | 1,929 | 0 | 50 | 0 |
| · NHS Trusts and Foundation Trusts | 1,270 | 0 | 6,527 | 0 |
| **Total of balances with NHS bodies:** | **3,199** | **0** | **6,577** | **0** |
| · Public corporations and trading funds | 0 | 0 | 0 | 0 |
| · Bodies external to Government | 64 | 0 | 7,514 | 0 |
| **Total balances at 31 March 2014** | **4,464** | **0** | **15,360** | **0** |

**38. Related party transactions**

Details of related party transactions with individuals are as follows:

Comparative information for the prior year is also reported.

| North Tyneside GP Practices | **2014-15 Payments to Related Party Total** £000 | **2014-15 Payments in carrying out CCG Functions** £000 | **2014-15 Payments for Enhanced Services** £000 | 2013-14 Payments to Related Party Total £000 | 2013-14 Payments in carrying out CCG Functions £000 | 2013-14 Payments for Enhanced Services £000 |
|---|---|---|---|---|---|---|
| 49 Marine Avenue | 51 | 5 | 46 | 41 | 5 | 36 |
| Appleby Surgery | 39 | 4 | 34 | 66 | 5 | 61 |
| Battle Hill Health Centre | 16 | 4 | 13 | 20 | 7 | 13 |
| Beaumont Park | 44 | 6 | 38 | 35 | 5 | 30 |
| Bewicke Medical Centre | 54 | 7 | 47 | 119 | 9 | 110 |
| Collingwood Surgery | 104 | 41 | 63 | 170 | 35 | 135 |
| Dr Smith & Partners | 25 | 3 | 22 | 21 | 3 | 18 |
| Dr Young & Partners | 19 | 2 | 17 | 41 | 4 | 37 |
| Drs Preston and Austin | 27 | 3 | 25 | 26 | 1 | 25 |
| Earsdon Park Surgery | 62 | 5 | 56 | 30 | 2 | 28 |
| Forest Hall Medical Centre | 45 | 5 | 40 | 79 | 7 | 72 |
| Garden Park Surgery | 102 | 44 | 58 | 74 | 4 | 70 |
| Lane End Surgery | 40 | 12 | 28 | 101 | 33 | 68 |
| Marine Avenue Medical Centre | 55 | 17 | 37 | 51 | 5 | 46 |
| Monkseaton Medical Centre | 11 | 5 | 6 | 72 | 13 | 59 |
| Nelson Health Group | 26 | 5 | 21 | 74 | 4 | 70 |
| Park Parade Surgery | 34 | 6 | 28 | 11 | 10 | 1 |
| Park Road Medical Practice | 121 | 92 | 29 | 124 | 78 | 46 |
| Portugal Place | 163 | 96 | 68 | 210 | 91 | 119 |
| Priory Medical Group | 107 | 5 | 101 | 151 | 7 | 144 |
| Redburn Park Medical Centre | 21 | 5 | 16 | 45 | 10 | 35 |
| Spring Terrace Health Centre | 74 | 42 | 32 | 103 | 30 | 73 |
| Swarland Avenue Surgery | 25 | 8 | 17 | 63 | 6 | 57 |
| Village Green Surgery | 138 | 97 | 41 | 173 | 90 | 83 |
| Wellspring Medical Practice | 36 | 10 | 25 | 40 | 6 | 34 |
| West Farm Surgery | 33 | 8 | 25 | 54 | 6 | 48 |
| Whitley Road Health Centre | 89 | 4 | 84 | 121 | 3 | 118 |
| Wideopen Medical Centre | 48 | 8 | 40 | 64 | 4 | 60 |
| Woodlands Park Medical Centre | 166 | 62 | 104 | 195 | 68 | 127 |

There are no amounts owed to a related party and amounts due from a related party for the year ending 31 March 2015 and 31 March 2014.

Members of the North Tyneside GP Practices have carried out functions for the CCG and any remuneration received for these has been paid to the practice in recognition of their contribution. GP Practices are also entitled to additional payments in relation to extra services for patients and these are based on practice sizes and if the practice has delivered each service.

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. For example:

| | **2014-15 Payments related to DH** £000 | 2013-14 Payments related to DH £000 |
|---|---|---|
| • Northumbria Healthcare NHS Foundation Trust | 134,355 | 126,566 |
| • Newcastle upon Tyne Hospital NHS Foundation Trust | 64,062 | 60,969 |
| • Northumberland, Tyne & Wear NHS Foundation rust | 22,022 | 19,387 |
| • North East Ambulance Service. | 7,698 | 7,588 |
| | **228,137** | 214,510 |

The clinical commissioning group also had a number of transactions with NHS England, NHS Litigation Authority and NHS Business Services Authority The transactions with these entities were not material.

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 Tyneside Council in respect of joint enterprises (£9.6m).

TyneHealth Ltd is a provider of healthcare services. Its members are the 29 GP Practices in North Tyneside. There was £511k paid to it in 2014/15 (£0 in 2013/14).

The clinical commissioning group has not received revenue or capital payments from charitable funds.

The CCG maintains a formal register of interests which is referred to at each of its Council of Practice meetings, Governing Body and Committee meetings, providing a mechanism for handling any conflicts of interest.

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

There are no post balance sheet events which will have a material effect on the financial instruments of the clinical commissioning group or consolidated group.

**40. Losses and special payments**

*40.1 Losses*

There were no losses reported for the year ending 31 March 2015 and 31 March 2014.

*40.2 Special payments*

There were no special payments for the year ending 31 March 2015 and 31 March 2014.

**41. Third party assets**

The clinical commissioning group held no third party assets off their statement of financial position for the year ending 31 March 2015 and 31 March 2014.

**42. Financial performance targets**

The clinical commissioning group have a number of financial duties under the NHS Act 2006.

The clinical commissioning group performance against those duties was as follows:

| | | 2014-15 £'000 | 2014-15 £'000 | 2014-15 £'000 | | 2013-14 £'000 | 2013-14 £'000 | 2013-14 £'000 | |
|---|---|---|---|---|---|---|---|---|---|
| **National Health Service Act Section** | **Duty** | **Target** | **Performance** | **Total** | **Duty Achieved** | Target | Performance | Total | Duty Achieved |
| 223H(1) | Expenditure not to exceed income | 300,701 | 307,130 | (6,429) | No | 288,172 | 288,009 | 163 | Yes |
| 223I(2) | Capital resource use does not exceed the amount specified in Directions | 0 | 0 | 0 | Yes | 0 | 0 | 0 | Yes |
| 223I(3) | Revenue resource use does not exceed the amount specified in Directions | 300,701 | 307,130 | (6,429) | No | 288,172 | 288,009 | 163 | Yes |
| 223J(1) | Capital resource use on specified matter(s) does not exceed the amount specified in Directions | 0 | 0 | 0 | Yes | 0 | 0 | 0 | Yes |
| 223J(2) | Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | 0 | 0 | 0 | Yes | 0 | 0 | 0 | Yes |
| 223J(3) | Revenue administration resource use does not exceed the amount specified in Directions | 5,915 | 5,220 | 695 | Yes | 5,280 | 3,305 | 1,975 | Yes |

**43. Impact of IFRS**

There was no impact of IFRS on the clinical commissioning group in 2014-15 or 2013-14.

**44. Analysis of charitable reserves**

The clinical commissioning group had no charitable reserves for the year ending 31 March 2015 and 31 March 2014.