NHS
Nottingham North and East
Clinical Commissioning Group

Annual Report and Accounts 2013/2014

Putting good health *into practice*

Annual Report 2013/2014

This is the annual report for NHS NNE Clinical Commissioning Group 2013/2014. It includes information about the organisation and its activities during 2013/2014.

This document can be made available in large print and other formats including translations upon request.

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MEMBER PRACTICES INTRODUCTION

Welcome to our first Annual Report. This report looks back at our first year as a Clinical Commissioning Group (CCG), celebrates our achievements and looks ahead to the challenges facing us as a CCG and commissioners.

As members of Nottingham North and East CCG, we feel fortunate to have had a history of working together as part of a Practice Based Commissioning Consortium. This collaborative approach provided us with a firm foundation to build on as we took on the responsibilities of commissioning. This established relationship meant that during the 'shadow' period of 2012/13, our capability to work collectively and effectively with our CCG colleagues provided a solid base to be efficient and responsive in our first year as a statutory body.

Over the last year, there have been significant changes within the NHS and more specifically within Primary Care. These changes have been a challenge for every practice but as members of the CCG we have been better placed to meet these challenges. We have made substantial progress in delivering our responsibilities as both a provider and commissioner of NHS services and we have welcomed the support and commitment of our CCG colleagues in delivering a robust organisation, with the patient at the centre.

The unique nature of CCGs, placing Clinical input into the heart of Commissioning has been at the centre of Nottingham North and East's vision "Putting Good Health into Practice". This is been delivered through:

1. Improving the health of the community and reducing health inequalities
2. Securing the provision of safe, high quality services
3. Achieving financial balance and value for money

During our first year of operation, we have already successfully overcome some substantial challenges. With member engagement, strong leadership, a robust strategy and an effective business plan, we turned our financial position around and ended the year delivering against plan.
As clinicians we understand that good quality care and financial health go hand in hand. In the first year through strong clinical commitment from each member practice the CCG has delivered the required savings and planned surplus to turn around our financial position. As member practices of the CCG we appreciate that year two will be equally as challenging and this will be supported by the developments that have already taken place.

Due to the unique nature of CCGs and the clinical focus the CCG has been focused on the health priorities of the local community working with Right Care to develop the Commissioning for Value packs which allows a targeted approach to improving quality of care and cost effectiveness in areas which have been highlighted to be out of step with our patched peers. This approach of basing commissioning activity with the evidence base allows a more productive attempt to improving the health of our population. Key projects during 2013/14 include the implementation of the integrated health and social care model and a single point of access. This model allowed for immediate improvements in the

delivery of care in the community and directly addressed previous concerns that had been raised by member practices.

The Clinical Commissioning Group implemented the Nottinghamshire Musculoskeletal Assessment and Treatment Services (NMATS) which allows patients to receive the right care, in the right place at the right time. The CCG has also delivered successful enhancements in community services for diabetes, cardiology and dermatology and has delivered against its priorities of reducing first outpatient attendances, reducing emergency admissions for adults over 65 and increasing the number of patients receiving IV antibiotics in the community. All these projects have had a positive impact in primary care.

The member practices are fully supportive and recognise the impact of the Governing Body during the first year as a statutory organisation. The Governing Body have been developing as a team and have demonstrated themselves as effective leaders, both collectively and individually.

In particular, the Governing Body has maintained a continued focus on member practice engagement, delivery of quality, patient and public involvement, turning around the financial position and good governance. At the beginning of the year member practice engagement was identified as a area of development for the CCG. By recognising the importance of member practice engagement the CCG took the substantial step of setting expanding the Clinical Cabinet to include commissioning leads from each practice. This provides “line of sight” from the CCG to each member practice aiding two way commination and engagement.

The direct involvement in decision making has started to provide ownership to member practices for changes in the local health community and commissioned services. Patient and public involvement has developed through the year through the strong People’s Council which allows for direct input by patients and public into the decisions we make in the Clinical Cabinet. We will continue to support the work of the Peoples Council by encouraging active engagement from individuals from our Practice Patient Groups.

The Governing body has had a strong clinical focus on Quality of patient care which has been reflected in the supportive interaction with providers in order to improve the quality of commissioned services. Annual Report highlights that Nottingham North and East started the year with a challenging financial position and through the work of the Governing Body, this has been turned around allowing the CCG to be in a more robust position to meet the challenges of 2014/15. Good governance underlies the performance of the CCG and has met the challenges during 2013/14.

We recognise as member practices and as a CCG that success in the coming years depends upon a collaborative approach in the local health community. The Governing body over the past year has worked hard at building strong relationships and partnerships to provide a strong foundations for meeting the challenges of 2014/15. The likelihood is that the challenges in the coming years are likely to be great and in order to deliver the primary care strategy, continue tackling unwarranted variation, deliver transformational change through integrated working and strong partnership and deliver against financial stability, all members of the health community need to work together in a collaborative way.

As member practices we seen the need to change and work closer together as providers as well as commissioners and will look forward to evolving this vision with the support and commitment of the Clinical Commissioning Group.

We are aware that the Governing Body effectiveness has been challenged throughout the year by the NHS England Assurance process through which the CCG has been “assured”. The Governing Body has also carried out a self-assessment identifying areas of development which can be reviewed in the Governance Statement. As a result we recognise and support the Governing Body in further developing themselves as leaders of the organisation, focussing on the capabilities of working as part of the wider health community in partnership with neighbouring CCGs and delivering against key targets.

2013/14 has been a challenging year and achievements would not have been possible without the continued hard work and commitment of our colleagues in the CCG and equally importantly in our member practices. We recognise that the strength of our CCG is based on the engagement of each member practice and despite the challenges our colleagues have worked tirelessly throughout the year to ensure the development of services for our patients and to improve the quality of care they receive. We would like to extend our collective gratitude to the CCG, our member practices, local authority and the local health community as our success is dependent on our collaborative working and team work. We commend this report.

Dr Parm Panesar, Assistant Clinical Chair and Dr James Hopkinson, GP Member Governing Body
on behalf of Member Practices

STRATEGIC REPORT

We are pleased to be able to present our first annual report from NHS Nottingham North and East Clinical Commissioning Group (NNE CCG). The report is an informative review of our development in the first year as a statutory body, including our achievements as well as risks and uncertainties.

This annual report is prepared as per the requirements of the National Health Service Act 2006 (as amended). The accounts have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended).

About Us

NNE CCG is composed of 21 member practices with a registered population of 147,700.

We became statutory from the 1st April 2013 with three financially related conditions. The conditions were as follows:

3.1.1 B – CCG must have a clear and credible integrated plan that meets authorisation requirements.

3.1.1 C – CCG must have detailed financial plan that deliver financial balance, sets out how it will manage within its management allowance, and is integrated with the commissioning plan.

3.1.4 B – Provide evidence that the area covered by the CCG is on track to meet the plan for 2012-13 and if not, provide evidence that is a clear and time limited resolution path to recover.

The conditions required the production of a comprehensive recovery plan. Through the continued support of NHS England Area Team, we produced and implemented robust turnaround and Quality, Innovation, Productivity and Prevention (QIPP) plans, allowing the conditions to be removed on 8 October 2013.

On reflection, working towards the removal of the conditions was a positive experience, as it accelerated and enhanced the capabilities of the CCG and the leadership of the Governing Body. It established an open and honest relationship with the Area Team and helped to cement the processes and procedures of the teams with a central focus on turning the CCG around.

We continue to work closely with the Area Team and, through the quarterly checkpoints against the assurance framework, have received the overall rating of 'assured' for 2013/14.

We have had a challenging year which has helped to establish NNE CCG as a strong organisation within the new NHS landscape.

Our Local Population

The registered population of NNE CCG is distributed across five local authority areas within Nottinghamshire County, namely Gedling, Ashfield, Broxtowe, Nottingham City, and Newark and Sherwood. The majority of patients registered with GP practices in the CCG area live within three districts: Gedling Borough, Ashfield District (mainly Hucknall), and Broxtowe Borough (parts of Eastwood). The remainder live in Nottingham City, Newark & Sherwood District and other parts of Nottinghamshire. The CCG is responsible for the unregistered population in the areas of Arnold,

Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley and Netherfield. The CCG has established good links with local councils and will continue to build on these as an important feature of our partnership arrangements.

The registered population of Nottingham North and East CCG in April 2014 is 147,700 (HSCIC). This is projected to grow by 8.6% by 2025, to 161,000 (Based on ONS projections for Gedling, Ashfield, and Broxtowe).

Compared with other areas in England, the population of NNE has a higher percentage of both men and women aged 45 and older, and a lower percentage aged less than 30.

In 2010, Gedling had 24,700 residents aged between 0-19 years. This is projected to increase by 15% between 2010 and 2030. The proportion of children in Gedling statemented for Special Educational Needs is 0.9%, compared to a County figure of 1.1%. The number of children diagnosed with autistic spectrum disorder across Nottinghamshire has increased substantially (3 fold) over the last 10 years.

In 2010, Ashfield had the highest number of 0-19 year olds in Nottinghamshire County, at 28,100. Ashfield is projected to have a 14% increase in its 0-19 year old population by 2030. Children identified with special educational needs are the second highest in Ashfield (1.5% and 1.2% respectively). Across the NNE CCG area, the highest proportions of younger people live in Hucknall, Eastwood, Arnold, Carlton and Calverton.

There were 86,500 adults aged 20-64 registered with GP practices in NNE CCG in April 2014 (HSCIC). Based on the projected population growth described above, this is expected to grow to nearly 90,000 by 2025.

19.6% of the registered population of NNE CCG are over the age of 65 years (HSCIC April 2014), higher than the average across all South Nottinghamshire CCGs (including Nottingham City) of 15.6%. An increase of 18% is expected in the older population by 2025, rising from 28,900 to 34,800 people aged 65 or older, particularly in the 75-79 age group, and with a greater number of females than males (18,800 and 16,000 respectively). In addition, as the population ages, the number of older people living alone is expected to increase to around 40% across Nottinghamshire. Across NNE CCG area the highest proportions of older people live in Eastwood, Burton Joyce and Newstead.

In Gedling, 1 in 7 pensioners live in poverty. A similar ratio of the 50-64 year old population is claiming at least one benefit. Awareness about benefits that are available to claim in this age group is reasonable, with a good proportion of those that are eligible claiming winter fuel payments.

Across Ashfield district, 1 in 5 pensioners live in poverty. Of particular relevance to NNE CCG is the high numbers of pensioners living in poverty in the Hucknall area. A similar ratio of the 50-64 year old population is claiming at least one benefit. Awareness about benefits that are available to claim in this age group is reasonable, however the older people in Ashfield are least likely to claim winter fuel payments compared with older people living in all districts of Nottinghamshire. This suggests that there is inequity and lack of awareness with regard to this benefit payment.

Our Location and Structure of the Business

We are co-located with Gedling Borough Council at the Gedling Civic Centre, Arnot Hill Park, Arnold, Nottingham, NG5 6LU.

We moved into these facilities in December 2012 and the move has proven extremely beneficial in terms of strengthening our relationship with the Council in support of partnership working, including identifying efficiencies, and allowing both the CCG and Gedling Borough Council to gain a greater understanding of each other’s business models. Through this working relationship, we have also built

robust partnerships with Ashfield District Council, Broxtowe Borough Council and Newark and Sherwood District Council.

NNE CCG can be classed as a small organisation, with 44.56 Whole Time Equivalent employees. It is led by a Chief Officer and Chair and has four directorates; Service Improvement and Primary Care, Quality and Patient Safety, Finance, and Operations. Information and Outcomes and Contracting directorates are shared services hosted by NHS Rushcliffe CCG and NHS Nottingham West CCG respectively.

We have a flat structure and strongly support teams working together to provide a comprehensive approach to all activities. We reviewed make/share/buy arrangements alongside the other Nottinghamshire CCGs and as a result have robust arrangements for shared services in order to achieve efficiencies and economies of scale. These arrangements are supported by a Memorandum of Understanding and as part of this NNE CCG is the host employing organisation for the finance, quality and transformation services. We commission other back office services from Greater East Midlands Commissioning Support Unit.

The Governing Body is led by the Chair and includes an Assistant Clinical Chair, Chief Officer, Chief Finance Officer, GP, Pharmacist, Secondary Care Consultant, Registered Nurse, Lay Member Financial Management and Audit, Lay Member Patient and Public Involvement, as well as an Observer from the Local Authority and an Observer who is a Patient and Public Representative. Further detail can be found in the Members Report.

The Observers have full speaking rights and fully participate in all activities of the Governing Body. The Committees of the Governing Body are either NNE specific or are shared with the Nottinghamshire Clinical Commissioning Groups. Further detail can be found in the Governance Statement.

Our Vision and Values

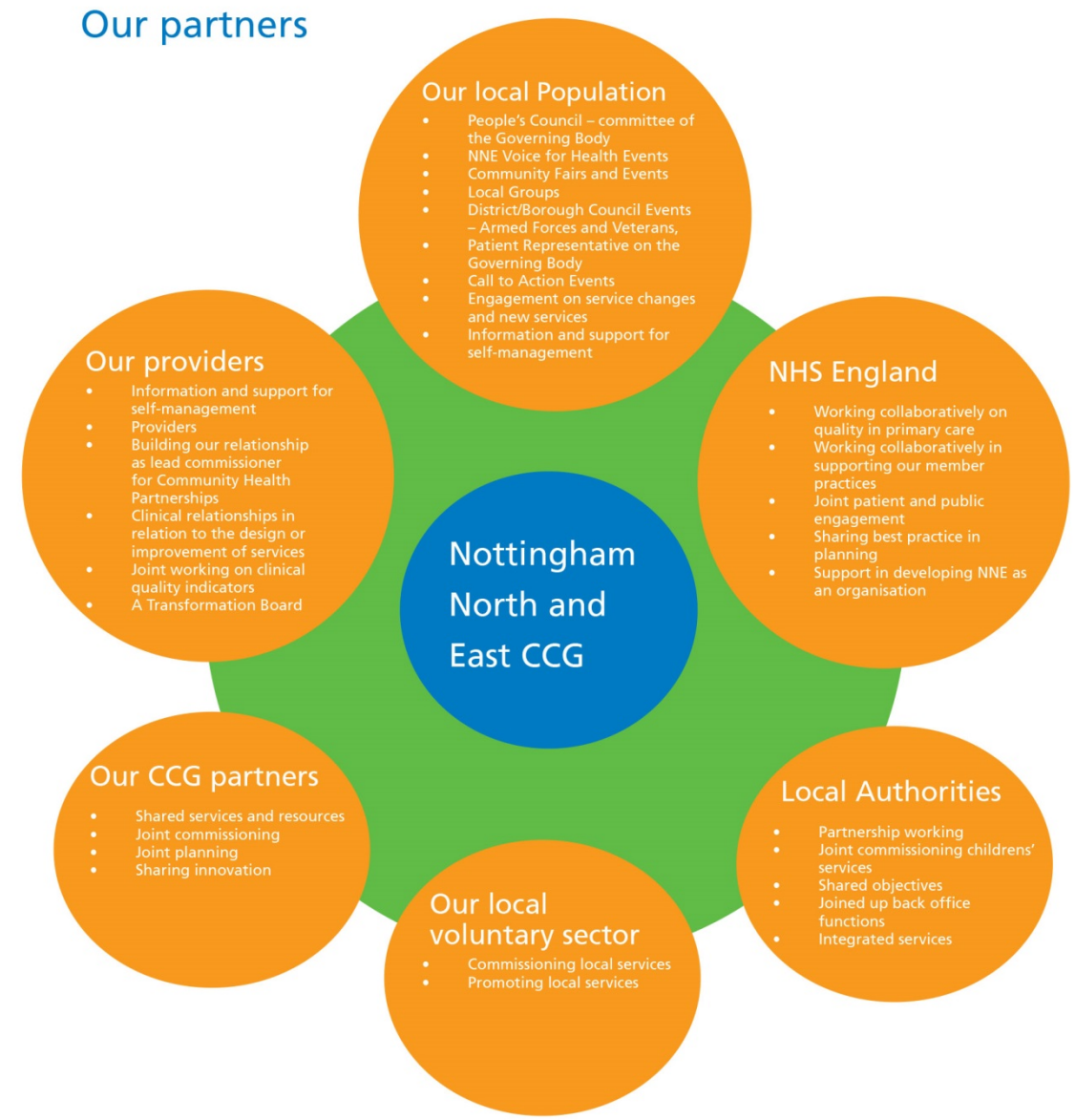
Our vision is "**Putting Good Health into Practice**" which will be delivered through:

- Improving the health of the community and reducing health inequalities
- Securing the provision of safe, high quality services
- Achieving financial balance and value for money

Our values are reflected in all that we do.

H **onesty**, openness and integrity are central to everything we do
E **mpowering** and communicating with our patient community
A **ppropriate** use of our resources to deliver best value
L **eadership** that is strong and visible
T **ogether** with our partners, strive to improve the health of our community
H **igh quality** is our standard

Our Stakeholders

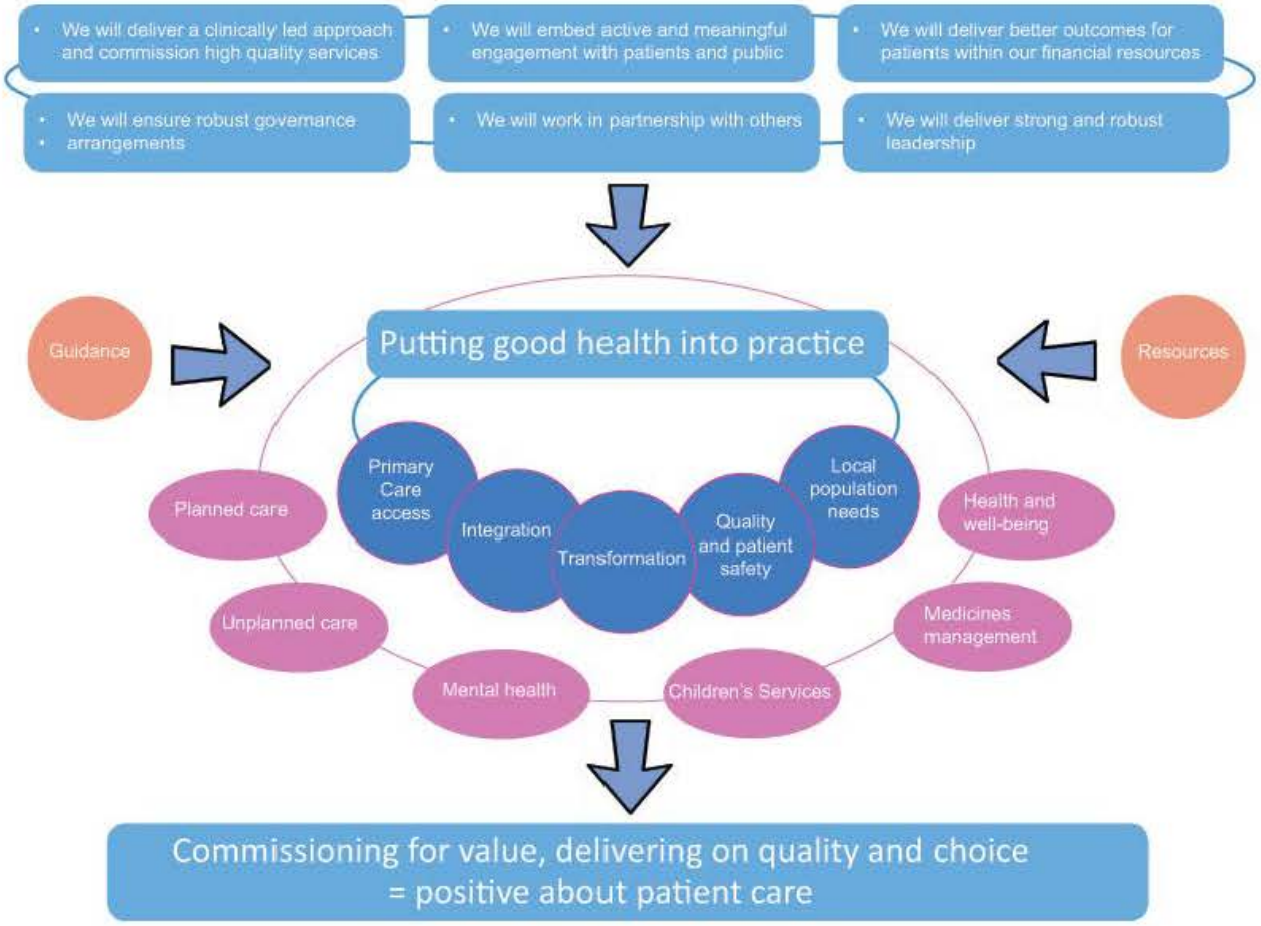


Continuing on from the shadow year and into our first year as a statutory organisation, we have established strong relationships with stakeholders and in turn have welcomed and appreciated the support and commitment that stakeholders have given to us.

The Governing Body has embedded collaboration across the whole health and social care economy through engagement with patients and the public, partnership working and delivering economies as fundamentals that are only achievable through our strong network of stakeholders.

Our Business Model

Our business model reflects how we will add value and commission high quality services and care by aligning our local strategic approach with the wider health and social care economy and objectives.



Delivery of Our Duties

We have maintained a strong focus on the delivery of our duties alongside our strategic objectives and how this has been achieved is illustrated below with further detail included within the Annual Report.

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

Acted with a view to ensuring that health services are provided in a way which promotes the NHS Constitution, and that it has promoted awareness of the NHS Constitution among patients, staff and members of the public. • Delivered against targets on patient rights under the NHS Constitution • Comprehensive reporting to the Governing Body • Driven forward self-management and shared decision making • Dedicated team supporting delivery of safety, effectiveness and experience • Promotion of NHS Constitution on intranet and internet	Assisted and supported NHS England in discharging its duties relating to securing the continuous improvement in the quality of primary medical services. • Dedicated team in the CCG working with practices • Development of a Primary Care Strategy, in collaboration with NHS England • Worked jointly with NHS England on issues relating to NNE GP practices • Worked jointly with NHS England on the future landscape of NNE GP practices
Promoted the involvement of patients, their carers and representatives in decisions that relate to the prevention or diagnosis of illness in the patient, their care and treatment. • Involved patients and public in all service design work • Lay Member PPI on the Governing Body. Patient Representative on the Governing Body • People's Council as a Committee of the Governing Body • Demonstrably acted on patient and carer feedback at all stages of the commissioning cycle • Published information on our web-site on activity that has taken place	Enabled patients to make choices with respect to the aspects of health services provided to them. • Implemented the Right Care approach and shared-decision making • Actively taken on board feedback from patients and public about more information on self-care which is supported through all commissioning activities • Implemented tele-health • Launched NNE MyHealth smartphone app • Patient information available through NNE site on digital TV channels
Promoted innovation, research, education and training • "Can do" culture supports innovative ideas • Promoted the key goal of NNE commissioning process is to promote a cycle of successful innovation • Actively engaged with a wide range of stakeholders to enhance innovative ideas • Supported various research projects on either an admin basis, promotion of trials amongst GP practices, undertaking research surveys, • Member of the East Midlands Academic Health Science Network • Education and training promoted to GP	Consulted widely when devising its commissioning plans • Consulted with the Health and Wellbeing Board • Consulted with neighbouring CCGs • Consulted with patients and public • Consulted with voluntary sector • Consulted with providers • Consulted with staff

practices on a weekly basis, supported training programme for GP Practice Managers, Practice Learning Times provided for clinical training, CCG staff are provided access to training through different sources and accredited programmes	
Taken appropriate steps to secure that it is properly prepared for dealing with a relevant emergency. • Business Continuity Plan • Have taken the operational lead for south CCGs on emergency planning • Worked jointly with Area Team on emergency plans • Represented on the Local Health Resilience Partnership which feeds into the Local Resilience Forum • Represented south Nottinghamshire CCGs on the Health Protection Strategy Group	Cooperated with its Health and Wellbeing Board in relation to the discharge of the Health and Wellbeing Board's functions. • Member on the Health and Wellbeing Board • Jointly contributed to the Health and Wellbeing Strategy • Supported delivery of the health and wellbeing strategy • Presented strategies to the Health and Wellbeing Board for approval • Health and Wellbeing Board members directly involved in the development of the Better Care Fund
Discharged its functions with regard to the need to safeguard and promote the welfare of children. • Member on the Nottinghamshire Safeguarding Children Committee • Director of Quality & Patient Safety has a lead responsibility • Processes in place to link in and report through the Nottinghamshire agencies • Training carried out with staff and the Governing Body	Cooperated in relation to the preparation of Joint Strategic Needs Assessments. • Member on working group with Public Health • Inputted to the analysis and CCG reflection on NNE population • Utilised as part of commissioning cycle and in commissioning plan • Inputted to the update for 2014/15

Our Strategic Objectives

Our strategic objectives align with the NHS England CCG Assurance Framework and are both achievable and aspirational. During 2013/14, the strategic objectives have supported the CCG by defining and exploiting our strengths, focusing us on grasping opportunities whilst managing and defending against weaknesses and risks.

1. We will deliver a clinically led approach and commission high quality services

We have welcomed and embraced a clinically led approach, which is championed by our Clinical Lead and Chair, Dr Paul Oliver. The clinicians on the Governing Body have ensured this approach by taking a strategic lead on work streams that have delivered direct results to the CCG.

The work streams for 2013/14 included planned care, unplanned care, mental health, prescribing and children's services. The Commissioning Plan provides detail on all these projects, and below are areas where the CCG have been able to achieve a significant impact during 2013/14

Planned Care – Integrated Health and Social Care Model

Implementation of the Integrated Health and Social Care Model was a radical change in how adult community services were delivered. The change delivered immediate improvements in care and the results to date include a reduction in emergency admissions, capacity to align resource to evenings and weekends, improved patient experience by reducing the number of people visiting and providing consistency in care. Integrated teams offer a significantly improved patient experience reducing the number of unnecessary visits from multiple staff and providing more holistic care. Staff now have the skills to assess and manage a range of nursing and therapy problems during the visit making sure the most appropriate team member attends for complex care needs.

Unplanned Care – Urgent Care Model

The Urgent Care Model is a pilot which radically changes the way urgent appointments are managed within NNE CCG. The business model indicates that the approach will allow more time for other appointments, in particular for individuals with long-term conditions and co-morbidities.

Mental Health

We have provided additional resources to carers services for people with Dementia, developed a carers pack of information which will be available through member practices, invested in a website that will provide advice, services, clinical information on dementia, are members of the Dementia Action Alliance, and has invested in a memory assessment service.

Children's Services

We took the lead in Nottinghamshire for the development of the health and Local Authority joint commissioning service. This has allowed for resources to be more effectively managed through the elimination of duplication, as well as tackling disjointed pathways and access to services.

Prescribing

The prescribing team work directly within GP practices and have been successful in supporting Medicines Management Facilitators within all NNE practices. Other projects include optimising medicines, wound care and urinary incontinence products. With respect to optimising medicines, the team have been working with practices to identify high risk patients leading to a review of medications and actions to help improve patient safety. The team also introduced centralised ordering of dressings through NHS Logistics as opposed to by GP prescriptions. The initiative has provided savings to the CCG and time savings to GP practices. Evaluation forms were distributed to CHP staff, GP practices and patients. First indications are that this is a preferable service and neither District Nurses or GP practices wish to return to ordering dressings on prescriptions. The team also streamlined the ordering of urinary incontinence products with products being prescribed by continence nurses instead of GPs.

Quality

For NNE CCG, 2013/14 has been about enhancing systems and processes to understand and improve the quality of services that are being provided. Through the strong efforts of the Director of Quality and Patient Safety and her team, NNE CCG has robust systems in place supported by effective

relationships with providers. NNE CCG has also been successful in ensuring that these systems and processes work as a shared service to NHS Rushcliffe CCG and NHS Nottingham West CCG. The Quality and Patient Safety Team are working centrally and collaboratively with the Nottinghamshire health and social care community, including NHS England. We are active members of the NHS England Area Team Quality Surveillance Group where we share quality information.

Key deliverables are as follows:

- The Governing Body have delivered to the Quality Strategy for 2013/14, improved the safety culture of the organisation and approved a Quality Strategy for 2014/15.
- Quality is a core part of every Governing Body agenda, including patient experience through patient stories which brings back discussions to the impact of care on patients.
- Patient experience has been embedded in the CCG, with resources directly responsible for gathering and using intelligence to improve care. The Governing Body actively supported the implementation of an electronic issues log, which enables GPs and other clinicians to gather real time feedback from patients.
- The Governing Body Secondary Care Consultant has led on the implementation of an Action Plan to ensure the CCG is fully compliant with the recommendations made in the Francis Report.
- Safeguarding Committees for children and adults have been established and have embedded safeguarding governance and accountability arrangements.
- The Multi Agency Safeguarding Hub has been directly approved by the CCG
- The actions from the Winterbourne View Hospital review have been implemented
- A strategic approach with the Local Authority on the review of care homes has had a direct impact on patient safety and standards of care. This has also allowed for the elimination of duplication in work and improved information sharing and timely interventions.
- Systems and processes have been established with the main providers and NHS England to gather and interpret intelligence on quality areas. Quality panels and quality visits have been working effectively to highlight concerns and acknowledge best practice. Lay members have been trained to carry out quality reviews.
- A reduction in harm has been achieved through the CCG working with providers on systems and processes.
- Quality standards are built into service specifications and contract quality schedules.
- Quality is an integral aspect of the current review of clinical referral thresholds for secondary care
- Commissioning for Quality and Innovation (CQUIN) scheme and contract quality schedules include innovative schemes to improve the safety and experience of patients.

Performance

Through the Director of Outcomes and Information and the Systems Analyst resource in the CCG, robust performance management systems were established in 2013/14 and we are confident that the Governing Body receive reliable and robust data and intelligence.

Key points to highlight on performance include the following:

- The CCG, along with the neighbouring south CCGs are working, with support from the Area Team, to improve the four hour target for Accident & Emergency (A&E). Since this has continued to be an area of challenge during 2013/14, a comprehensive Action Plan will be delivered during 2014/15. In the NNE CCG area, 93.99 per cent of patients were treated within four hours of attending Accident and Emergency (the required National Standard is 95 per cent).
- Year to date A&E attendances up to March 2014 have seen a slight increase from the previous year (1%). Despite this NNE CCG has maintained the second lowest rate in Nottinghamshire (City & County CCGs).
- Overall Outpatient first attendances have reduced from last and previous years, particularly from GP referrals, despite a one per cent increase in registered population. This could be a reduction in inappropriate referrals. In Nottinghamshire (City and County CCGs), NNE CCG achieved the second lowest referral rate in all specialties excluding diagnostic imaging. Our 'relative' position compared to other local CCGs has also improved as other CCGs have seen an increase in outpatient activity. The largest reduction has occurred in Orthopaedic attendances following the introduction of the Nottingham MSK Assessment & Treatment Service (NMATS).
- Emergency admissions up to March 2014 have seen a slight decrease from last year. Emergency admissions requested by a GP have seen a five per cent reduction, while admissions for patients aged 65 and over have reduced by four per cent, which means we have achieved our Local Priority 2. This could be partially attributed to the introduction of the Community Hub.
- Referrals to Outpatients in Cardiology and Diabetic Medicine have increased slightly. However, follow-up attendances in Cardiology and Diabetic Medicine have both seen a big reduction (nine per cent and 11 per cent respectively), which is a result of more patients being managed in Primary Care following programmed discharges from Secondary Care which the CCG clinically supported.

Further detail on performance is provided in the section on Key Performance Indicators.

2. We will embed active and meaningful engagement with patients and public

During 2013/14, we have welcomed the support and active involvement from patients and public and we would like to thank the People's Council who give their time, skills and experiences to the substantial benefit of the CCG.

We have established a robust platform for active and meaningful engagement through the following:

- We have two lay members, including a lay member for patient and public engagement who takes an active role in ensuring that the Governing Body is focused on the patient voice. We also have a Patient and Public Representative on the Governing Body who actively brings the patient to the centre of all discussions and decision making in relation to governance as well as the commissioning cycle.
- The Lay Member chairs the People's Council, which is attended by patient and public representatives from the registered population within NNE CCG, as well as the voluntary sector. The People's Council receive feedback on patient and public engagement activities to inform discussions.
- The Clinical Cabinet receive patient and public feedback on all items relevant to service changes, improvements and contracting decisions.

- We publish evidence on their website on what activity has taken place and how the feedback has been used.
- We are using technology as an enabler for engagement and now delivers patient information and services on a range of digital channels, including a new CCG website, a NNE CCG App, Sky TV, Virgin TV, games consoles and social media.
- We actively promote individual participation in care and treatment through commissioning activities by involving patients and public in all service design and redesign work. During 2013/14 patients, carers and the general public have been involved through engagement activities and providing feedback or directly inputting into the design of services. Through these activities, NNE CCG ensures that it listens and acts upon patient and carer feedback at all stages of the commissioning cycle.
- The CCG also involve patients and public in the ongoing contract monitoring through quality panels, patient stories and lessons learnt.
- We hold quarterly 'Voice for Health' events, which are open presentations and discussions on the local NHS and the progress of the CCG. During 2013/14, these have also been linked to 'Call to Action', which the CCG has been working on with NHS Nottingham City CCG, NHS Rushcliffe CCG and NHS Nottingham West CCG.
- Leading on a Citizens Advisory Group for the South Nottinghamshire Transformation Board. The Citizens Advisory Group includes representation from the local providers and Local Authority.
- Directly working with Public Health on the joint strategic needs assessment.
- Actively working with Healthwatch by sitting on the Healthwatch Advisory Group as the South Nottinghamshire CCG representative.

3. Through robust plans, we will deliver better outcomes for patients within our financial resources

We began the year in a challenging financial position, with a reduced surplus target set by NHS England. As such, the achievement of these targets is a notable success and thanks go to our staff, managers and members for their support in this achievement.

Furthermore, delivery of QIPP (Quality, Innovation, Productivity and Prevention) schemes and targets, plus control on expenditure, has enabled the CCG to agree and achieve a higher surplus target of £1.01m (against the opening target of £0.52m).

We developed a robust turnaround plan that has resulted in improved outcomes for patients. Further to the projects listed above, we have implemented the following:

- We have been using the Right Care methodology since 2012/2013, which has provided the baseline and foundations to effectively target resources and priority areas. During 2014/15, NNE CCG has commissioned 'deep dives' in neurology, respiratory and mental health, as these have been identified as areas where quality of care and cost effectiveness could be of better value. Along with NHS Nottingham West CCG and NHS Rushcliffe CCG, we have also commissioned in-depth analysis on cancer services, which will provide focus and direction in order to deliver real change in 2014/15.

  Through the work of Right Care, we are committed to implementing shared decision making. Shared decision making allows a patient to work with their clinician to make informed decisions regarding treatment based on clinical evidence. The process is applied systematically and involves the provision of evidence-based information about options, outcomes and

uncertainties, together with decision support counseling and a system for recording and implementing patients' informed preferences.

- Member practices highlighted the benefits of educating GPs to confirm suspicion of a Basal Cell Carcinoma (BCC) with patients at the GP practice. In an attempt to reduce referrals and patients unnecessarily having to attend outpatient appointments, the two-week wait BCC Community Triage Training Clinic was commissioned to up-skill GPs in the recognition of BCC. The aim of the Training Clinic was to enable GP attendees to confirm suspicion of (but not confirm diagnosis of) a BCC. Seventeen GPs across 13 practices have completed the training.

- In 2013/14, we commissioned a home oxygen assessment service hosted by Nottingham University Hospitals NHS Trust (NUH). The aims of the service are to improve the accessibility and quality of services, reduce inappropriate prescribing, improve the clinical pathway for long term oxygen therapy assessment and review, develop patient education and safety when prescribed home education, improve outcomes for patients, and ensure the service is affordable and value for money.

  Through the development of the services, we also designed and built a home oxygen portal, which is a centralised access point for recording reviews and their outcomes. This has enabled the respiratory teams both in NUH and the community to improve their communication, joint working and has, ultimately, improved outcomes for patients.

- In December 2013 the business case was approved for the continuation of Flo-Telehealth in 2014/15. Telehealth is a remote monitoring system which can be used to monitor patients with specific conditions. The system collects, monitors and alerts health care professionals to patients whose data falls outside of agreed parameters. The system uses daily encouragement, prompts and interactive contact via text messages to improve patient cooperation with treatment plans. It is currently being used in NNE CCG with patients who have diabetes, hypertension, and weight management difficulties. It can be used for medication and appointment reminders, and has also been trialled with smoking cessation, care homes and the traveller community in other CCG areas.

4. We will ensure robust governance arrangements

Statutory Duties	Full Year Actual Position (£'000)	Full Year Planned Position (£'000)	Risk Rating	Comments
Nottingham North and East CCG Remain within the Programme Cost allocation.	- 943	-1,013	Green	Nottingham North and East CCG has delivered the required position and underspent by £943k against the Programme budget allocation.
Nottingham North and East CCG Remain within Running Cost Target.	3,339	3,414	Green	Nottingham North and East CCG has delivered the required position and underspent by £75k against the agreed Running Cost Allowance
The CCG has achieved the delegated duty to keep expenditure within the revised planned surplus for the year to 31st March 2014.	-1,018	-1,013	Green	The CCG planned surplus was increased from £516k to £1,013k. The £943k Programme underspend plus the £75k Running Cost underspend delivers the combined surplus of £1,018k.
Remain within maximum cash draw down limit	48.1	<250	Green	Nottingham North and East CCG has achieved the necessary requirements.

Our governance arrangements were established whilst in shadow form and have proven robust during 2013/14 as we evolved to meet the changing landscape and challenges within the health economy. In carrying out their self-assessment, the Governing Body acknowledge the capabilities of the governance structure in ensuring that that they are effective.

As already mentioned, our financial performance at the beginning of the year required the delivery of a robust turnaround plan. We achieved all the key financial NHS England requirements for the year, including remaining within resources available, delivering our planned surplus, achieving our agreed year end cash balance and delivering against the Better Payment Practice Code target.

We started the year in a challenging financial position, with a reduced surplus target set by NHS England. As such, achieving these targets is a notable success and thanks go to our staff, managers and members for their support in this achievement. Furthermore, delivery of QIPP (Quality, Innovation, Productivity and Prevention) schemes and targets, plus control on expenditure, has enabled us to agree and achieve a higher surplus target of £1.01m (against the opening target of £0.52m).

We acknowledge that providing health services is an inherently risky business and that risk can bring with it positive advantages, benefits and opportunities. NNE CCG is not aiming to create a risk-free environment, but rather one in which risk is appropriately identified, considered as part of everyday business and then appropriately mitigated.

The CCG Integrated Risk Management Framework is embedded in the normal management processes and structures and encouraged by a responsible culture. The Integrated Risk Management Framework promotes the philosophy of integrated governance and requires all risk management to be systematic, robust and evident. It requires that risk management and prevention processes are applied at all levels and that risk management issues should be communicated to key stakeholders where necessary.

The framework covers clinical (including safeguarding), corporate, organisational and financial risk and identifies the key management structures and processes defining objectives and responsibilities at the different staff tiers within the organisation. The principles of the framework are consistent with the organisations culture and key priorities of people, quality, health outcomes, financial management, reputation and environment.

The framework is supported by the CCG internal meetings and processes which provide reasonable assurance for the prevention of risk, deterrent to risks arising and management of current risks. Risk management is embedded within the organisation through its effective management of risk registers, incident reporting, equality impact assessments, quality impact assessments, committee structure and meetings.

We are confident that are governance arrangements will support us in the challenges, trends and factors for 2014/15 namely transformational change, sustainable financial recovery, continued development of primary care, integration and partnership working and specifically the management of the urgent care system as a health community.

The CCG are committed to respecting and promoting human rights in our operations and in our circle of influence through the actions of the Governing Body and leaders of the CCG and in working with our partners. As such, NNE also recognise the benefits of working within local communities themselves and supporting them to change. Working alongside local partners and member practices who are part of their local communities, NNE CCG are delivering community projects that work to address the needs of the local population and provide additional support. NNE are also delivering directly in relation to the Health and Wellbeing Strategy.

Trends and Factors

Transformational Change

- The current cost of the health and social care economy in South Nottinghamshire is in the region of £1,032m (excluding NHS England expenditure on nationally commissioned services which includes GP contracts and specialised services and LA services such as public health). The largest proportion of this spending is on acute services (39%), followed by adult social care (26%) and then primary care (10%) which does not include spend on general practitioners.
- The costs of delivering care will increase as a result of population growth and ageing and as a result of medical inflation. The result of this is that if services continue to be delivered as they are now, current estimates are that there will be a gap in the region of £100m and £140m by 2018/19 between available funding and the actual costs of delivering health and social care in South Nottinghamshire.

Sustainable Financial Recovery

The key risks impacting on financial recovery are as follows:

- There are a number of key risks in delivering the planned surplus target in 2014/15 and 2015/16. The delivery of the QIPP target is key to attaining financial balance, and the CCG has currently identified QIPP schemes in excess of the £4,222k target.

- Acute spend will continue to be a risk area for the CCG and delivery of acute QIPP targets and maintaining referrals and admissions within growth targets are key. Careful investment of the non recurrent monies will be required to assist in the transformation agenda and strategy to reduce secondary care activity.
- Other risk spend areas will be Continuing Healthcare costs and Prescribing costs. Mitigations for these are the QIPP plans in excess of target as noted above, plus contingency and other risk reserves. As in 2013/14, an element of non-recurrent funds will also be held back at plan stage, until the in-year spend position becomes clearer.
- In 2014/15 and, perhaps more so in 2015/16, there will be pressure on the CCG resulting from the Local Authority budget cuts. Work to quantify the scale of the impact from the proposals is continuing. Discussions with LA and other partners around the deployment of the Better Care Fund in 2015/16 are underway.

Development of Primary Care

- The provider/commissioner arrangements hold both benefits and risks and it is important that the CCG continues to work closely with our members to ensure they feel confident in the new environment. Development of primary care needs to focus on developing the individual GP practices as separate businesses, ensuring access within the NNE communities, ensuring quality of care.
- Development of primary care also means member practices working differently together. Then need to ensure that they are fully supportive of each other and will work integrally with other providers of care, including other primary services, community and secondary care providers to deliver joined up services that provide person-centred accessible care and which enables people to take control of their health and independence.
- Where appropriate, innovation will be embraced as will new technologies and ways of working to enable the delivery of the above. Member practices will seek to adopt an ethos of continuous improvement through education and peer support.

Integration and Partnership Working

- Partnership working has been challenged during 2013/14 and will need to work together effectively during 2014/15 to ensure that we are delivering as a health community. The management of the urgent care system was a top priority in 2013/14 and remains a high risk for 2014/15.
- Integrated working with the Local Authority is a challenge which the local authority and CCG have embraced and it is a new way of working for organisations with different cultures. Effective management of resources in order to meet the needs of the local population will continue to be a central focus.

5. We will work in partnership with others

The current environment is challenging for all NHS organisations and NNE CCG are committed to building on existing relationships and driving forward integrated and partnership working. 2013/14 saw a sharp increase in partnership working due to the strong commitment across all sectors to improve the local health and social care economy and services.

In particular, during the shadow year and 2013/14 NNE CCG has built robust and sustainable partnership arrangements with the other Nottinghamshire CCGs. The arrangements are supported through Memorandums of Understanding for collaborative commissioning and for governance and shared services. The partnership arrangements have proven their effectiveness as they have been challenged during 2013/14, and through this strengthened.

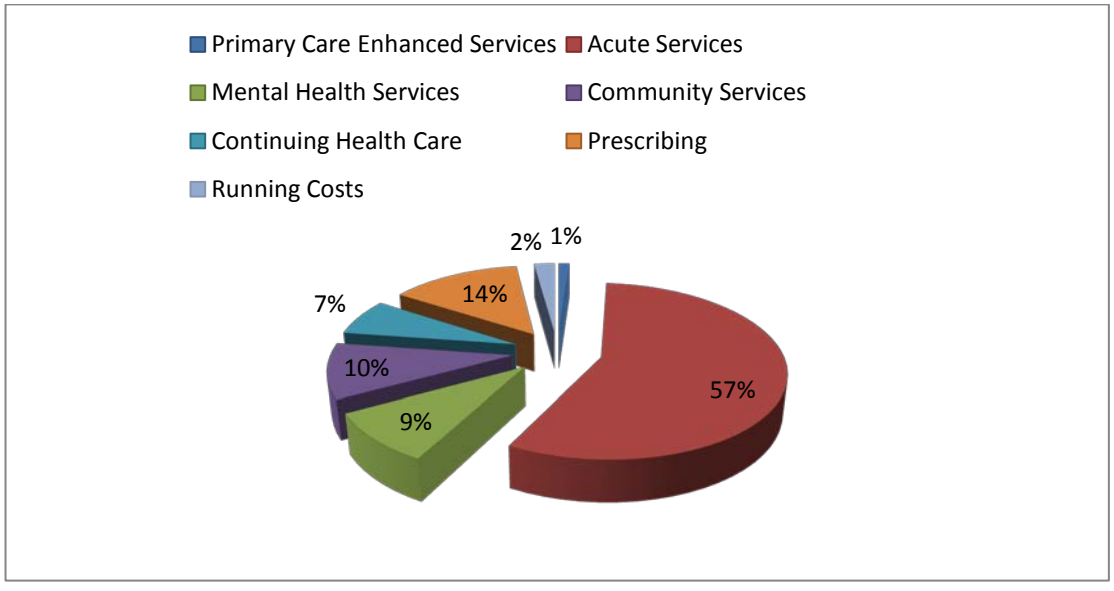
Further to the relationship with NHS England mentioned above with respect to assurance, the CCG has built a strong partnership with the Area Team on commissioning and quality of services. As part of the Nottinghamshire/Derbyshire Area Team, NNE CCG are pleased to have won the bid for the Prime Minister's Challenge Fund and are committed to using this opportunity to improve access and transform primary care.

NHS NNE CCG, alongside the other Nottinghamshire CCGs, are also actively working in partnership with local authorities and are driving forward the development of the Better Care Fund and associated plans. The Greater Nottingham health and social care economy (CCGs, local authorities, practices and citizens) have come together to develop a vision for seamless integrated care which is focused on providing proactive, holistic and more responsive services for local communities.

The provider partners the CCG commissions from include hospital (secondary care) services, mainly from Nottingham University Hospitals NHS Trust (NUH) but also from Sherwood Forest Hospitals NHS Foundation Trust and Derby Hospitals Foundation Trust.

NHS Nottinghamshire Healthcare Trust is the main mental health provider and County Health Partnerships (CHP), a division of NHS Nottinghamshire Healthcare Trust, is the main community services provider. The CCG also commissions services from Circle Nottingham based at the NHS Treatment Centre.

The CCG also commissions services from the voluntary sector and has been providing a Crisis Intervention Community Support Service through the British Red Cross for five years (originally commissioned as Practice Based Commissioning Consortium).



Furthermore, during 2013/14 NHS England introduced units of planning that support the commitment to working in partnership. NNE CCG is part of a 'unit of planning' which also includes NHS Rushcliffe CCG, NHS Nottingham West CCG and NHS Nottingham City CCG.

The unit of planning is formally working as the south Nottinghamshire healthcare economy (South Notts), which is a system comprised of twelve partner organisations across health and social care who have come together to agree, refine and implement the vision to support improvement in health and social care outcomes.

Aside from the CCGs, the partner organisations include Nottingham City Council, Nottinghamshire County Council, Nottingham University Hospital Trust, County Health Partnerships, Nottinghamshire Healthcare Trust, Nottingham CityCare Partnership, East Midlands Ambulance Trust and Circle Partnership, NHS England Primary Care and Specialised Commissioning and Primary Care. Healthwatch Nottingham and Healthwatch Nottinghamshire are represented on the South Nottinghamshire Transformation Board as participating observers.

The Governing Body have championed and led on partnership working in order to drive forward the success of the CCG in a dynamic and sometimes complex environment. To deliver the scale and pace of change necessary for the NHS to continue to deliver against health care needs, the focus needs to be on forecasting for the future within the whole health and social care economy while delivering locally.

External Environmental Factors

Factors which will continue to be fundamental consideration for the Governing Body during 2014/15 include the following:

- Economic factors – continued pressure on savings within the NHS and the local health economy, challenging QIPP savings specific to the CCG, and the Local Authority cutbacks; minimal growth in NNE CCG allocation; preparing for reduced running cost allowance from 2015/16 impacting on workforce; increasing costs in delivering services; financial position of local NHS Trusts; limited market or new entrants to the market due to the increasing costs of providing care against the savings; short term contracts for providers reducing viability of business cases; capacity of CCG team to manage scale of contracts through increased any qualified provider; risk of limited market due to complexities and challenges of delivering care.
- Technological factors – CCG commitment and spending on research; managing GP IT in order to ensure efficiency as well as improvements in care through technology; government spending on research; taking advantage of improved opportunities to deliver efficiencies, responsiveness, access to services and quality of care through technology.
- Legal factors – delivery against the statutory duties and subsequently the assurance process in order to remain viable as an organisation; employment law; capability to provide choice and competition in a limited market.
- Political factors – government stability; government policy and regulation; extent of top down influence on the CCG; delivery of guidance, ensure strong relationships with the different district/borough councils associated with NNE.
- Social and cultural factors – population demographics and reducing health inequalities; income distribution and potential pressures due to impact of benefit changes; acceptance and change towards self-management and health promotion; Public Health moving to the Local Authority supporting health promotion; lifestyle changes.

6. We will ensure strong and robust leadership

Our achievements during 2013/14, during a period of substantial change, demonstrate strong and robust leadership.

The Governing Body have self-assessed themselves against the Standards for Members of NHS Boards and Governing Bodies in England, Framework for Excellence in Clinical Commissioning for CCGs and The Healthy NHS Board 2013. In comparing the most recent self-assessment against that which was done prior to the CCG became a statutory organisation, the Governing Body are demonstrably more confident with an increase in approximately two points across each domain. Through facing the challenges during the first year in operation, the Governing Body are working as a strong team with accountability to the CCG and its population. Areas of development include technical knowledge, working at a strategic level versus operational and managing roles and responsibilities alongside the executive team, assurance on the complexity of planning and outcomes for the local population.

The CCG went through a re-structure the beginning of 2013/14 and this has served to strengthen the organisation by aligning roles and providing clarity on responsibilities. As vacancies have arisen during the year, roles have been reviewed relative to the changing landscape and an increased understanding of the balance of priorities for the CCG. The Organisational Development plan has been delivered during 2013/14 and is being updated to reflect the changing environment and increased responsibilities for 2014/15. We encourage and support our employees and Governing Body members in achieving their full potential by providing a range of learning and development programmes and this will be expanded in 2014/15 through the East Midlands Leadership Academy, Gedling Borough Council accredited management development programmes and NVQs and through services provided by GEM Commissioning Support Unit.

During 2014/15 we will continue to work in close partnership within the Nottinghamshire health and social care economy. This is being supported by an organisational development programme through the South Notts Transformation Board.

We are looking forward to our Chair increasing his commitment for 2014/15 in order to support our capability and capacity to deliver transformational change.

Key Performance Indicators

How well did we perform?

Delivery against CCG dashboard, including the NHS Constitution, provides the following highlights. Further information on the performance of the CCG can be found in the NHS England Balanced Scorecard. NNE also has a balanced scorecard providing a summary of business performance.

Indicator	National Standard	NNE Performance
Referral to Treatment		
Admitted and treated within 18 weeks	90%	95.49%
Non-admitted and treated within 18 weeks	95%	97.64%
Incomplete patients treated within 18 weeks	92%	96.72%
Wait more than six weeks for diagnostic test	1% tolerance	14 patients
Cancer		
Seen within 14 days of referral by a GP	93%	95.46%
First treatment within 31 days following a diagnosis	96%	96.85%
Treated within 62 days of referral	85%	84.75%
Accident and Emergency		
Treated within four hours from arrival to admission, transfer or discharge	95%	93.99%
Ambulance Calls		
Emergency response within eight minutes	75%	72.55%
Emergency response within 19 minutes	95%	93.49%
Psychological Therapies	NNE Target	NNE Performance
The percentage of people who have depression and/or anxiety disorders who receive psychological therapies	10.42%	8.13%

Technical Definitions can be found at http://www.england.nhs.uk/wp-content/uploads/2013/04/ec-tech-def.pdf

Risk Overview

What might challenge the delivery of our strategic objectives?

The following provides an overview of the resources, principle risks, uncertainties and relationships that may affect NNE's long-term performance.

Risk	Specific risks we face
Lack of adequate clinical challenge may lead to compromised quality, outcomes or inappropriate prioritisation. The CCG is unable to provide confidence to its local population that it is commissioning clinically safe, high quality, compassionate services.	• Failure to manage urgent care as a community • Failure to meet targets through Providers • Challenges to aligning Transformation as a CCG community alongside local priorities
Culture and leadership approach inhibit focus on equality and diversity, resulting in inappropriate corporate and commissioning decision making and limited impact on reducing health inequalities.	• Challenges in balancing resources and priorities diverts focus from population needs • Additional pressure changes "can do" attitude and staff motivation • Focus on the delivery of the scale of financial savings reduces capability to deliver against health inequalities • Failure to successfully engage with employees
Joint (shared) commissioning is negatively impacted by an ineffective commissioning and decision making architecture resulting in the CCG not being recognised as a system leader. Also resulting in the CCG not being able to harness its collective influence and commissioning power.	• Unable to achieve ongoing commitment to transformation programme due to conflicting priorities in individual organisations • Challenges to achieving commissioning success for transformation projects • A substantial increase in activity for any of the organisations in the health community destabilises decision making approach • Changes in leadership, failure to attract and retain key personnel
Ineffective patient and public engagement results in services which do not fully reflect the patient voice and local needs – in relation to every decision taken in the purchasing, commissioning and provision of services.	• Misuse of interactions with patients and public fail to deliver intelligence • Failure to take a strategic approach resulting in limited capacity • Competing priorities • Pace of change limits capabilities to engage with patients and public
Lack of wider clinical engagement in the development and implementation of commissioning strategy and QIPP plan, resulting in inadequate transparency in decision making and measurable improvements.	• Clinicians fail to appreciate priorities within the wider health economy • Clinical capacity is not available to contribute effectively to business cases and service specifications • Competing provider and commissioner priorities impact on capacity
Lack of significant QIPP service transformation in order to deliver improved outcomes, quality and productivity (against plan) whilst reducing unwarranted variation and health inequalities within available finances	• Adverse impact of wider community changes impacts on CCG's delivery of QIPP • Negative effect of competing priorities • Individual member practices business issues affect inability to engage with changes • Unable to change patient behaviour

Governance arrangements are not rigorous enough to withstand challenge or flexible enough to enable local leadership from the clinical community.	• Adverse impact of new guidance • Resource limitations • Failure to adhere to regulations • Additional responsibilities move to CCGs
Failure to meet expenditure within financial allocations and to deliver against statutory duties, national financial metrics and local commitments.	• Sudden increase in demand on local acute and community health services. • Integrated budgets and delivering effectively • Capability to change patient behaviour to allow for added value in changes to the way services are delivered • Managing day to day and activity alongside transformational change
Make/share/buy arrangements do not provide added value and support the CCG in delivering statutory functions efficiently, effectively and economically.	• Commissioning Support Unit fails to deliver against key performance indicators • Failure to receive agreed level of shared resource • Changes in landscape for Commissioning Support Units impacts on capability to deliver services
Failure to maintain an organisational structure appropriate for commissioning high quality services and meeting the requirements of a good employer	• Reduction in running cost allowance impacts on structure • Additional responsibilities impact on capability • Make/Share/Buy structure is no longer sustainable
Financial and performance information is not sufficiently developed to enable appropriate scrutiny and challenge and/or the Governing Body fail to challenge the information provided	• Failure to retain key analysts • Failure to align reporting in order to provide a comprehensive overview
The strategic direction fails to reflect common local needs and national priorities due to a lack of engagement with stakeholders and partners (eg Health and Wellbeing Board, local authorities, voluntary sector)	• Inability of partners in South Notts Transformation Board to work together effectively • Challenges in culture impact on capability to deliver • Inability to transform strategy into local achievable deliverables
Inadequate contract and performance management systems at individual and collective CCG level.	• Inability to effectively manage volume of contracts in shared team • Unable to maintain effective management of ongoing contracts alongside delivering change
Patients and public do not feel able to impact on CCG decision making and the CCG is not a recognisable public body resulting in lack of confidence and individuals do not support participation in their own care.	• Adverse impact on resource resulting in limited capability to promote the CCG • Change in Lay Member for Patient and Public Involvement • Inability to work effectively as health economy on patient and public engagement
Lack of member practice engagement in priorities, service redesign and ownership of the CCG commissioning responsibilities impacts on delivery of transformational change.	• Challenges for member practices to balance limited resources, allowing for buy in to commissioning decisions • Increased patient activity at individual member practices diverts focus on commissioning • Member practices do not engage with commissioning programme
Insufficient Governing Body and CCG management leadership skills individually and collectively, to allow for commitment, capacity, capability and deliver transformational change	• Inability to retain key employees • Pace of change impacts on capabilities • Inefficient alignment of resources against priorities

Financial Review

Financial Position

During the year we achieved all the financial key performance indicators including:

- We achieved the delegated duty to keep expenditure within the planned surplus of £1.01 million for the period April 2013 to March 2014.
- We kept within the planned running cost (administration and management) allocation of £3.41 million.
- We remained within the cash limit for the period April 2013 to March 2014.
- We achieved the Better Payments Practice Code (BPPC) of paying 95 per cent of invoices both in terms of invoice volume and value within 30 days.

2014/15 Onwards

The CCG's financial plans for 2014-15 and beyond seek to fulfil the broader strategic objectives, whilst retaining a sound financial position. NNECCG will receive 2.14% growth in 2014-15 and the CCG's financial plan delivers all recurrent outturn pressures. The Marginal Rate Emergency Tariff (MRET) funds, linked to hospital urgent and emergency care, have been ring fenced and will be invested in the health community in line with Urgent Care Working Group guidance. The 2.5% non-recurrent funds (Call to Action and Transformational Funds) will also be invested, together with the re-ablement and readmissions funds on a basis shared with other greater Nottingham CCGs. This pooling of resource will enable the funds to be used in a more strategic manner, including the continuation of QIPP pump priming, primary care developments, community care beds and home care investment.

The CCG will invest £4.1m in 2014-15 which includes recurrent developments, investments from the readmissions and MRET reserves and investments non-recurrently from the £1.0m surplus brought forward from 2013-14 and the Transformational Fund. In order to deliver against our objectives, investments will focus on our primary care strategy including primary care access, integration and transformation.

For 2014/15, NNE CCG has received a programme allocation uplift of £3,436k (2.1%). Once the planning assumptions, outturn pressures and developments are factored into the expenditure plans, the CCG has a QIPP target of £4,222k (2.5%) in 2014/15 and £4,332k (2.5%) in 2015/16. A breakdown is provided in table 1.

Table 1

	2014-15 (£'000)	2015-16 (£'000)	2016-17 (£'000)	2017-18 (£'000)	2018-19 (£'000)
Total Revenue Resource Limit	168,420	174,641	177,910	180,867	183,887
Running Costs (Admin. & Manag.)	3,375	3,201	3,201	3,201	3,201
Contingency Reserve	843	874	898	922	965
Surplus	1,686	1,763	1,780	1,810	1,842
Underlying Recurrent Surplus	4,687	4,327	3,558	3,581	3,643
Net QIPP savings	4,222	4,332	3,800	3,800	3,800

Risk Pooling

A financial risk pooling agreement has been in place for the Nottinghamshire County Clinical Commissioning Groups (CCGs) since they started in shadow form as part of Nottinghamshire County PCT. The 2013/14 financial risk pooling arrangements in place for the five CCGs in Nottinghamshire have been approved by the Governing Body.

A review of the current arrangements has been undertaken which has recommended:

- High cost patients and one-off "major incidents" would be risk shared at a City/County basis
- Risk sharing on year-end surplus/deficit positions would be done at a Mid Notts/South Notts level on an informal basis.

MEMBERS REPORT

NNE CCG Member Practices

1. Apple Tree Medical Practice Burton Joyce
2. Calverton Practice, Calverton
3. Daybrook Medical Practice, Daybrook
4. Giltbrook Surgery, Giltbrook
5. Highcroft Surgery, Arnold
6. Ivy Medical Group, Burton Joyce
7. Jubilee Practice, Lowdham
8. Newthorpe Medical Centre, Eastwood
9. Oakenhall Medical Practice, Hucknall
10. Om Surgery, Hucknall
11. Park House Medical Centre, Carlton
12. Peacock Heathcare, Carlton
13. Plains View Surgery, Mapperley
14. Stenhouse Medical Centre, Arnold
15. Torkard Hill Medical Centre, Hucknall
16. Trentside Medical Group, Colwick
17. Unity Surgery, Mapperley
18. Westdale Lane Surgery, Gedling
19. West Oak Surgery, Mapperley
20. Whyburn Medical Practice, Hucknall
21. Willows Medical Centre, Carlton

Governing Body Profiles

Dr Tony Marsh acted as Chair up until his retirement on the 1st May 2013

Photo Dr Paul Oliver	Photo Sam Walters	Photo
Dr Paul Oliver **Chair (from May 2013)**	**Sam Walters** **Chief Officer (Accountable Officer)**	**Jonathan Bemrose** **Chief Finance Officer**
A graduate of Nottingham University Medical School in 1980, Dr Oliver has been a GP and partner at Peacock Healthcare in Carlton, Nottingham for 30 years. Dr Oliver has a strong reputation in Nottingham through his involvement in various roles in the health community. Dr Oliver has worked as a lecturer at the University of Nottingham for 15 years and as a GP Appraiser for 10 years. Dr Oliver was a strong member on the NNEC PBC Board. More recently he has worked as the NNE Clinical Director for County Health Partnerships and has been active on the CCG Governing Body since the transition from PBC Board. Dr Oliver has succeeded Dr Tony Marsh as Chair and Clinical Lead of NNE CCG. Having been involved in NHS Alliance activities for five years, Dr Oliver is both holistic as an individual practitioner and holistic in terms of seeing the whole landscape of 'care' across Health and Social Services as one patient centred continuum. Dr Oliver is currently Health Lead and Vice Chair of the Better Care Fund from the Health and Wellbeing Board.	Currently Chief Officer of NNE Clinical Commissioning Group (CCG), Sam has steered the organisation through its journey from 'shadow' form to statutory body. Originally a qualified physicist, she began her career working for British Rail Engineering Ltd and Rolls Royce and Associates on nuclear submarines. Sam transferred her talents and skills to the public sector in the early 1990s and has since enjoyed an NHS career spanning over twenty years. She has held positions in a wide range of disciplines, including human resources, public health and finance, as well as senior roles in primary care commissioning and leading one of the country's largest cancer networks. In 2003, as executive director for Nottingham City Primary Care Trust, Sam championed a broad remit, including strategic planning, governance and safety, with her particular passions being patient engagement, quality and equality. Now responsible for commissioning healthcare for NNE, Sam is committed to designing health services with local people and for local people, applying her knowledge, expertise and vision to help deliver innovative health solutions to the local communities.	Jonathan qualified as an accountant in 1994 and has over 20 years' experience of working within health and local authority finance, particularly in social care. His previous role was Director of Resources for Nottingham CityCare Partnership where he was responsible for finance, workforce, training, organisational development, support services, estates and IT. He also carried out the Finance Manager role at Nottingham Emergency Medical Services (NEMS) which has provided him with additional business exposure and experience. Prior to this Jonathan held the role of Deputy Director of Finance for NHS Nottingham City Primary Care Trust.
Ownership & Director of Peacock Healthcare Nottingham Lead - ISKCON (Charity) Vaishnava Priest **Wife:** Peacock Healthcare Partner & Director Share holder in NEMS- less than 5% Nottingham Lead - ISKCON (charity) Vaishnava Priest **Relatives**: Peacock Healthcare Partners & Directors.	None	Patient at Westdale Lane Surgery. Wife: employed part-time at NUH at Medical Secretary. Family members are patients at Westdale Lane Surgery.

Photo	Photo	Photo
Dr James Hopkinson **GP Member**	**Dr Parm Panesar** **Assistant Clinical Chair**	**Adrian Kennedy** **Allied Health Professional (Pharmacist) Member**
Dr James Hopkinson has been involved with local NHS leadership for 12 years. Initially he sat on the board on Gedling PCT, then when community trusts were formed he sat on the board of Nottinghamshire PCT. Dr Hopkinson has sat on the governing body and clinical cabinet since the inception of NNE CCG. Dr Hopkinson works in General Practice in Calverton. He also works as a Consultant in Sport and Exercise Medicine at Nottingham University Hospitals, as well as in the local community musculoskeletal service (NMATS). Dr Hopkinson is passionate about improving the quality and cost effectiveness of medical care.	Dr Paramjit Panesar has been working within the NHS for fourteen years and soon became a GP in 2004. He became a member of the Royal College of General Practitioners with Merit in 2004. In 2006, he then moved on to becoming one of the founders and senior partner at The Ivy Medical Group. Clinically Dr Panesar has a keen interest and experience within Rheumatology and Cardiology. He has a keen interest in Commissioning and opportunities to improve quality of care for patients by redesigning pathways and promoting innovation. Dr Panesar joined the NNE Governing body in October 2011 and as a new contributor to commissioning he is able to provide a different clinical focus to decision making. During his time with NNE Dr Panesar has provided leadership and implemented successful initiatives within planned care and diabetes.	NNE wanted to ensure a wide clinical input and as such, have maintained the position of Allied Health Professional on the Governing Body. Adrian Kennedy has been a practice Pharmacist at Calverton Medical Practice for six years and in this position has also provided consultancy support to Nottingham North and East Consortium Practice Based Commissioning and has worked as a Community Pharmacy Manager. Adrian was a Professional Executive Committee member for Gedling Primary Care Trust. Adrian joined the NNE Governing Body in October 2011.
GP and Partner in Calverton Practice. Minor shareholder in NEMS. Employed by NUH as a Consultant in Sports and Exercise Medicine. **Wife** - employed by NUH as a Clinical Nurse Specialist.	Partner at The Ivy Medical Group	Employed Pharmacist Clinical management patient contact. Calverton Practice Ltd

Photo	Photo	Photo
Terry Allen **Lay Member – Financial Management and Audit**	**Mike Wilkins** **Lay Member- Patient and Public Involvement**	**Dr Mohammed Al-Uzri** **Secondary Care Consultant**
Terry Allen joined the Governing Body in November 2013 and brings a wealth of financial, governance and commissioning expertise. FCCA qualified, Terry has almost 40 years experience of working in the NHS across the East Midlands. Recent appointments include Deputy and Acting Finance Director for Nottingham Health Authority, Director of Finance & Corporate Services for Broxtowe & Hucknall PCT and Finance Director & Deputy Chief Executive for Nottingham City PCT and CCG. He has played a lead role in the financial planning and commissioning of healthcare services across Nottingham for many years and was responsible Director, together with Local Authority partners, for the development of a number of Joint Service Centres across Greater Nottingham.	Mike Wilkins has been a member on the Governing Body since October 2011. He was initially recruited as a Non-Executive Director and then was successful in applying for the position of Lay Member PPI. Mike Wilkins is a registered patient in NNE and has experience across public, private, not-for-profit and non departmental public body (quango) sectors. He was a Non-Executive Director on the NHS Nottingham City PCT and later NHS Nottingham City and Nottinghamshire County PCT Board and has been Chair of a number of Partnership Boards bringing a wealth of experience to NNE. Mike is a qualified social worker with first and second degrees and MBA.	Dr Al-Uzri is a Consultant Psychiatrist at Leicestershire Partnership NHS Trust and Honorary Senior Lecturer at the University of Leicester. Dr Al-Uzri previously filled the position of Clinical Director of a large business unit in Leicestershire Partnership NHS trust. He has been involved in service development programmes and successful pathway redesigns and has a full understanding of the commissioning landscape. Dr Al-Uzri joined the Governing Body in August 2012.
None	Trustee and Treasurer Water Works Charity **Wife:** Practice Nurse in GP Practice	Governing Body member - Newark & Sherwood CCG. Clinical Advisor to SISO (service user organisation) Honorary Senior Lecturer,

Photo	Photo	Photo
Dr Cheryl Crocker **Registered Nurse**	**Caroline Baria** **Observer** **Service Director, Nottinghamshire County Council**	**Stephen Storr** **Observer** **Patient and Public Representative**
Cheryl has had a number of senior leadership positions and her experiences ensure she is ideal for the position of Registered Nurse on the Governing Body. She was lead nurse for the Mid Trent Critical Care Network. This regional post spanned 9 trusts across a wide geographical area. She was also a nurse consultant for eight years. Cheryl held the post of deputy director of nursing and quality at an ambulance service. This was a regional service covering 6 counties. Cheryl was awarded a fellowship with the NHS Institute for Improvement and Innovation. This was a leadership development opportunity and allowed Cheryl to	Caroline has been a member of the Governing Body since November 2013. She is a Service Director within the Adult Social Care, Health and Public Protection Department at Nottinghamshire County Council. Caroline qualified as a social worker and gained a Masters in Social Sciences at the University of Birmingham in 1992. Since this time Caroline has held a number of posts within Nottinghamshire County Council and Nottingham City Council. This includes the post of Head of Purchasing and Market Management with the responsibility for developing and commissioning care services across the county. Caroline has been a Service	Stephen Storr has been a member of the Governing Body since October 2013. He originally started as a member & then chair of a local PPG group. After 2 years on the Peoples Council he was successful in applying for the position of Public & Patient Representative in October 2013. Before retiring in 2009, after working for 42 years in a Multi-National Company, Stephen Storr had held various management positions which were always involved in direct contact with customers or a Franchise Network at senior level nationwide to ensure the delivery of service to the

study at the Institute of Health Improvement in Harvard, USA. Cheryl is an honorary lecturer at the University of Nottingham and an improvement fellow at the NHS Institute of Improvement and Innovation. Cheryl is therefore well placed to lead on quality and patient safety and has extensive knowledge of a wide variety of provider settings.	Director since 2008, leading the development of a range of health and social care services, including adult safeguarding and on improving quality within care services. More recently, she has assumed lead responsibility for operational adult care services in the south of the County.	customer at all levels were paramount. Stephen Storr originally trained at a Production Engineer at HNC level & also completed Part 1 of a Business Degree with the Open University. Stephen is a registered patient within the NNE CCG.
Honorary lecturer - Nottingham University (no remuneration received)	Service Director, Adult Social Care Health & Public Protection, Nottinghamshire County Council.	None

Senior Manager Profiles

Photo	**Photo**	**Photo**
Jonathan Bemrose **Chief Finance Officer**	**Cheryl Crocker** **Director of Quality and Patient Safety**	**Sharon Pickett** **Deputy Chief Officer**
See Governing Body Profile	See Governing Body Profile	Sharon has been working in the NHS for over 30 years. Starting as a student nurse in 1981 she later went on to train as a midwife and health visitor. After 20 years clinical experience Sharon moved into a range of clinical development and managerial roles. From 2005 Sharon was an Assistant Director in NHS Nottingham City PCT and in January 2012 took up her position with the CCG as Director of Pathways and Improvement. Over the years Sharon has gained a significant amount of experience in a broad range of areas including clinical leadership, health promotion, service planning, GP contracting and primary care support, estates strategy, partnership working and service development.
See Governing Body	See Governing Body	None

Photo	Photo	Photo
Andy Hall **Director of Outcomes and Information**	**Maxine Bunn** **Director of Contracting (Directorate Level)**	**Hazel Buchanan** **Director of Operations (Directorate Level)**
Andy is Director of Outcomes and Information for Rushcliffe CCG and has 29 years' experience working in the NHS. He has held various senior posts in Lancashire hospitals before moving to Lincolnshire in 1998 and finally to Nottinghamshire in 2007. Andy has previously held posts as Director of Commissioning and Performance within Primary Care Trusts for four years and before that held the post of Director of Information Management and Technology at two separate health authorities. Andy is chair of the Information Governance, Management and Technology Committee.	Maxine took on the position of Director of Contracting from 1st November 2013. Prior to that, Maxine was Deputy Director of Contracting with lead responsibility for the County Health Partnership contract. Maxine was previously Head of Commissioning and Performance and lead on the Nottingham University Hospital NHS Trust contract having joined Nottingham County PCT in August 2007. Prior to that she worked in Leicestershire in several contracting posts - for Leicestershire County and Rutland PCT as Senior Account Manager - Acute and Melton and Rutland Harborough PCT as Commissioning and Performance Manager, having started the latter role in April 2000. Before that she was Regional Clinic Manager for Lasercare Clinics from 1995 to 2000.	Hazel has worked in the NHS and in Nottingham North and East for five years. Hazel's first role was in Practice Based Commissioning as a Service Improvement Manager and was involved in a wide range of business initiatives to support the General Manager. Prior to this, Hazel held a director level position in a financial services company. Hazel has an MBA from the University of Nottingham, a Masters in Social Policy and Administration from the University of Nottingham and a BA degree with honours in Public Policy from the University of Ottawa.
None	None	None

Governing Body Membership - Committees

Name	Audit	Remuneration	Clinical Cabinet	People's Council	Finance & Information Group
Dr Paul Oliver			✓	✓	✓
Dr Paramjit Panesar	✓ (from 01.06.14)	✓	✓		
Dr James Hopkinson		✓	✓		
Adrian Kennedy			✓		
Dr Mohammed Al-Uzri		✓	✓		
Dr Cheryl Crocker					
Sam Walters			✓	✓	✓
Jonathan Bemrose			✓		✓
Mike Wilkins	✓	✓	✓	Chair	
Terry Allen (02.11.13 – date)	Chair	Chair			Chair
Paul Johnson (01.04.13-31.10,13)	Chair	Chair			Chair
Caroline Baria			✓		
Stephen Storr			✓	✓	

Other Committees

Please refer to the Annual Governance Statement section 5.1 and 5.2 for details on other committees.

Sustainability Report

Performance and achievements

We are committed to continue in the UK leading and globally award winning work in health sector carbon reduction put in place by the local Primary Care Trusts over the last few years. To this end we have adopted the PCT's sustainability policies as part of the legacy arrangements and are working with the rest of the local health sector to deliver on sustainability as a collaborative 'health community' approach

Over the coming year we will work to establish our own emissions baseline from all our operations including direct and indirect through procurement and commissioning. From this we will set targets to work beyond the current national 2015 target, in line with and were possible in excess of the NHS and UK national targets. To this end we have appointed The Nottingham Energy Partnership to work with us.

Environmental, social and community issues

NHS NNE CCG is committed to having a positive impact on the environment, patients, employees and communities within and beyond its usual business activities. In its first year, the CCG has engaged with its local community to encourage a healthier lifestyle, where possible used local businesses

Over the last year the CCG has:

Governance

- Appointed a Governing Body sustainability lead
- Have ensured sustainability is on front sheets for Governing Body papers in order to identify any agenda items against the sustainability agenda
- Have done the Good Corporate Citizen self-assessment for the CCG

Behaviour and staff engagement

- Won a bid for Midlands and East NHS Carbon Reduction Project and as a result carried out a workshop to educate employees in each department and produced an action plan
- Appointed a green champion who sits on the Nottinghamshire Group
- Have asked all staff to carry out carbon footprint and post on the wall
- Raise sustainability issues at our Comms Cell which is a weekly meeting for all staff

Commissioning

- Ensured all providers are on the standard NHS contract, which includes a clause on sustainability
- Wound Care and Urinary Incontinence – have set up central supply systems reducing waste and deliveries

Procurement

- Have changed printing settings on all computers, so that default is double sided black and white, regularly communicate to staff to stop printing to reduce the need to procure paper

Building on the previous efforts of the local PCTs, the CCG has committed to monitoring its sustainability performance in terms of energy used in buildings, waste arising and subsequent greenhouse gas emissions while limited data is available for 2013-14 this will be carefully recorded throughout 2014/15, a summary of data available so far and the areas of focus going forward can be found in the tables which follow. Overall, the CCG is committed to maintain the UK leading progress made by the Nottinghamshire teaching PCT and detailed in the PCTs Board-approved Carbon Management Plan (2010).

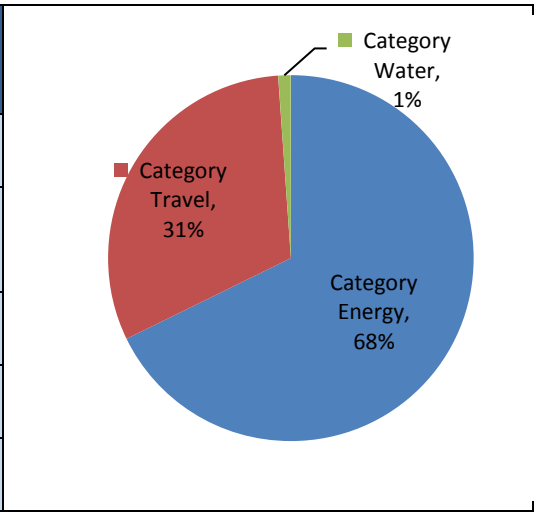
NHS Nottinghamshire County's sustainability work enabled the Trust to continue to save money at a time of financial constraint, whilst reducing its environmental impacts and ensuring legal compliance. It also resulted in the Trust developing a ground-breaking and leading role within the health community and the public sector locally, regionally -and in some indices nationally-, by meeting and exceeding targets on carbon reduction, corporate sustainability and use of natural resources this has inspired others to follow suit.

The CCG will work closely with our partners and stakeholders to embed sustainability and carbon reduction into everything we do, from our internal activities to delivering and commissioning frontline services in the communities we serve. To this end we have appointed the internationally award winning environmental and public heath social enterprise NEP energy services to support.

NEP will support likely future developments that will support NNE staff to make a difference through their own actions alongside developing a clear action plan on how we can influence decision making and agreements towards sustainability.

NNE CCG – Summary of sustainability performance

Area (totals)		Nottm. N and E CCG (2013-14)	CO2e Tonnes	tCO2e Per capita
GHG emissions (tCO2e gross)			39.18	0.89
Energy in buildings	Consumption (kWh)	72,501	26.59	0.59
Water	Consumption (m^3)	413.5	0.44	0.01
Transport	Mileage (Km)	53,190	12.21	0.27
	Expenditure (£)	22,149	-	£498



Equality Report

Compared with other areas in England, the population of NNE has a higher percentage of both men and women aged 45 and older, and a lower percentage aged less than 30.

In 2010, Gedling had 24,700 residents aged between 0-19 years. This is projected to increase by 15% between 2010 and 2030. The proportion of children in Gedling attending for Special Educational Needs is 0.9%, compared to a County figure of 1.1%. The number of children diagnosed with autistic spectrum disorder across Nottinghamshire has increased substantially (3 fold) over the last 10 years.

In 2010, Ashfield had the highest number of 0-19 year olds in Nottinghamshire County, at 28,100. Ashfield is projected to have a 14% increase in its 0-19 year old population by 2030. Children identified with special educational needs are the second highest in Ashfield (1.5% and 1.2% respectively). Across the NNE CCG area, the highest proportions of younger people live in Hucknall, Eastwood, Arnold, Carlton and Calverton.

There were 85,900 adults aged 18-64 living in NNE CCG in 2010. The adult population is expected to increase by 9.7% by 2025 (compared with 8.9% increase for Nottinghamshire's registered population average).

NNE CCG has the second highest percentage of older people over the age of 65yrs (16.9%) compared with all Nottinghamshire CCGs. An increase of 33% is expected in the older population by 2025, particularly in the 75-79 age group. This would see a rise from 26,000 to 34,500 people aged 65 or older across NNE CCG, with a greater number of females than males (18,900 and 15,600 respectively). In addition, as the population ages, the number of older people living alone is expected to increase to around 40% across Nottinghamshire. Across NNE CCG area the highest proportions of older people live in Eastwood, Burton Joyce and Newstead.

In Gedling, 1 in 7 pensioners live in poverty. A similar ratio of the 50-64 year old population is claiming at least one benefit. Awareness about benefits that are available to claim in this age group is reasonable, with a good proportion of those that are eligible claiming winter fuel payments.

Across Ashfield district, 1 in 5 pensioners live in poverty. Of particular relevance to NNE CCG is the high numbers of pensioners living in poverty in the Hucknall area. A similar ratio of the 50-64 year old population is claiming at least one benefit. Awareness about benefits that are available to claim in this age group is reasonable, however the older people in Ashfield are least likely to claim winter fuel payments compared with older people living in all districts of Nottinghamshire. This suggests that there is inequity and lack of awareness with regard to this benefit payment.

Further information from the census can is provided in the following tables.

2011 UK Census

Population Summary

	NNE CCG	East Midlands	England
All people	145,627	4,533,222	53,012,456
Males	71,478	2,234,493	26,069,148
Females	74,149	399,080	26,943,308

Marital and Civil Partnership

	NNE CCG	East Midlands	England
Single (never married)	32.0 (36,104)	32.3	34.6
Married	48.4 (54,658)	48.5	46.6
In Registered Same-Sex Civil Partnership	0.2 (240)	0.2	0.2
Separated (but still legally married)	2.6 (2,883)	2.6	2.7
Divorced or Formally Dissolved Same-Sex Civil Partnership	9.7 (10,961)	9.3	9.0
Widowed or Surviving Partner	7.2 (8,172)	7.2	6.9

Ethnic Group

	NNE CCG	East Midlands	England
White: English/Welsh/Scottish/Northern Irish/British	91.2 (125,985)	85.4	79.8
White: Irish	0.7 (966)	0.6	1.0
White: Gypsy or Irish Traveller	0.0 (62)	0.1	0.1
White: Other White	1.8 (2,467)	3.2	4.6
Mixed/Multiple Ethnic Group: White & Black Caribbean	1.2 (1,672)	0.9	0.8
Mixed/Multiple Ethnic Group: White & Black African	0.2 (286)	0.2	0.3
Mixed/Multiple Ethnic Group: White & Asian	0.4 (589)	0.5	0.6
Mixed/Multiple Ethnic Group: Other Mixed	0.3 (419)	0.3	0.5
Asian/Asian British: Indian	1.0 (1,341)	3.7	2.6
Asian/Asian British: Pakistani	0.7 (982)	1.1	2.1
Asian/Asian British: Bangladeshi	0.2 (84)	0.3	0.8
Asian/Asian British: Chinese	0.3 (455)	0.5	0.7
Asian/Asian British: Other Asian	0.4 (603)	0.8	1.6
Black/African/Caribbean/Black British: African	0.3 (451)	0.9	1.8
Black/African/Caribbean/Black British: Caribbean	0.9 (1,244)	0.6	1.1
Black/African/Caribbean/Black British: Other Black	0.2 (211)	0.2	0.5
Other Ethnic Group: Arab	0.1 (70)	0.2	0.4
Other Ethnic Group: Any Other Ethnic Group	0.2 (236)	0.4	0.6

Religion

	NNE CCG	East Midlands	England
Christian	57.2 (79,061)	58.8	59.4
Buddhist	0.3 (370)	0.3	0.5
Hindu	0.4 (417)	2.0	1.5
Jewish	0.1 (100)	0.1	0.5
Muslim	1.2 (1,698)	3.1	5.0
Sikh	0.5 (720)	1.0	0.8
Other Religion	0.4 (477)	0.4	0.4
No Religion	34.6 (47,759)	27.5	24.7
Religion Not Stated	7.4 (10,189)	6.8	7.2

Long Term Activity-limiting Illness or Disability[1]

[1] **2011 UK census**

	NNE CCG	East Midlands	England
Day to Day Activities Limited a lot (% population)	9.0 (13,029)	8.7	8.3
Day to Day Activities Limited a lot (aged 16-64)	n/a	5.7	5.6
Day to Day Activities Limited a little (% population)	10.5 (15,215)	10.0	9.3
Day to Day Activities Limited a lot (aged 16-64)	n/a	7.7	7.2
Day to Day Activities Not Limited (% population)	80.5 (116,374)	81.4	82.4
Day to Day Activities Not Limited aged (16-64)	n/a	86.7	87.3

We have worked closely with NHS Rushcliffe and NHS Nottingham West for the past 12 months to continue to build upon the strong foundation of equality work established by the former organisation NHS Nottinghamshire County, as set out in the strategic document 'Single Equality and Diversity Strategy 2011-13'.

This strategy, which incorporated the national NHS Equality Delivery System (EDS), set out the statutory requirements placed on the NHS by the Equality Act 2010 and the Public Sector Equality Duties. At the time of writing, the document was future-proofed to include objectives for CCGs during their first and second year of operation. This ensured equality was mainstreamed into the new structures without losing ground and stayed true to the NHS White Paper 'Liberating the NHS' strap line that there was 'no decision in the NHS is made without you'.

In meeting our Public Sector Equality Duties (PSED), we remain committed to promoting and advancing equality by providing equitable healthcare and related services to all protected characteristic groups including vulnerable people in all the communities they serve.

We continue to commission 'Disabled Go' – ensuring that there is access information to disabled people who are going to be visiting our GP surgeries and healthcare centres. We have also supported the Derbyshire and Nottinghamshire Area Team in commissioning and providing accessible information and interpreting and translation services to people who do not have English as a first language, including British Sign Language users.

NNE CCG has provided a governance structure to ensure there is accountability in advancing and mainstreaming equality into our business. As a sub-group of the Quality and Risk Committee, the Equality and Diversity Forum is chaired by a lay member and includes equality leads, patient involvement and engagement leads and governance officer representatives from each CCG.

Other representatives including Voluntary Action, Self Help Nottingham, Healthwatch and other health and social care organisations and representatives of protected characteristic groups are invited as appropriate.

The forum acts as a working group for NNE CCG alongside Nottingham West and Rushcliffe CCGs and work to date has included development of an Equality and Diversity Policy, development of a work plan towards completion of EDS2 and identification of all self-help groups across South Nottinghamshire. The forum is particularly keen to hear from seldom heard groups to help steer the agenda and work plan and in early 2014, heard from the Travellers' Health Ambassador project about traveller health inequalities which it agreed to investigate further as part of the 2013/14 EDS.

The UK censuses took place on 27 March 2011. They were run by the Northern Ireland Statistics & Research Agency (NISRA), National Records of Scotland (NRS), and the Office for National Statistics (ONS) for both England and Wales. The UK comprises the countries of England, Wales, Scotland and Northern Ireland. ONS is responsible for disseminating census statistics for the UK.

The forum also links into wider Equality networks and has representation on the Nottinghamshire NHS Equality and Engagement Network that is a network of equality leads across the Nottinghamshire health community.

NNE CCG continues to seek to eliminate discrimination and will not condone any actions that obstruct access to, or delivery of, the services they provide. Through the organisational toolkit 'Quality and Equality – Integrated Impact Assessment' NNE has ensured that commissioned services are impact assessed. NNE also ensures that providers have robust equality impact assessment processes in place through the Quality Scrutiny groups. We recognise that we have an essential role to play in trying to eliminate health inequalities across the Nottingham health community and by working with Public Health England, Local Authorities, statutory public bodies and public and community partners, the CCGs also seek to address the wider determinants of health.

At the heart of everything NNE does are people. In order to understand the needs of people in the local communities, NNE must continually consult with patients and encourage them to become involved in planning services. NNE endeavours to consult widely to gather views on local services from all sections of the community including seldom heard groups and fully consider all the opinions received. NNE has been listening to patients through the events titled 'A Call to Action - The NHS belongs to the People' in which all people have an equal opportunity to inform and enable our commissioning plans.

Local patients feature heavily in NNE CCGs governance structure. The CCG's People's Council membership has key representatives from various patient groups and is a committee of the Governing Body. The People's Council considers service improvements and changes, patient and public feedback and this information is triangulated and supports discussions in the Clinical Cabinet, also a committee of the Governing Body.

NNE aspires to be representative of all the communities they serve, and take pride in being an equal opportunities employer. We treat all job applicants and employees (including trainees, agency workers, those on government employment schemes and students) equitably. NNE operates the guaranteed interview scheme for disabled candidates meeting the essential criteria. Nobody will be disadvantaged by conditions that cannot be shown to be justified. NNE CCG is in the process of gaining reaccreditation for the 'Positive About Disabled people 'two tick' scheme and 'Mindful Employer' which promotes positive attitudes to disability and mental health respectively. NNE CCG actively encourage all members of staff to become 'Personal Fair and Diverse (PFD) Champions', a campaign run by NHS Employers to create a vibrant network of champions who are committed to taking action, however small, to create a personal, fair and diverse NHS. NNE also actively encourages development of staff members who fall within one of the protected characteristics through the 'Liberating the Talents' programme. This is a leadership and development training programme aimed at NHS staff in Bands 1-6 who feel that they have faced barriers in their career progression relating to their protected characteristic status.

The diversity of our workforce and Governing Body:

	Male	Female
Governing Body (including observers)	9	3
Chair, Very Senior Managers and Senior Executives*	2	4

**Includes NNE employed staff only.*

NNE Staff

Protected Characteristic			**Protected Characteristic**		
FEMALE	25	75.76%	Male	8	24.24%
Age	19-25	1 (3.03%)		46-60	13 (39.39%)
	26-35	8 (24.24%)		61-85	0
	36-45	9 (27.27%)		Do not wish to disclose	2 (6.06%)
Is your Gender the same you were assigned at Birth	Yes	29 (87. 88%)	Is your Gender the same you were assigned at Birth	Prefer not to say	2 (6.06%)
	No	2 (6.06%)			
Marriage & Civil Partnership Status	Single	7 (21.88%)	Marriage & Civil Partnership Status	Divorced	3 (9.38%)
	Married	21 (65.63%)		Widowed	1 (3.13%)
	Civil Partnership	0			
Ethnic Background	British	26 (78.79%)	Ethnic Background	Chinese	1 (3.03%)
	Irish	0		Other Asian	1 (3.23%)
	Other White	1 (3.03%)		African	0
	Mixed: White & Black Caribbean	0		Caribbean	1 (3.03%)
	Mixed: White & Black African	0		Other Black	0
	Mixed: Other Mixed	0		Any Other Ethnic Group	0
	Indian	1 (3.03%)		Do not wish to disclose	3 (9.09%)
	Pakistani	0			
	Bangladeshi	0			
Religion/Belief	Buddhist	0	Religion/Belief	Muslim	0
	Hindu	1 (3.23%)		Sikh	0
	Islam	0		Atheism	4 (12.90%)
	Christian	16 (51.61%)		Do not wish to disclose	10 (32.26%)
	Jewish	0			
Pregnancy/ Maternity (within the past year)	Yes	1 (3.13%)	Pregnancy/ Maternity	Prefer not to say	2 (6.25%)
	No	29 (90.63%)			
Sexual Orientation	Heterosexual	31 (93.94%)	Sexual Orientation	Bisexual	0
	Lesbian	0		Do not wish to disclose	2 (6.06%)
	Gay	0			
Disability	No disability	31 (93.94%)	Disability	Long Standing Illness	1 (3.13%)
	Learning Difficulty	0		Physical Impairment	0
	Mental Health Condition	0		Other	0
	Sensory Impairment	0			

Our efforts to promote equality and eliminate discrimination will only succeed if staff fully understand the principles of inclusion, exclusion, equality and discrimination. To that end we continue to ensure staff have access to learning and development opportunities. We have invested training through the high quality 'equality essentials' e-learning package as well as classroom based training for all staff at every level of the organisation and ensured sustainability of this programme through training staff to deliver the 'equality essentials' package in the future. Equality and Diversity training was identified within the South Nottinghamshire Mandatory Training and Induction as necessary to complete three yearly for all staff and Governing Body members.

Future developments relate to delivery against the EDS2 which will be supported by a robust action plan.

Political and Charitable Donations

We did not make any political or charitable donations from our exchequer during 2013/14.

Pension Liabilities

In respect of how pension liabilities are treated in the accounts please see accounting policy note in financial statements and remuneration report

Sickness and Absence Data

A table is included in the employee benefits note to the Financial Statements.

Staff sickness absence and ill health retirements 2013-14

	Number
Total Days Lost	974
Total Staff Years	292
Average working Days Lost	3

The numbers above are the total for the old Nottinghamshire County PCT area, of which Nottingham North and East is a part.

Further to the above, NNE has the following information.

NNE CCG Sickness/Absence Data April 2013 - March 2013

Lost Time Days

- Average of 169 days (1.78%) within the period April 2013 to March 2014
- Average of 31.5 days (0.34%) within the period April 2013 to March 2014
- Average of 137.7 days (60.8%) within the period April 2013 to March 2014

We recognise the valuable contribution made by each employee to the delivery of its services and is committed to the promotion of employee health, safety and well-being. We are committed to acting as a

fair and reasonable employer dealing with employees who suffer ill health or incapacity either of a temporary or permanent nature in a fair and compassionate way.

We encourage the attendance of all employees throughout the working week but recognise that a certain level of absence may be unavoidable due to sickness or other reasons.

Line managers take responsibility for monitoring sickness absence levels in their area, putting in place agreed procedures for reporting in and to enable employees to report their fitness to return to work after sickness absence. A return-to-work meeting is arranged which can help identify short-term absence concerns and facilitate the early identification of any problems, enabling support and assistance to be offered.

Line managers monitor sickness absence levels on an ongoing basis. After four separate episodes of sickness in a rolling 12 month period, a short term absence review takes place. This includes a discussion with the employee around sickness absence concerns and looks at any areas of support required. An expected level of improvement and a review date are agreed between the manager and the employee.

Following a continual period of absence of four weeks or more, or repeated episodic absence for a related condition, or where an employee is experiencing absence which is due to a chronic underlying condition or long term incapacity, a formal structured review process is put in place.

Serious Untoward Incidents

NHS NNE Clinical Commissioning Group (CCG) has not reported any Serious Untoward Incidents involving information, confidentiality or security between April 2013 and March 2014. During this time one incident was reported by CCG staff which was a minor breach of confidentiality.

Using the Department of Health (DH) guidance*[1] and the Health and Social Care Information Centre (HSCIC) guidance*[2], the incident was graded as severity level 1.

A level 1 unauthorised disclosure incident was reported on 18 October 2013.

NHS NNE CCG is committed to reporting, managing and investigating all information governance incidents and near misses. The CCG encourages staff to report all incidents and near misses to ensure learning can be collated and disseminated within the organisation.

References

*[1] *Department of Health (January 2010), 'Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents'*

*[2] *HSCIC (June 2013), Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation'*

Cost allocation

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

Principles of Remedy

The Parliamentary and Health Service Ombudsman (PHSO) has produced guidance on how public bodies provide remedies for justice or hardship resulting from their maladministration or poor service

The six key 'Principles for Remedy' are:

- Getting it right – by quickly putting the poor service right that has led to injustice or hardship
- Being customer focused – understanding expectations and saying sorry for poor service
- Being open and accountable – being open about how the organisation has decided on the remedy including documentation
- Acting fairly and proportionately – treating people equally, fair and proportionately to the hardship caused
- Putting things right – where possible returning the person to the position they would have been in if the poor service hadn't occurred
- Seeking continuous improvement – ensuring we can demonstrate that CCGs learn from patients' experience and complaints and act upon them.

NNE CCG has adopted the six principles for remedy in the development of their complaints handling procedure and they form a core part of the organisation's complaints handling policy that clearly sets out the process for handling complaints in order for the CCG to meet statutory requirements. The complaints policy sets out how the CCG take responsibility, acknowledges failures and both apologises and uses the learning from any complaint investigation to improve their services. These remedies can be either financial or non-financial remedies.

Employee Consultation

NNE maintains on-going communication with its employees through various channels.

Communications Cell

The CCG holds a weekly Communications Cell (Comms Cell) that is attended by all employees and is an opportunity for all to feedback on performance updates, new developments, provides updates, signpost to important documentation, carry out brief training sessions and to feedback on issues as well as golden moments. The Comms Cell provides all staff with a common awareness on the part of all employees of the financial and economic factors affecting the performance of the clinical commissioning group.

Team Meetings

As well as the Communications Cells the different teams hold bi-weekly or monthly team meetings in order that business and progress can be discussed amongst team members.

Intranet and Email

The CCG has an intranet which holds all key documents. All important information is also emailed to employees.

Disabled Employees

NNE aspires to be representative of all the communities they serve, and take pride in being an equal opportunities employer. NNE treats all job applicants and employees (including trainees, agency

workers, those on government employment schemes and students) equitably. NNE operate the guaranteed interview scheme for disabled candidates meeting the essential criteria. Nobody will be disadvantaged by conditions that cannot be shown to be justified. NNE CCG is in the process of gaining reaccreditation for the 'Positive About Disabled people 'two tick' scheme and 'Mindful Employer' which promotes positive attitudes to disability and mental health respectively. NNE CCG actively encourage all members of staff to become 'Personal Fair and Diverse (PFD) Champions', a campaign run by NHS Employers to create a vibrant network of champions who are committed to taking action, however small, to create a personal, fair and diverse NHS. NNE also actively encourages development of staff members who fall within one of the protected characteristics through the 'Liberating the Talents' programme. This is a leadership and development training programme aimed at NHS staff in Bands 1-6 who feel that they have faced barriers in their career progression relating to their protected characteristic status.

Emergency Preparedness, Resilience & 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. NHS England, as the lead body within the shared plan, regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan.

External Audit

Our external auditors are KPMG. During 2013/14, they have focused on providing an opinion on the financial accounts and providing a Value for Money (VFM) conclusion on arrangements for securing economy, efficiency and effectiveness.

The total fee for external audit for 2013/14 was £66,000 (plus VAT £ 13,200) in respect of the completion of the statutory audit work.

The External Auditors did not undertake any additional work for NNE CCG during 2013/14.

Better Payments Practice Code

The Better Payment Practice Code requires the Clinical Commissioning Group to aim o pay all valid invoices by the due date, or within 30 days of receipt of a valid invoice, whichever is the later. The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. During the 2013/14 financial year, we achieved all four targets in this area as summarised below:

2013/14 Better Payment Practice Code Performance	NHS	Non NHS
Value	98.72%	96.58%
Volume	97.54%	97.29%

Prompt Payments Code

On 1 April 2013 the CCG became an approved signatory of The Prompt Payment Code. The initiative was devised by the government and the Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses get due payment. Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute.

Approved signatories undertake to:

- Pay suppliers on time;
- Give clear guidance to suppliers and resolve disputes as quickly as possible; and to
- Encourage suppliers and customers to sign up to the code.

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 there is no relevant audit information of which the CCG's external auditor is unaware; and that the member has taken all the steps that they ought to have taken as a member in order to make themself aware of any relevant audit information and to establish that the CCGs auditor is aware of that information.

REMUNERATION REPORT

The Accountable Officer confirms the following individuals are "senior managers" and are included within the Remuneration Report:

- Director of Outcomes and Information
- Deputy Chief Officer
- Director of Finance
- Director of Quality and Patient Safety

The following are senior managers with responsibilities at directorate level and not included in the Remuneration Report

- Director of Contracting
- Director of Operations

Remuneration Committee

Membership

- Paul Johnson - Lay Member Finance & Audit (Chair) until 31 October 2013
- Terry Allen - Lay Member Finance & Audit (Chair) from 2 November 2013
- Mike Wilkins - Lay Member Patient & Public Engagement

- As relevant, membership will also be drawn from:
- Governing Body Secondary Care Consultant
- Governing Body GPs

In Attendance

- Jonathan Bemrose - Director of Finance
- Hazel Buchanan - Director of Operations

Attendance

Two meetings have been held. The first was Chaired by Paul Johnson in May 2013, the second Chaired by Terry Allen April 2014, all other members in attendance

Hazel Buchanan – Director of Operations (secretary)
Jonathan Bemrose – Director of Finance
Oliver Pritchard - Partner Browne Jacobson Solicitors attended 31.05.13 to provide information on benchmarking remuneration for Governing Body members

Remuneration of Senior Managers

We seek to recruit and retain senior managers of a high calibre in order to ensure CCG leaders who can guide health commissioning for our local population and drive transformational change and deliver an effective and efficient public sector organisation. We seek to create sustainable development that supports the successful implementation of our CCG strategy. As such, remuneration is set at agenda for change and very senior manager level to be sufficient (but no more than necessary) to attract, retain and develop high-calibre individuals.

All senior managers are employed on substantive contracts with a minimum notice period of three months. Senior Managers do not receive performance related pay. Pay and employment conditions of other employees are taken into account in relation to affordability within the running cost allowance and maintenance of a structure providing efficiency and strong reporting lines. We do not make termination payments to senior managers which are in excess of contractual obligations. There have been no such payments during the 2013/14 financial year.

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 member of the Membership Body/Governing Body in Nottingham North and East CCG in the financial year 2013/14 was £210-215k. This was 6.01 times the median remuneration of the workforce, which was £35,532.

In 2013/14, 0 employees received remuneration in excess of the highest paid member of the Governing Body.

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

Exit Packages

The Treasury requires as part of the Remuneration Report the disclosure of exit package information. The figures disclosed relate to exit packages agreed in the year. The actual date of departure may be in a subsequent period, and the expense in relation to the departure costs may have been accrued in a previous period. Therefore the figures disclosed are calculated differently to those included in the expenditure note within the financial accounts.

There have been no exit packages in 2013/14 for Nottingham North & East CCG.

ANNUAL GOVERNANCE STATEMENT 2013/14

Governance Statement by the Chief Officer as the Accountable Officer of Nottingham North and East Clinical Commissioning Group.

1. Introduction and Context

The clinical commissioning group was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006.

The clinical commissioning group operated in shadow form prior to April 2013, to allow for the completion of the licensing process and the establishment of function, systems and processes prior to the clinical commissioning group taking on its full powers.

As at 1 April 2013, the clinical commissioning group was licensed with conditions as follows:

3.1.1 B – CCG must have a clear and credible integrated plan that meets authorisation requirements.

3.1.1 C – CCG must have detailed financial plan that deliver financial balance, sets out how it will manage within its management allowance, and is integrated with the commissioning plan.

3.1.4 B – Provide evidence that the area covered by the CCG is on track to meet the plan for 2012-13 and if not, provide evidence that is a clear and time limited resolution path to recover.

The Clinical Commissioning Group was licensed without conditions 8th October 2013.

The CCG is a clinically led membership organisation made up of general practices. The members of the CCG are responsible for determining the governing arrangements for the organisation, which are set out in the Constitution.

In its first year of operation, the clinical commissioning group has met many challenges that have served to enhance the governance arrangements and robustness of the organisation. This includes enhancing operations, focusing on member practice engagement and delivering clear plans in order that the conditions were removed and the financial position was turned around. The conditions were removed October 2013.

2. Scope of responsibility

As Accountable Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and departmental 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 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.

As the Accountable Officer, I work closely with the Chair of the Governing Body ensuring that proper constitutional; governance and development arrangements are put in place to assure the members (through the Governing Body) of the organisation's on-going capability and capacity to meet its duties and responsibilities. This will include arrangements for the on-going development of its members and staff.

3. Compliance with the Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate how the CCG had regard to the principles set out in the Code considered appropriate for CCGs.

For the financial year ended 31 March 2014, and up to the date of signing this statement, we complied with the provisions set out in the Code, and applied the principles of the Code.

4. The Clinical Commissioning Group Governance Framework

The governance framework of NHS Nottingham North and East CCG evolved whilst in shadow form, which allowed for enhancements and the functioning of a robust NHS organisation providing effective and efficient delivery during 2013/14. This is evidenced through the successes of the clinical commissioning group during its first year in operation.

The framework ensured the CCG delivered its function and duties with the Governing Body collectively taking responsibility for the long-term success of the CCG. The framework includes effective shared arrangements with other Nottinghamshire CCGs and demonstrated robust collaborative commissioning. The members of the Clinical Commissioning Group and the Governing Body recognise that the organisation, and the supporting shared services, are young and maturing and as a result have been committed to making changes that have allowed for added value and the capability to respond to challenges as they arise.

Developments in year have included the enhancement in membership on both the People's Council and the Clinical Cabinet. The People's Council has been expanded to include patient representatives for each GP practice as well as individuals who would like to input based on their experiences through others for example carers. The membership is still forming however the Council is developing well and supporting robust patient and public involvement in decision making. The Clinical Cabinet has been expanded to include a GP representative from each member practice and this was done in order to ensure member practices are central to the clinical decisions impacting directly on primary care.

4.1 The NHS Nottingham North and East Constitution

The Clinical Commissioning Group is accountable for exercising its statutory functions. It may grant authority to act on its behalf to any of its members, its Governing Body, employees, a committee of the Group.

The extent of the authority to act of the respective bodies and individuals depends on the powers delegated to them by the Group as expressed through the Group's scheme of reservation and delegation; and for committees, their terms of reference.

In the Constitution, the Clinical Commissioning Group's scheme of reservation and delegation sets out those decisions that are reserved for the membership as a whole, those decisions that are the responsibilities of its Governing Body (and its committees), the Group's committees, individual members and employees. The Clinical Commissioning Group remains accountable for all of its functions, including those that it has delegated. In discharging functions of the Group that have been delegated to its Governing Body (and its committees), committees, joint committees, and individuals must comply with the Group's principles of good governance, co-operate in accordance with the Group's scheme of reservation and delegation, comply with the Group's standing orders,

4.2 The Governing Body

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.

Each member of the Governing Body shares responsibility as part of a team to ensure that NHS Nottingham North and East CCG exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of this constitution. Each brings their unique perspective, informed by their expertise and experience.

The Governing Body members include:

Chair
Assistant Clinical Chair
Chief Officer
Chief Finance Officer
GP Member
Allied Health Professional Member
Registered Nurse
Secondary Care Doctor
Lay Member – Patient and Public Involvement
Lay Member – Finance and Governance

The Governing Body membership is supported by two Observers who are an Officer from the Local Authority and a Patient and Public Representative. The Observers are fully active participants in the CCG and the Governing Body, whilst maintaining their independence. They complement the skill set of the members and provide added insight into decision-making.

The Governing Body has self-assessed themselves against the Standards for Members of NHS Boards and Governing Bodies in England, Framework for Excellence in Clinical Commissioning for CCGs and The Healthy NHS Board 2013. In comparing the most recent self-assessment against that which was done prior to the CCG became a statutory organisation, the Governing Body are demonstrably more confident with an increase in approximately two points across each domain. Through facing the challenges during the first year in operation, the Governing Body is working as a strong team with accountability to the CCG and its population. Areas of development include technical knowledge, working at a strategic level versus operational and managing roles and responsibilities alongside the executive team, assurance on the complexity of planning and outcomes for the local population.

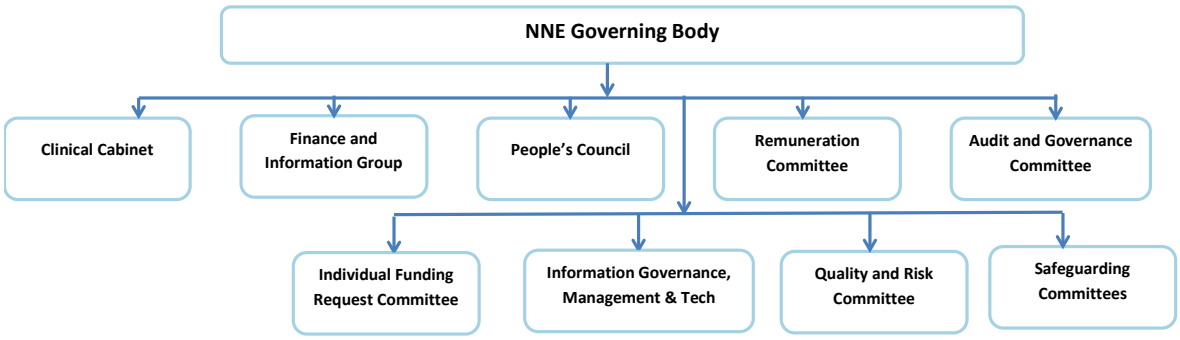
The Governing Body has been effective in discharging the functions of the CCG, which in the first year of establishment has presented challenges working in a new and untested system.

The Governing Body's work has covered items under finance, performance, quality, engagement and inclusion, planning and governance. Performance reports in relation to finance, provider contractual performance and quality have been presented to the Governing Body. The Governing Body has also addressed a wide range of issues and a summary of these are as follows:

4.3 Committees

The Practice Forum is the only committee of the Group established by the Constitution. During the year, providing for robust decision making and engagement through the Practice Forum was challenged as part of the wider governance structure. As a result, representatives from each member practice now sit on the Clinical Cabinet with the capability to call a Practice Forum as required to discuss reserved matters and commissioning business.

The following is a diagram of the governance structure and committees of the Group and the Governing Body as established by the Constitution. In order to deliver effectively and efficiently the Clinical Commissioning Group has established shared committees with NHS Nottingham West CCG, NHS Rushcliffe CCG, NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG. The structure of the Committees has withstood the challenges of the year and all have been able to provide assurance to the Governing Body on delegated responsibilities.



The Committees of the Governing Body include the following:

1. Clinical Cabinet
2. Peoples' Council
3. Finance and Information Group
4. Audit and Governance Committee
5. Remuneration Committee
6. Individual Funding Request Committee - shared
7. Quality and Risk Committee - shared
8. Information Governance, Management and Technology Committee - shared
9. Safeguarding Committees – shared

4.3.1 Clinical Cabinet

Membership

The membership of the Clinical Cabinet changed during 2013/14 in response to a greater understanding of the challenges of the committee and the right membership to ensure that it was fit for purpose. Changes include the GP commissioning representative from each member practice and a reduction in Practice Managers from two to one. The Governing Body feel the member practice representation is a positive step forward and an opportunity to engage in more robust clinical decision making for the CCG.

The current membership includes the following:

- Chair and Clinical Lead
- Assistant Clinical Chair
- NNE GPs – 1 per practice
- 1 Practice Manager
- 2 Practice Nurses or 1 Practice Nurse and 1 Other Primary Care Healthcare Professional (1 is Governing Body representative)
- Governing Body GP
- Governing Body Secondary Care Consultant
- Public Health Consultant
- Governing Body Lay Member PPI and Deputy Chair
- Upper Tier Local Authority Representative
- Patient and Public Representative
- Chief Officer
- Chief Finance Officer
- Deputy Chief Officer

The Clinical Cabinet is chaired by the Clinical Lead and is responsible for effective discussions and decision making on clinical matters. The Clinical Cabinet has the following responsibilities;

- Approve new pathways and changes to pathways for all services relative to delegated limits, except those that the NHS England or local authorities are responsible for commissioning.
- Advising the Governing Body on the commissioning of healthcare services to meet the reasonable needs of the persons for whom the CCG is responsible, within limits and subject to appropriate scrutiny.
- To obtain appropriate advice to enable the CCG to discharge its functions effectively from people who have a broad range of professional expertise in the prevention, diagnosis or treatment of illness and in the protection or improvement of public health.
- To acknowledge arrangements to secure public involvement in the planning of commissioning arrangements and in developing, considering and making decisions (within limits) on any proposals for changes in commissioning arrangements that would have an impact on service delivery or the range of health services available.
- Promote innovation in the provision of health services.
- Act with a view to enabling patients to make choices about aspects of health services provided to them.
- Have regard to the need to reduce inequalities between patients with respect to their ability to access health services and the outcomes achieved for them.
- Act with a view to securing that health services are provided in an integrated way, and that provision of health services is integrated with provision of health-related or social care services, where the CCG considers that this would improve quality of services or reduce inequalities.
- Assist and support the Group in securing continuous improvements in primary care.
- Promote the NHS Constitution.

- To help plan services for carers.
- Support delivery of the QIPP agenda.

Clinical Cabinet Attendance

Name	Committee Role	Possible	Actual	Name	Committee Role	Possible	Actual
Dr Paramjit Panesar	Asst Chair/GP Rep (ivy)	5	5	Dr Tony Marsh (01.04.13-31.05.13)	Chair	1	1
Dr Paul Oliver (01.06.13-date)	Chair	5	3	Sam Walters	Chief Officer	5	3
Sharon Pickett	Deputy Chief Officer	3	3	Finance Representative	Finance Reps	5	5
Dr Arun Shetty	GP Rep (Apple Tree)	1	1	Dr James Hopkinson	GP Rep (Calverton)	5	4
Dr Gerry Gallagher	GP Rep (Daybrook)	1	1	Dr Jacques Ransford	GP Rep (Giltbrook)	1	1
Dr Tariq Bashir	GP Rep (Highcroft)	1	1	Dr Claire Hatton	GP Rep (Jubilee)	1	1
Dr Sarah Bamford	GP Rep (Newthorpe)	1	1	Dr David Myers	GP Rep (Oakenhall)	1	1
Dr Suman Mohindra	GP Rep (Om)	1	0	Dr Luke Louca	GP Rep (Park House)	1	0
Dr Elaine Maddock	GP Rep (Stenhouse)	1	1	Dr Chic Pillai	GP Rep (Plains View)	1	1
Dr Caitriona Kennedy	GP Rep (Trentside)	1	1	Dr David Hannah	GP Rep (Torkard)	1	0
Dr Graham Cox	GP Rep (West Oak)	1	1	Dr Azim Khan	GP Rep (Unity)	1	1
Dr Amelia Ndirika	GP Rep (Whyburn)	1	1	Dr Richard Baynham	GP Rep (Westdale)	1	1
Adrian Kennedy	H/C Professional	5	1	Dr Sylvester Nyatsuro	GP Rep (Willows)	5	3
Paul McKay (Observer) (01.04.13-30.11.13)	LA Rep	4	3	Caroline Baria (Observer) (01.12.13 – date)	LA Rep	1	1
Mike Wilkins	Lay Member	5	4	Paul Johnson	Lay Member	3	3
Jean Lewis (01.04.13-31.10.13)	PPI Rep	3	3	Dr Cheryl Crocker	Nurse	1	0
Pam Husband	Practice Manager	1	1	Stephen Storr (01.11.13 – date)	PPI Rep	2	2
Sheila Price (01.04.13-31.10.13)	Practice Nurse	3	3	Colleen Mulvany	Practice Nurse	1	1
Dr Mohammed Al-Uzri	Secondary Care Consultant	5	4	Dr John Tomlinson	Public Health	5	4

A summary of specific items covered during the year includes the following:

- Reports delivered: Finance and Performance, Chief Officer and Chair, Quality and Performance, Health and Wellbeing Board, Annual Prescribing, Immunisation and Vaccination Report, Safeguarding Children's' Board
- Review of Recommendations: Francis Report
- Approval of projects and service improvements: Prescribing and Supply of Gluten Free Products, Centralised Wound Care, Reducing Emergency Admissions in People over 65, Chronic Care Management, Anti-coagulation Services, Primary Care Aspirations, GP Contract Changes and Enhances Services, Community Dermatology, Pain Management Service, MSKN Briefing, Optimising Medicines, Pathology Ordering System, Redesign of Emergency Services, Productive General Practice Business Case and Mental Health Building Block Presentation
- Review Commissioning Plans 2013-14, Better Care Fund, Balance Scorecard, Greater Nottinghamshire Improvement Plan, Integrated Commissioning Hub for Children and Plan on a Page
- Planning for Patients Everybody Counts

4.3.2 Peoples' Council

Membership

The membership of the People's Council has also expanded to include greater representation from patients and public from within the registered populace of NHS Nottingham North and East. The membership has included a representative from each member Practice Patient Group, as well as individuals who do not sit on a group but are registered with an NHS Nottingham North and East practice.

- Lay Member PPI (chair)
- 3 x Patient Representatives
- 3 x Representatives from PPE locality groups
- A Carer or representative from carers forum
- Gedling CVS
- Healthwatch
- NNE Patient and Public Representative
- PALS/Patient Experience
- NNE Stakeholder Engagement Manager
- NNE Clinical Chair (GP)
- Representative from a Local Group

The Peoples' Council covers the following responsibilities:

- To work actively with the CCG to ensure meaningful patient and public involvement in commissioning decisions
- To inform the consultation and engagement plans and processes of the CCG in order to ensure effective public involvement (patients, public, carers, community)
- To proactively identify and support the implementation of projects and campaigns to support change being driven by patients and public
- To be involved in the development of the commissioning plan
- To actively link in with Practice Patient Reference Groups (PRG)
- To support Patient and Public locality groups in driving patient and public change
- To promote patient and public engagement and embed in the CCG
- To deliver actions which support patient change and patient and public engagement

- Support NNE in delivering against the recommendations in the Francis Report relative to public accountability of commissioners and public engagement

A summary of items discussed in the People's Council includes the following:

- Service Improvement and Projects with regular Patient & Public updates including: Local Enhanced Service Review ,Patient Pledge, Facilitating Early Discharge, Same Day/Urgent Care, Challenge Fund
- Development of the CCG commissioning plan including Commissioning Intentions
- Involvement in the future of health services in Nottinghamshire including, the South Nottinghamshire Transformation Board and NHS Call to Action
- Review and participation in the Health and Wellbeing and Primary Care Strategy, the Integrated Health and Social Care and the Transformation Fund
- Liaison with the NHS England Area Team in Primary Care and input into GP services Including: Primary Care Access Group feedback, Extended Hours for GP Practices, Primary Care GP Access Aspirations

Attendance at the People's Council

Name	Committee Role	Possible	Actual	Name	Committee Role	Possible	Actual
Geoff Barker	PPG Rep Newthorpe	9	7	Dennis Purbrick	PPG Rep Oakenhall	9	4
Phil Barlow	PPG Rep Westdale Lane	9	6	Lorraine Robinson-Up	PPG Rep Plains View	9	1
Jeff Burgoyne	PPG Rep Calverton	9	9	Anne Scudder	PPG Rep Oakenhall	9	6
Bruce Cameron	Patient	9	6	John Slater	PPG Rep Westdale Lane	9	1
Brenda Chambers	PPG Rep Highcroft	9	3	Stephen Storr	PPE Representative on Governing Body	9	9
Pauline Clarke	PPG Rep Trentside	9	1	Diane White	PPG Rep Om	9	1
Anne Collis	PPG Rep Unity	9	1	Richard White	PPG Rep Om	9	1
David Comerie	PPG Rep Trentside	9	4	Doreen Williams	PPG Rep Whyburn	9	8
Richard Cornish	PPG Rep Willows	7	3	Les Williams	PPG Rep Whyburn	9	8
John Donaldson	PPG Rep Willows	9	1	Dale Wells	PPG Rep Appletree	5	5
Clive Duckworth	PPG Rep Stenhouse	9	5	Peter Newton	Patient	9	1
Chris Foster	PPG Rep Highcroft	9	3	Doreen Jones	PPG Rep Plains View	9	1
Don Gifford	PPG Rep Jubilee	9	0	Lawrence Quirk	Gedling Community & Voluntary Services	9	1
Kelly Gillingham	PPG Rep Plains View	9	2	Mike Wilkins	Chair	9	8
Francis Henman	PPG Rep Westdale Lane	9	9	Hazel Buchanan	Director of Operations	9	9
Neil Hutchinson	PPG Rep Giltbrook	9	0	Mariea Kennedy	Patient Advice & Liaison	9	6
Robert Jeffrey	PPG Rep Peacock	9	3	Michael Ellis	Patient & Public Engagement	9	8
Janet Kenwood	PPG Rep Burton Joyce	9	1	Dr Paul Oliver	Clinical Lead	9	3
Jean Lewis	Healthwatch	9	6	Sam Walters	Chief Officer	9	5
Terry Lock	PPG Rep Park House	9	6				
Tony Morris	PPG Rep Park House	9	2				

4.3.3 Finance and Information Group

Membership

- Lay Member lead for Finance (Chair)
- Clinical Lead (or designate) of the CCG
- Chief Officer
- Deputy Director of Finance
- NNE Head of Finance
- NNE Information and Contract Analyst
- Deputy Chief Officer
- Director of Operations

The Finance and Information Group has delegated authority from the Governing Body to monitor budgets and activity and ensure their delivery against plan, reporting all deviations and respective corrective action to the Governing Body. The Finance and Information Group will be responsible for monitoring delivery against the QIPP and financial recovery plans. The Finance and Information Group will also oversee the financial planning process, agreeing the financial plan assumptions and principles.

Specifically the Finance and Information Group carries out the following:

- Receive and discuss the monthly Financial Performance Report.
- Receive and discuss monthly activity reports.
- Consider relevant financial, activity and information issues affecting the CCG and its member practices.
- Assess financial risk and recommend mitigating actions to Members and the Governing Body.
- Receive updates on QIPP initiatives and monitor returns against priorities and schedule of delivery.
- Identify risks of non-delivery in the QIPP plan and recommend mitigating actions in relation to realignment of the plan against initiatives that are delivering and schedule of delivery.
- Agree financial plan principles and assumptions
- Receive regular updates on the financial plan and key milestones, together with funding gaps / QIPP requirements
- Review Service Improvement Group plans and Medicines Management Group plans for future QIPP initiatives to address the financial plan gap.
- Agree Practice budget setting methodology

A summary of specific items covered includes:

- GP Commissioning Budget
- GP Prescribing Budget
- Reserve Schemes Surplus
- Resource Allocations 2014/15 and 2015/16
- Framework for Incentive Scheme

Attendance at the Finance and Information Group

Name	Committee Role	Possible	Actual	Name	Committee Role	Possible	Actual
Paul Johnson (01.14.13 – 31.10.13)	Lay Member Chair	4	4	Jonathan Bemrose	Director of Finance	7	5 (+ 2 deputy)
Terry Allen (02.11.13 – date)	Lay Member Chair	3	2	Audrey McDonald	Head of Finance	7	0
Dr Paul Oliver	Clinical Lead	7	6	Hazel Buchanan	Director of Operations	7	7

Sam Walters	Chief Officer	7	5	Sergio Pappalettera	Data Analyst	7	7
Sharon Pickett	Deputy Chief Officer	7	7				

4.3.4 Audit and Governance Committee

Membership

NNE CCG Lay members Financial Management and Audit and Patient and Public Involvement

Nottingham North and East previously advertised to recruit a GP from the member practices to join the Audit and Governance Committee and due to concerns on time commitment, this was not feasible. The Audit and Governance Committee is being expanded for 2014/15 to include the Assistant Clinical Chair.

As well as the members, attendees have included internal and external audit, counter fraud, the Chief Finance Officer and the Director of Operations.

The Audit and Governance Committee has met five times during the year. The Audit Committee has also held integrated meetings with NHS Rushcliffe Clinical Commissioning Group and NHS Nottingham West Clinical Commissioning Group.

The Committee critically reviews the Clinical Commissioning Group's financial reporting, risk and internal control principles and ensures an appropriate relationship with both internal and external auditors is maintained.

Financial reporting

The Committee will monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCGs' financial performance. It will ensure that the systems for financial reporting to the CCG Governing Body, including those of budgetary control are subject to review as to completeness and accuracy of the information provided to the CCG governing body. The committee will review the annual report and financial statements before submission to the CCG Governing Body.

Internal control and risk

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Clinical Commissioning Group's activities that support the achievement of the Clinical Commissioning Group's objectives.

Its work will dovetail with that of any quality Committees, which the Clinical Commissioning Group establishes to seek assurance that robust clinical quality is in place. In addition the Committee will review the work of other Committees within the Clinical Commissioning Group whose work can provide relevant assurance to the Audit Committee's own scope of work

A summary of items covered during the year includes the following:

- Governing Body Assurance Framework
- Internal Audit Reports
- CCG authorisation and removal of conditions
- CCG Turnaround plan
- Transition from PCT
- Standing order and delegations
- Review and approval of policies

- Internal Audit annual work plan
- Counter Fraud annual plan and progress against plan

Name	Committee Role	Possible	Actual
Paul Johnson (01.14.13 – 31.10.13)	Lay Member Chair	2	2
Terry Allen (02.11.13 – date)	Lay Member Chair	2	2
Mike Wilkins	Lay Member Patient & Public Rep	4	4
GP Member	GP Member	4	0

4.3.5 Remuneration Committee

The members of the Remuneration Committee include the Lay Member for Financial Management and Audit and Lay Member for Patient and Public Involvement, Governing Body Secondary Care Consultant and Governing Body GPs.

The Remuneration Committee makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the Group and on determinations about allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme.

The Remuneration Committee will also review proposals and make recommendations on commissioning decisions where GP providers may have a potential financial interest relative to a pathway and/or a payment to GP practices, in relation to promoting improvements in the quality of primary medical care and payments relative to carrying out designated duties as healthcare professionals.

A summary of items covered during the year includes the following:

- Governing body payments
- Practice Forum Chair
- Very Senior Managers, specifically plans for Transformation

Attendance at the Remuneration Committee

Name	Committee Role	Possible	Actual
Paul Johnson (01.14.13 – 31.10.13)	Lay Member Chair	1	1
Terry Allen (02.11.13 – date)	Lay Member Chair	1	1
Mike Wilkins	Lay Member Patient & Public Rep	2	2

4.3.6 Quality and Risk Committee

The Quality and Risk Committee has been established under a memorandum of understanding with NHS Nottingham North & East CCG NHS Nottingham West CCG and Rushcliffe CCG.

The Quality and Risk Committee monitors, reviews and provides assurance that services commissioned by the CCGs are being delivered in a high quality and safe manner, promoting a culture of continuous improvement and innovation by focusing on the three quality domains: Patient Safety, Patient Experience and Clinical Effectiveness.

The Committee acts on behalf of the 3 CCGs to fulfil their obligations in respect of the following functions:

- Clinical Governance
- Risk Management
- Infection Prevention and Control
- Equality and Diversity and EDS
- Complaints and PALS
- Health and Safety

Key areas of work during 2013/14 for the Quality and Risk Committee:

- Responding to actions and recommendations from the Mid Staffordshire Public Inquiry (Francis Report)
- Monitoring the Governance Assurance Framework, clinical risk register for the CCGs and CQUIN progress for the 3 key providers with whom contracts are held (Circle, Nottingham, Nottingham University Hospitals NHS Trust and County Health Partnership
- Director of Quality updates from sub-groups which have included: Health and Safety, Equality and Diversity Forum, South CCG Care Homes, Shared Learning Review, Primary Care Quality Group
- Review of reports and data including: 2 monthly South CCG's Quality Report, Serious Incidents for key providers, Quality Accounts, Quality dashboards from 3 key providers and associate commissioned providers
- Feedback from the Performance Review, NHS England Area Team and EMIAS Internal Audit
- Review of progress in Training and Development
- Lay Member and Lay Representative involvement in scrutiny of 3 key providers
- Service reviews and surveys including NUH A&E and PMS
- Review and ratification of policies

The membership of the Quality and Risk Committee is as follows:

- Director of Quality and Patient Safety
- Assistant Director of Quality and Patient Safety
- Assistant Director Strategy, Planning and Assurance (NNE)
- Head of Quality, Governance and Engagement (NW)
- Head of Governance and Integration (RCCG)
- Consultant in Public Health
- Governing Body Lay Member/Lay Representative x 3 (one from each CCG)
- Secondary Care Consultant
- GP
- Chairs or Vice-Chairs of all sub-groups

Attendance at the Quality & Risk Committee

Name	Quality Risk Committee Role	Possible	Actual	Name	Quality Risk Committee Role	Possible	Actual
Mike Wilkins	Lay Member, NNE CCG and Non-Executive, PCT Cluster (Chair)	5	4	Hazel Buchanan	Director of Operations, NNE CCG	5	3 +1 (deputy)
Dr Cheryl Crocker	Director of Quality and Patient Safety, NNE, NW and Rushcliffe CCGs	5	5	Sheila Hyde	Lay Member, Rushcliffe CCG	5	5
Helen Cawthorne	Head of Quality and Patient Safety, NW CCG	3	3	Val Blackmore Becky Stone	Assistant Director of Quality and Patient Safety, NNE, NW and Rushcliffe CCGs Assistant Director of Quality and Patient Safety, NNE, NW and Rushcliffe CCGs	1 2	1 2
Max Booth	Patient Representative, Rushcliffe CCG	5	4	Amanda Jones	Safeguarding Lead – Adults, NNE, NW and Rushcliffe CCGs	5	2
Shirley Inskip	Patient Representative, NW CCG	5	2	Dr Mohammed Al-Uzri	Consultant Psychiatrist, Leicestershire Partnership NHS Trust/ NNE CCG Clinical representative	5	3
Rachael Rees	Head of Primary Care Operations, NNE CCG	2	2	Dr Ian McCulloch Dr. Ram Patel	GP Representative – Rushcliffe CCG Role share	5	2
Lynne Sharp	Head of Governance and Integration, Rushcliffe CCG	5	5	John Tomlinson	Deputy Director of Public Health, NHS Nottinghamshire County	5	3

4.3.7 Information Governance, Management and Technology (IGM&T)

The clinical commissioning group hosts a joint Information Governance, Management and Technology Committee under a memorandum of understanding with NHS Nottingham North & East CCG, NHS Nottingham West CCG, NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG.

The IGMT Committee supports and drives the broader information governance (IG) and information management and technology (IM&T) agendas, including ensuring risks relating to information governance and health informatics are identified and managed; leading the development of community-wide IG and IM&T strategies; and developing IM&T to improve communication between services for the benefit of patients.

Key areas of work during 2013/14 for the IGM&T Committee:

- tracking and responding to the national updates and publication of national guidance relating to the transfer of personal confidential data for commissioning purposes, tracking progress towards formal agreements with Commissioning Support Units, achieving Accredited Safe Haven (ASH) status, completion of the CCGs Controlled Environment for Finance (CEfF) assurance statements and development of the risk stratification algorithm and data management strategy.
- responding to the Caldicott Report 2 conclusions and twenty-six recommendations by reviewing progress against each recommendation.
- monitoring the CCGs' progress of completion of the Information Governance Toolkit.
- maintaining an information governance risk register for the CCGs.
- receiving reports from Greater East Midlands Commissioning Support Unit on delivery of support against the Information Governance Service Level Agreement.
- receiving quarterly data quality reports on SUS data submitted by Trusts relating to their patients.
- following the progress of all local IT projects and approving a range of policies and

Attendance at the IGMT Committee

Name	IGMT Committee Role	Possible	Actual	Name	IGMT Committee Role	Possible	Actual
Andy Hall	Director of Outcomes and Information (Chair) and SIRO for Rushcliffe CCG	6	6	Helen Horsfield	Governance Officer for Nottingham West CCG	4	4
				Susan Clarke		2	0
Debbie Pallant	Information Governance Lead for GEM CSU	6	5	Diane Butcher	Head of Information & Performance for North Nottinghamshire CCGs	6	6
Dr Mike O'Neil	Clinical Representative & SIRO for Nottingham West CCG	6	5	Gary Flint	Acting Head of Technical Delivery & Support for NHIS	6	4
Dr Sean Ottey	Clinical Representative for Rushcliffe CCG	6	4	Jacqueline Taylor	Head of Transformational ICT Services for NHIS	6	5
Trevor Mills	Caldicott Guardian for Mansfield and Ashfield	5	1	Eddie Olla	Director of Health Informatics for NHIS	6	6
Dean Temple		1	0				
Dr Cheryl Crocker	Director of Quality and Patient Safety and Caldicott Guardian for South Nottinghamshire CCGs	6	3	Ian Blair	Lay Member for Rushcliffe CCG	6	0
Dr George Ewbank	Clinical Safety Officer	6	6	Paul Morris	Lay Member for Newark and Sherwood CCG	6	4
David Harper	Corporate Governance Manager for Mansfield and Ashfield	6	4 + 1 deputy	Sergio Pappalettera	Contract and Information Manager for Nottingham North and East CCG	6	6
Nicola Treece	Corporate Governance Manager for Newark and Sherwood CCG	6	3	Caroline Stevens	Primary Care Governance Officer for Rushcliffe CCG	4	4
Ei Cheng Chui	Caldicott Guardian for Newark and Sherwood CCG	5	5				

4.3.8 Individual Funding Requests Committee

The joint Individual Funding Request panel is hosted under a memorandum of understanding by NHS Nottingham West CCG in conjunction with NHS Nottingham North & East CCG, NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG and NHS Rushcliffe CCG.

Clinical Commissioning Groups are required to have a process for considering funding for individuals who seek NHS commissioned services outside established commissioning policies. This may either be a request for funding treatment where there is no commissioning policy or where the medical condition is not included in a current policy or does not meet the criteria set out in the policy.

The IFR panel is constituted in accordance with the scheme of reservation and delegation of Nottingham West CCG. The applicable policies and procedures are owned and maintained by Nottingham West CCG.

Key areas of work during 2013/14 for the IFR Committee:

- A review was undertaken of the IFR systems, processes and policies to ensure that they are fit for purpose and reflect the NHS England changes.
- Implementation of robust systems to assess requests for treatments and procedures where the CCG hold the commissioning responsibility (including obtaining feedback on patient outcomes)
- Provision of 2 training sessions for IFR panel members as per the training needs analysis.
- 34 Individual Funding Request applications were processed in accordance with the IFR Policy eligibility criteria. Three cases were approved, 19 cases were not approved, 8 cases were redirected/returned and 4 cases were withdrawn.
- Responded to 6 MP letters/complaints
- Process agreed with the CCGs for approving funding requests from the European Healthcare Abroad Team in line with policy.
- Provision of a quarterly IFR report for each CCG

Attendance at the IFR Committee

Name	**Individual Funding Request Committee Role**	**Possible**	**Actual**	**Name**	**Individual Funding Request Committee Role**	**Possible**	**Actual**
Peter Robinson	Chair	4	3	Amanda Sullivan *	Chief Officer - NHS Mansfield & Ashfield CCG and NHS Newark & Sherwood CCG	4	0 + 2 deputy
Usha Gadhia	(Nominated Deputy Chair)	4	4	Elaine Moss *	Director of Quality & Governance NHS N&S CCG	4	0 +2 deputy
Dr Mary Corcoran	Consultant in Public Health Medicine	4	4	Jane Urquhart	IFR Manager – NHS Mansfield and Ashfield CCG	4	4
Oliver Newbould	Chief Officer – NHS Nottingham West CCG	4	4	Lesley Carmen	Deputy Chief Operating Officer, M&A CCG	4	1
Sharon Pickett	(Deputy Chief Officer) NHS Nottingham North and East CCG	3	2	Nicky Bird	Senior Prescribing Advisor (South) – Manages IFR Team – NHS Mansfield and Ashfield CCG	4	4

Dr Simon Brenchley	GP – Lombard Medical Practice – NHS Newark and Sherwood CCG	4	4	Darrin Baines	Health Economist – The University of Nottingham	4	1
Dr Sean Ottey	GP – West Bridgford Medical Practice – NHS Rushcliffe CCG	4	4	Dr James Read	GP – The Manor Surgery – NHS Nottingham West CCG	4	4
Dr Hilary Lovelock	GP –Huthwaite Health Centre – NHS Mansfield and Ashfield CCG	4	1				

**agreed representation via Chief Officer, NHS Nottingham West from January 2014*

4.3.9 Safeguarding Committees

The clinical commissioning group has established a joint Safeguarding Committee under a memorandum of understanding with NHS Nottingham North & East CCG, NHS Nottingham West CCG, NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG and NHS Bassetlaw.

The Safeguarding Committee ensures that systems and process are in place to safeguard vulnerable adults and children as a core component of the services provided and commissioned by the Nottinghamshire Clinical Commissioning Groups and works in close partnership with the Safeguarding Children and Adult Boards to ensure a partnership approach.

The safety and welfare of children and vulnerable adults is at the forefront of the clinical commissioning group's planning, commissioning and governance arrangements. The Committee has ensured that a safeguarding strategy and policy are in place and are monitored through this Committee.

The clinical commissioning group's Chief Nurse and quality team are active members of both Nottinghamshire Safeguarding Children and Adult Boards and their sub-committees. Statutory safeguarding roles including Designated Nurse and Doctors for Safeguarding Children and Children in Care, and Designated Pediatricians for Unexpected Deaths are commissioned. These roles provide clinical leadership and specialist advice to the clinical commissioning group, as well as to independent contractors and provider organisations.

The Committee produces a Safeguarding Annual Report which provides more detailed information on how the clinical commissioning group fulfils its safeguarding responsibilities.

During 2013/14 the Safeguarding Committee was divided into the Adults Safeguarding Committee and the Children's' Safeguarding Committee.

The membership of the Safeguarding Adults committee is as follows:

- Director of Quality, Governance and Performance, Chief Nurse for Newark and Sherwood and Mansfield and Ashfield CCG's (Chair)
- Director of Quality and Safety, Chief Nurse for Nottingham North & East, Nottingham West and Rushcliffe CCG's (Vice Chair)
- Chief Nurse and Executive Lead for Quality and Patient Safety for Bassetlaw CCG
- Consultant in Public Health nominated by the Director of Public Health, Nottinghamshire County Council

- General Practitioner
- Continuing Care and Discharge Policy/Procurement Manager (GEM)
- Adult Safeguarding Leads from the CCGs
- Head of Quality and Patient Safety N&S & M&A CCG

The safeguarding committees promote the safety and welfare of vulnerable adults and children with the CCGs and across all commissioned and contracted services. The committees provide direct links to the Nottinghamshire safeguarding boards and other relevant committees. The Committees also monitor resulting actions following serious case reviews, independent management reviews and other relevant safeguarding incidents and to promote the dissemination of learning. :

A summary of specific items covered during the year includes the following:

- Quality Assurance in Care Homes
- Safeguarding Adults Network Updates
- Quality Assurance Sub Group Updates
- MASH Progress Report
- Change of Statutory Duties Assurance Framework
- Bassetlaw Report
- Working with NHS England Area Team
- Multi-Agency Safeguarding Policy
- Head Injury Pathway
- PREVENT Feedback
- Continuing Health Care Feedback
- Safeguarding Risk Register
- Competency Framework
- Roles and Responsibilities of the Designated Nurse
- Domestic Violence Strategy Sub Group
- Transforming Care – Winterbourne View Hospital
- Work Plan
- Early Indicators of Concern in Residential Support Services – Learning Disabilities

Attendance at the Safeguarding Adults Committee

Name	Committee Role	Possible	Actual	Name	Committee Role	Possible	Actual
Chris West	Chair Head of Quality and Governance, NHS Newark and Sherwood CCG	6	5	Nicola Ryan	Head of Assurance, NHS Bassetlaw CCG	6	5
Cheryl Crocker	Director of Quality and Patient Safety, NHS Nottingham North and East CCG	6	4	Jo Rooney	Continuing Care Commissioning Manager, GEM	6	3
Mary Corcoran	Consultant in Public Health, Nottinghamshire County Public Health	6	3	Amanda Jones	Adult Safeguarding Lead, NHS Nottingham North and East CCG	6	3
	Newark & Sherwood and Mansfield & Ashfield CCG Nurse	6	3	Rebecca Stone	Assistant Director, Quality & Patient Safety NNE, NW and Rushcliffe	3	3

					CCGs*		
	Nurse consultant Safeguarding, Bassetlaw CCG	6	2		Chief Nurse Bassetlaw CCG	6	0
	Adult Safeguarding Managers (shared post)	6	3				

The members of the Safeguarding Children's committee are as follows:

- Director of Quality and Governance (and GP representative) for Newark and Sherwood and Mansfield and Ashfield CCGs (Chair)
- Director of Quality and Patient Safety (Caldicott Guardian and GP representative) for Nottingham North & East, Nottingham West and Rushcliffe CCGs (vice Chair)
- Chief Nurse and Executive Lead for Quality and Safety (Caldicott Guardian and GP representative) Bassetlaw CCG
- Designated Professionals Safeguarding Children CCGs
- Designated Professionals Children in Care
- Continuing Care Commissioning Manager (children lead) Greater East Midlands Commissioning Support Unit (GEM)
- Public Health Manager (children lead)

Items discussed include:

- Safeguarding Training in GP Practices
- Safeguarding Children Annual Report
- Safeguarding Policy and Procedure Update
- Sherwood Forest Hospitals Safeguarding Assurance Action Plan
- Quarterly Briefing for Governing Bodies
- Children in Care Good Markers
- Training Matrix
- Survey – GP Attendance Child Protection Conferences
- Sexual Abuse Medical Service
- Self-Harming Behaviour
- MASH Review
- Ministerial Statement – Working Together
- Bassetlaw Quality and Patient Safety Group
- Nottinghamshire Safeguarding Children Board Meeting
- CQC Safeguarding and Children In Care Inspection Framework
- Wings Residential Unit
- Named Doctor Provision
- MAPPA Arrangements
- Notts County Council – Children and Young People's Committee
- Area Team
- PREVENT
- British Association for the Study and Prevention of Child Abuse and Neglect
- Framework for Contracting
- Risk Register
- Information Sharing and Issuing Alerts to Safeguarding Children in Primary Care
- Domestic Violence Strategy Group

The safeguarding committees promote the safety and welfare of vulnerable adults and children with the CCGs and across all commissioned and contracted services. The committees provide direct links to the Nottinghamshire safeguarding boards and other relevant committees. The Committees also monitor resulting actions following serious case reviews, independent management reviews and other relevant safeguarding incidents and to promote the dissemination of learning.

Attendance at the Children's Safeguarding Committee

Name	Committee Role	Possible	Actual	Name	Committee Role	Possible	Actual
Val Simnett	Chair Designated Nurse Safeguarding Children, NHS Newark and Sherwood CCG	6	5	Victoria Walker	Consultant Community Paediatrician and Lead for Looked After Children, Sherwood Forest Hospitals Foundation Trust	6	3
Jo Rooney	Continuing Care Commissioning Manager, GEM	5	4	Sarah Everest	Senior Public Health Manager, Nottinghamshire County Public Health	6	3
Nicola Ryan	Chief Nurse Bassetlaw CCG rep by Head of Assurance, NHS Bassetlaw CCG	6	5		Designated Nurse Notts CCGs	6	5
Rebecca Sands	Designated Doctor, Sherwood Forest Hospitals Foundation Trust	6	6		Chief Nurse NNE, NW & Rushcliffe CCG	6	5
	Designated Nurse Bassetlaw CCG	6	2		Designated Nurse Children in Care	6	3
	Designated Doctor Children in Care*	6	4				

5. The Clinical Commissioning Group Risk Management Framework

5.1 How is the framework embedded

The CCG Integrated Risk Management Framework is embedded in the normal management processes and structures and encouraged by a responsible culture. The Integrated Risk Management Framework promotes the philosophy of integrated governance and requires all risk management to be systematic, robust and evident. It requires that risk management and prevention processes are applied at all levels and that risk management issues should be communicated to key stakeholders where necessary.

The framework covers clinical (including safeguarding), corporate, organisational and financial risk and identifies the key management structures and processes defining objectives and responsibilities at the different staff tiers within the organisation. The principles of the framework are consistent with the organisations culture and key priorities of people, quality, health outcomes, financial management, reputation and environment.

The framework is supported by the CCG internal meetings and processes which provide reasonable assurance for the prevention of risk, deterrent to risks arising and management of current risks. Risk Management is embedded within the organisation through its effective management of risk registers, incident reporting, equality impact assessments, quality impact assessments, committee structure and meetings. Internal management includes the following meetings and tools:

- Weekly executive team meeting – attendees include the NHS Nottingham North and East CCG Directors, Chief Officer, Chair. The meeting includes a discussion on current risks and potential risks.
- Weekly communications cell (Comms Cell) meeting – attendees include all NHS Nottingham North and East staff. Current risks are highlighted, alongside potential risks.
- Service Improvement Group – membership includes Assistant Director of Pathways and Improvement, Clinical Lead/Chair, CCG GPs, Deputy Chief Officer, Finance, Primary Care Operations. Risks are discussed in relation to QIPP delivery.
- Finance and Information Group – membership includes Lay Member Audit, Deputy Chief Officer, Clinical Lead/Chair, Director of Operations, Chief Finance Officer, Contract and Information Manager.
- The delivery of all service improvement activities are managed through a work plan and an accompanying transformation plan. The transformation plan includes a risk rating for delivery in order that areas of concern can be highlighted and discussed in the relevant meetings.
- Equality Impact and Quality Impact Assessments are carried out for all initiatives and are integral to the process for the internal management of changes.
- Incident reporting is openly encouraged through the weekly Comms Cells where incidents are highlighted and discussed with all staff.
- Training on risk management was provided in December 2013 for all CCG staff.

5.2 Monitoring of the Framework

Implementation of the Integrated Risk Management Framework is coordinated and monitored by the CCG Executive Team and the Audit and Governance Committee. The Framework clearly states the processes that the CCG follows when identifying a risk. This has been a coherent and consistent approach from April 2013. The process ensures that the highest risks progress through to the Integrated Risk Management Framework with a systematic approach to lower risks. The process makes sure that where risks are identified there is a requirement for action to be taken to mitigate the risks. Where risks remain at a high level, they are subject to regular scrutiny by the Governing Body, relevant Committee or the Executive Team so that they receive constant management attention. The risks go to the relevant committees and groups as follows:

Corporate – CCG Executive Team
Finance – Finance and Information Group
Clinical – Quality and Risk Committee
Information Governance – Information Governance, Management and Technology Committee
Safeguarding Adults – Safeguarding Adults Committee
Safeguarding Children – Safeguarding Children's Committee

As part of the 2013/14 Internal Audit Plan, a review of the clinical commissioning group's governance arrangements was undertaken with regard to the Governing Body Assurance Framework and risk register. The report showed the grading in the Nottingham North and East Assurance Framework was in line with benchmarking across other CCGs with 5 reds, 10 amber and 17 risks in total. The Governing Body Assurance Framework was originally done prior to becoming a statutory body and was relevant to the authorisation process and as such, was updated in year to align with new risks.

5.3 Risk Appetite

Nottingham North and East CCG are working towards a 'mature' risk appetite. Nottingham North and East CCG have no appetite for fraud/financial risk and zero tolerance for regulatory breaches. Nottingham North and East CCG may take considered risks, where the long term benefits outweigh any short term losses. Nottingham North and East CCG supports well managed risk taking and will ensure that the skills, ability and knowledge are there to support innovation and maximise opportunities to further improve services. Nottingham North and East CCG Governing Body commit to review its risk appetite statement on an annual basis.

Nottingham North and East CCG acknowledges that providing health services is an inherently risky business and that risk can bring with it positive advantages, benefits and opportunities. NNE CCG is not aiming to create a risk-free environment, but rather one in which risk is

5.4 Counter Fraud

A Counter Fraud report is received at each Audit and Governance Committee. The report aims to inform the Committee of the proactive and reactive activity carried out by the Local Counter Fraud Specialist (LCFS). The content of the report is formatted to accord with the requirements of the NHS Counter Fraud Manual outlining where relevant activity has taken place across the 5 areas of counter fraud work; Strategic Governance, Inform & Involve, Prevent & Deter and Hold to Account.

The CCG receives updates through the Counter Fraud newsletter which is circulated to all staff and key points are highlighted in the CCG Communications Cell (detailed above). All staff have received Counter Fraud training.

5.5 Public Stakeholders

Public stakeholders are involved in managing risks which impact on them through direct engagement and communication with the CCG. Also, a key element for the CCG is listening to patient experiences. The following mechanisms are available:

- Lay Members and Patient Representative on the Governing Body
- Patient and Public Engagement events which are held on a quarterly basis and allow for questions and answers
- Through a dedicated patient experience team, including PALS, with direct reporting of experiences to CCG committees and the Governing Body
- The People's Council which is attended by patient representatives from all Practice Patient Groups
- Practice Patient Group meetings are attended by CCG representatives
- Direct links with the district/borough councils
- During 2013/14, the CCG have presented to the Nottinghamshire Joint Health Scrutiny Committee and the Gedling Borough Council Scrutiny Committee

6. The Clinical Commissioning Group Internal Control Framework

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

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

6.1 Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incident. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

At NHS Nottingham North and East CCG all Information Governance incidents are taken extremely seriously. These include incidents relating to personal confidential data loss, any breach of confidentiality, the insecure disposal of information and any other incidents where staff or patient information may have been at risk. All staff have been made aware of the incident reporting process and are encouraged to report all incidents and near misses in order to ensure that we can investigate the reason for an incident occurring and take measures to prevent the incident happening again.

Guidance issued in June 2013 states that all incidents occurring at level 2 or above should be reported on the Information Governance Toolkit and to the Department of Health. Level 1 or below incidents should be managed locally.

NHS Nottingham North and East CCG are committed to reporting, managing and investigating all information governance incidents and near misses. The CCG encourages staff to report all incidents and near misses to ensure learning can be collated and disseminated within the organisation.

There were no cases reported to the Information Commissioners Office or Department of Health in 2013/14.

Confirmation that Confidentiality and Data Protection Assurance arrangements established by the Nottingham North and East CCG to ensure adequate protection of all information for which it is responsible was received from Internal Audit in December 2013 following their review of Information Governance arrangements. The Nottingham North and East CCG have been accredited Level 2 of the Information Governance Toolkit requirements.

6.2 Pension Obligations

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

scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

6.3 Equality, Diversity and Human Rights Obligations

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

Nottingham North and East CCG has continued to build upon the strong foundation of equality work established by the former organisation NHS Nottinghamshire County, as set out in the strategic document 'Single Equality and Diversity Strategy 2011-13'. This strategy, which incorporated the national NHS Equality Delivery System (EDS), set out the statutory requirements placed on the NHS by the Equality Act 2010 and the Public Sector Equality Duties. At the time of writing, the document was future-proofed to include objectives for CCGs during their first and second year of operation. This ensured equality was mainstreamed into the new structures without losing ground and stayed true to the NHS White Paper 'Liberating the NHS' strap line that there was 'no decision in the NHS is made without you'.

In meeting its Public Sector Equality Duties (PSED) Nottingham North and East remain committed to promoting and advancing equality by providing equitable healthcare and related services to all protected characteristic groups including vulnerable people in all the communities they serve.

6.4 Sustainable Development

The clinical commissioning group is required to report its progress in delivering against sustainable development indicators.

We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

We will ensure the clinical commissioning group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

We are also setting out our commitments as a socially responsible employer.

Specific actions taken by the CCG during 2013/14 include:

- Sustainability workshop held for leads within the CCG
- Participation in the Midlands and East NHS Carbon Reduction Project
- Introduction of a carbon monitoring and reduction scheme internally
- Direct links with Gedling Borough Council on sustainability schemes
- Sustainability included on the front sheet for Governing Body and Clinical Cabinet papers
- Sustainability raised at the CCG Comms Cell
- The CCG has a Governing Body sustainability lead

7 Risk Assessment in Relation to Governance, Risk Management and Internal Control

The CCG Integrated Risk Management Framework was developed as the organisation established itself and was then fit for purpose. The Integrated Risk Management Framework is reviewed regularly in the CCG and the risks re-aligned and removed in accordance with the Framework. Risks are assessed and identified utilising the standard Risk Matrix of Likelihood x Consequence.

Since this is the first year in operation, all risks have been newly identified and a description of those that are major and mitigating actions are listed below:

- Due to national regulations, there is no legal basis on which CCGs can lawfully process patient identifiable data (PID) from 01 April 2013. Could impact on contract management, financial reporting, validation processes, risk stratification, certain clinical processes, support to practices. Working in partnership with CCGs in Nottinghamshire, NNE CCG received authorisation to become an Accredited Safe Haven and have had approval for a Secure Environment for Finance. This risk has been stepped down
- Better Care Fund – impact on health costs and objectives. Mitigating actions have included close working with the Local Authority on the plans and outcomes. The Better Care Fund is being supported through the Transformation Board and named individuals are responsible for the management.
- Expenditure will exceed budget and the CCG will not deliver its required surplus due to QIPP not delivered or not delivered recurrently. Mitigating actions included reporting to the Governing Body, exception reporting to the Finance and Information Group, a robust transformation plan, dedicated resource to monitor delivery against plan.
- Expenditure will exceed budget and the CCG will not deliver its required surplus due to activity over performance – Regular reporting to the Governing Body and Finance and Information Group, primary care team working directly with practices, review of specialties and a robust transformation plan.
- ED performance at the acute provider fell below the national target for four hour waits in September 2013. Continued failure to achieve the target resulted in an increased rating and it remains red on the risk register. Lead Commissioners are in daily contact with the Provider and the Urgent Care Board is taking action through working groups.

Further to the above, the CCG has not faced any risks to compliance and this has been mitigated by responding effectively to change and evolving the CCG structures and lines of responsibility accordingly. In particular, the Finance and Information Group was included as a committee of the Governing Body following the identification of a gap in robust scrutiny on the financial position. Responsibilities of existing Directors were aligned following the departure of a previous Director to deliver greater integration between teams and efficiency gains.

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

As the Accountable Officer I have the responsibility to ensure resources are used economically, efficiently and effectively.

8.1 Committees and Officers

The following Committees and Officers of the CCG have played a significant part in maintaining and reviewing the effectiveness of the system of internal control in 2013/14 and the use of resources

Governing Body: Responsible for providing clear strategy and commitment for the effective use of resources. This is not only achieved through Governing Body meetings but also through areas of responsibility and by providing a strategic approach to planned and unplanned care working groups.

People's Council and Clinical Cabinet: - These committees of the Governing Body ensure that resources are using effectively and efficiently through the review of objectives and actions carried out by the Clinical Commissioning Group. The People's Council approaches from a patient and public perspective and the Clinical Cabinet from a clinical perspective.

Audit & Governance Committee: Responsible for providing an independent overview of the arrangements for risk management with responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews Internal and External Audits.

Finance & Information Group – The Finance and Information Group supports sound financial governance arrangements by reviewing performance against the statutory financial duties. The Finance & Information Group applies a level of scrutiny to allow for clear and informed discussions in the Governing Body.

The CCG has the following shared committee arrangements with neighbouring CCG's as identified in the Nottingham North and East CCG Constitution. These committees serve the collective CCG's and providing equal levels of assurance within the range of their functions.

a) Individual Funding Request Panel (led by Nottingham West CCG)
b) Information Governance, Management and Technology Committee (led by Rushcliffe CCG)
c) Quality and Risk Committee (led by Nottingham North and East CCG)
d) Safeguarding Adult Committee and Safeguarding Children Committee (led by Newark and Sherwood CCG).

Chief Officer: As the Accountable Officer for the CCG,

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

Directors and Senior Managers: Each Director/Senior Manager is responsible for a budget and ensuring that elements within their remit are managed effectively and efficiently.

8.2 Risk Pooling

A financial risk pooling agreement has been in place for the Nottinghamshire County Clinical Commissioning Groups (CCGs) since they started in shadow form as part of Nottinghamshire County PCT. The 2013/14 financial risk pooling arrangements in place for the five CCGs in Nottinghamshire have been approved by the Governing Body.

A review of the current arrangements has been undertaken which has recommended:

- High Cost Patients and one-off "major incidents" would be risk shared at a City/County basis

- Risk Sharing on year-end surplus/deficit positions would be done at a Mid Notts/South Notts level on an informal basis

These arrangements were approved in the Governing Body in March 2014/

8.3 Internal and External Audit

Both Internal and External Audit carry out independent reviews of systems and processes within the organisation. Recommendations and action plans are put in place following these reviews to ensure controls are safe and adequate, providing safeguard of assets and resources. Key risks highlighted in these reports are added to the corporate risk register and escalated to the Assurance Framework if a threat to strategic objectives. Management action plans are routinely tracked through the Audit Committee meetings.

8.4 Counter Fraud and Deterrence

A Counter Fraud report is received at each Audit Committee. The report aims to inform the Committee of the proactive and reactive activity carried out by the Counter Fraud Specialist (CFS). The content of the report is formatted to accord with the requirements of the NHS Counter Fraud Manual outlining where relevant activity has taken place across the 7 generic areas of counter fraud work:

- Anti-fraud culture (including 3-yearly mandatory staff training)
- Deterrence (including policy reviews)
- Prevention
- Detection
- Investigations
- Sanctions
- Redress

Staff have received Counter Fraud face to face training and have completed a Counter Fraud survey the results of which will form an action plan and will be considered when developing the clinical commissioning group's Counter Fraud Risk Assessment for the forthcoming year. Regular bulletins are issued to staff which raise awareness, vigilance and reporting.

8.5 NHS England Assurance Process

As per the national assurance process, the CCG has quarterly checkpoint meetings with the Area Team which reviews delivery against the six domains. The CCG assurance process has been designed to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high-quality and sustainable services within their resources. The Area Team support the CCG through this process by also holding monthly meetings.

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 within the clinical commissioning group.

9.1 Capacity to Handle Risk

The risk process is given significant leadership within the CCG through coordination by the Chief Officer and management by the Director of Operations, Director of Quality and Patient Safety and the Chief Finance Officer, ensuring regular reporting to the executive team meeting and associated internal risk management committees as directed through the Integrated Risk Management Framework. Capacity is managed by continually promoting risk management and demonstrating leadership, involvement and support, ensuring an appropriate committee structure is in place, with regular reports to the Governing Body, ensuring appropriate policies, procedures and guidelines are in place and operating throughout the CCG. Staff are provided with training on risk management to ensure they are appropriately equipped within their individual roles and responsibilities to carry out their duties.

The Integrated Risk Management Framework was updated and approved by the Governing Body in December 2013.

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

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

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

Governing Body: Responsible for providing clear commitment and direction for risk management and in assuring that risks are effectively identified and that the processes and controls in place to mitigate those risks, the impact they have on the organisation and its stakeholders are managed and administered with effect.

Audit & Governance Committee: Responsible for providing an independent overview of the arrangements for risk management with responsibilities for financial risk management. It undertakes its own annual self-assessment of its effectiveness and reviews Internal and External Audits.

The CCG has the following shared committee arrangements with neighbouring CCG's as identified in the Nottingham North and East CCG Constitution. These committees serve the collective CCG's and providing equal levels of assurance within the range of their functions.

e) Individual Funding Request Panel (led by Nottingham West CCG)
f) Information Governance, Management and Technology Committee (led by Rushcliffe CCG)
g) Quality and Risk Committee (led by Nottingham North and East CCG)
h) Safeguarding Adult Committee and Safeguarding Children Committee (led by Newark and Sherwood CCG).

Chief Officer: As the Accountable Officer for the CCG,

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

Directors and Senior Managers: Each Director/Senior Manager is responsible for ensuring that risks have been properly identified and assessed across all their work areas, paying particular attention to crosscutting risks. They are responsible for agreeing the risk register entries for their work areas and for ensuring that each team lead is actively addressing the risks in their area and escalating risks up to Senior Management for their attention as appropriate. Each Director has the expectation to own the main risks in their Team/s and personally addressing them, thus setting the tone for risk management in their areas of responsibility.

Head of Internal Audit: The Head of Internal Audit has a central role in the process of securing this Annual Governance Statement, and in advising the Chief Officer and the Audit and Governance Committee on the status of the Nottingham North and East CCG's risk management processes. They also provide information on the various strengths and weaknesses of the approach adapted to Nottingham North and East CCG and advise where improvements are necessary for the good governance of the organisation.

My review was also informed by:

- CCG Assurance Framework
- Delivery of Audit Plans by External and Internal Auditors
- NHS and CCG Staff Survey Results
- 360 Stakeholder Survey

9.3 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.

In providing an opinion for the 2013/14 financial year, it is important to reflect on the environment in which the CCG has been required to function and the impact such an unprecedented period of change

and development will have on the operation of control. However, the system of internal control is designed to manage risk to a reasonable level rather than eliminate all risk of failure. From my review of your systems of internal control, primarily through the operation of your Assurance Framework and the individual assignments I have undertaken, I am providing **Significant Assurance** that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

9.4 Internal Audit Reports

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

9.4.1 Review of Engagement with Member Practices

Limited Assurance was provided due to the need for further development of systems and processes. Internal Audit acknowledges that the CCG has developed systems and processes and a number of forums to enable practices to contribute to discussions and these now need to run to optimum efficiency.

Follow up Audit Findings

We consider that The CCG has made considerable progress consulting with the membership to review the governance arrangements to ensure that GP participation in the commissioning process is developed and enhanced in future. The membership of the Clinical Cabinet has been amended to ensure that each practice is represented. In addition, the role of the GPs and the representative from the Practice Managers will be formalised within job descriptions and contractual arrangements.

9.4.2 Quality and Contract Monitoring in Care Homes – Report Reference 1213/NCO/15R May 2013 for NHS Nottinghamshire County incorporating 5 Nottinghamshire CCGs.

This report was inherited by the clinical commissioning group from the former PCT's Internal Audit Plan 2012/13.

The report gives a conclusion of **significant assurance** for the quality monitoring mechanisms in place for ensuring that care provided by care homes is of a sufficiently high standard. However, the report provides **limited assurance** in respect of the mechanisms in place to monitor compliance with the contract for care homes which provide NHS Continuing Healthcare.

Issues leading to the conclusion were:

- No contract exists which covers all the care a home is providing making monitoring the overall performance of the home against a formally agreed set of standards difficult; lack of resources in predecessor PCTs for the contract monitoring process; the nature of the care homes market where a company may own numerous homes across the country – a successful contractual arrangement would need to recognise this and achieve a consistent approach.
- Difficulties in agreeing an East Midlands wide CQUIN for 2013/14 contracts
- Alignment of the quality monitoring process with the quality standards in the contract – missing the opportunity to apply sanctions in the contract for poor quality
- Care homes are not routinely producing monitoring data under the terms of the contract due to the general lack of contract monitoring

The report highlights that issues exist that are not within the clinical commissioning group's jurisdiction or power to resolve in isolation, as they are regional and in some cases national in nature.

A regional group of Chief Nurses has been created to address some of the issues that can be taken up regionally and to bring about some improvement. The aim is partly to exert pressure 'upwards' to encourage national changes. An action plan has been developed and agreed by the Audit Committee and monitoring continues. In order to bring these actions to completion staff have been transferred from GEM to the clinical commissioning groups to assist with the contract process of care homes. Further work continues with GEM (CSU) to ensure actions are completed and there is oversight of the contract monitoring.

A follow up audit exercise will be undertaken in April 2014 to evaluate progress made in respect of the issues raised. The Audit Committee has been updated on progress made by the regional chief nurse group throughout the year.

9.4.3 NHS SBS Service Auditor Report

NHS SBS service auditor conducted an examination (assurance engagement) covering Payroll and associated general IT controls for the period 1 April 2013 to 31 March 2014. The audit was conducted in accordance with ISAE3402.

The report provides an unqualified opinion in relation to all control objectives examined.

9.4.4 Greater East Midlands Commissioning Support Unit (GEM CSU) Service Auditor Report.

Control weaknesses were identified during the year in Greater East Midlands Commissioning Support Unit's (GEM CSU) ability to achieve a substantially "clean" auditor report for 2013/14. The overall objective of the internal audit work undertaken was to evaluate the effectiveness of the control environment for the CSU and provide assurance to the CSU and therefore NHS England, on the adequacy and effectiveness of the key controls in operation.

The lack of assurance was around some control weaknesses in respect of the Human Resources Function, the Financial General Ledger and the Procurement Function. Some of these were implemented part-way through the 2013-14 Financial Year and we are still expecting final assurance around this work due in May 2014.

Where processes and control weaknesses have been identified, the CSU has taken/will be taking the necessary actions agreed with internal audit to enable the respective processes and controls to be assessed within the scope of the service auditor report.

The impact on the CCG is limited due to a number of reasons and it important therefore to put this audit report into context:-

1) The CCG commissions a limited range of finance services (primarily Balance Sheet maintenance, control account reconciliations and suspense clearance) from the CSU compared to other CCGs around the country with all the Management Accounting Function provided by the CCG's Finance Team G itself. This includes the key spend areas of Healthcare Service Level Agreements, Prescribing & Continuing Care.

2) In mitigating against any risk to the CCG, the CCG has a number of compensating controls in place and is taking a number of remedial actions to address the control weaknesses:-

   a) A Review of the Control Account Reconciliations on a monthly basis by a member of the senior finance management thereby limiting any risk to the reported Income & Expenditure Accounts.
   b) Supporting this the management accounting function is the responsibility of the CCG therefore variance analysis and reporting will highlight any areas to be investigated
   c) The **CCG's Budgetary Control and Financial Reporting** Audit Report, issued in March 2014, confirmed that ***significant assurance*** could be provided that there is a generally sound system of control designed to meet the system's objective. The objective of the review was to determine whether robust systems and processes are in place in relation to the CCG's budget setting, management and reporting processes.
   d) The CCG's **Key Financial Systems & Payroll** Audit Report, issued in March 2014, confirmed that ***significant assurance*** could be provided that there is a generally sound system of control designed to meet the system's objective. The objective of the review is to determine whether the CCG has robust systems and processes in place in respect of the Key Financial Systems and Payroll transactions.
   e) The CCG holds a monthly performance meeting with the CSU where it discusses performance against the SLA which covers the financial services provided by the CSU. This has occurred more frequently at the year-end to ensure robust controls and processes in place for the year-end accounts.
   f) The CSU has a number of agreed actions as a results of the internal audit work and Internal Audit have a process to follow up and report to NHS England on the implementation status of agreed management actions. The CSU have agreed to share with the CCG an update on how they are progressing with the implementation of their agreed actions on a periodic basis which will be picked up as part of the monthly SLA performance meetings held with the CCG's Deputy Chief Finance Officer.

9.5 Patient Identifiable Information

In 2013, section 251 (s251) support was approved for the transfer of data from the Health and Social Care Information Centre (HSCIC) to Commissioners. However, this mainly covered the outbound flow of SUS or HES data from the HSCIC to Accredited Safe Havens (ASHs), and it was explicit that this s251 did not cover patient-level invoice validation. Therefore, in the absence of a legal basis to use Personal Confidential Data (PCD), patient-level invoice validation was suspended nationally. This impacted upon the local validation of invoices for Non-Contracted Activity (NCAs) and Non-SUS contracts, where PCD had been previously used to help confirm the responsible commissioner for payment.

In November 2013, the Secretary of State for Health approved further s251 support, providing a temporary legal basis for Provider Trusts to disclose PCD to named approved organisations for the purposes of invoice validation, and without the need to obtain explicit consent from the individual patient. A CCG or CSU must establish a Controlled Environment for Finance (CEfF) before it can receive PCD backing data with the invoice. This CEfF is distinct from a Stage 1 ASH, in that staff within a Stage 1 ASH must have neither access to PCD nor the means to identify an individual patient – whereas CEfF authorised staff will be allowed to access the necessary PCD and systems for the purpose of invoice validation. All 5 Nottinghamshire County CCGs were accredited as Stage 1 ASH by the HSCIC in November 2013. It has been agreed that each of the 5 Nottinghamshire County CCGs should set up a CEfF.

In the first instance, focus is centred on systems and processes for the management of invoice validation in relation to Non-Contracted Activity (NCAs). Invoice validation for Non-SUS contracts will be progressed afterwards. In March 2014, Assurance Statements for all 5 Nottinghamshire County CCGs were submitted to NHS England. All 5 applications and have been granted and published on the register of CEfF Approved Organisations.

During the period where patient level data validation was not permitted, the impact on the CCG is limited due to a number of reasons. It is important to put this into context and to consider in mitigating against any risk the compensating controls and actions the CCG has in place:

1)Previous validation of patient identifiable data from the Trusts have found minimal errors in allocating patients to CCGs.
2)The CCGs hold a monthly "Data Review" meeting to scrutinise the data, both at Point of Delivery (POD), speciality level and HRG level from the
Trusts. Any queries or anomalies go back to the Trust and are followed up to ensure full understanding of the data, the position against plans and any
material variances.
3)The CCGs have good working relationships with the providers and when the CCGs are able to undertake retrospective checks, would work with the
providers to address any issues should they materialise although these are not expected.
4)Letters have been sent to all main providers by the Chief Finance Officer retaining the right for CCGs to retrospectively validate invoices.

9.6 Data Quality

The Governing Body received regular robust reporting and are confident in the level of quality. The strength of data quality has been supported through the process that the CCG has been through to become an accredited safe haven.

9.7 Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment. The submission was completed in October in line with becoming an accredited safe haven and received the appropriate internal audit review at this time which received significant assurance.

9.8 Business Critical Models

In line with the Macpherson report, the CCG has an environment where leaders value and recognise good quality assurance. There is adequate capacity, including specialist skill and sufficient time to conduct quality assurance effectively. Controls are in place and have been further enhanced through the processes that the CCG has been through to become an accredited safe haven and a controlled environment for finance. Capacity is enhanced through the shared services arrangements with other Nottinghamshire CCGs. There is a clear internal chain of responsibility and a route for challenge where analysts have concerns. Through our Systems Analyst, there is a systematic approach to make quality assurance accessible, easy and comprehensive.

9.9 Discharge of Statutory Functions

During establishment, the arrangements put in place by the clinical commissioning group and explained within the corporate governance documentation were developed in line with model guidance which included extensive expert external legal input, to ensure compliance with all relevant legislation. The clinical commissioning group regularly keeps under review its statutory duties and powers.

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.

The scheme of delegation identifies clear lines of responsibility and structures are in place supported by Memoranda of Understanding which have included external legal input, to ensure that the clinical commissioning group has the necessary capability and capacity to undertake all of its statutory duties.

10. Conclusion

My review confirms that Nottingham North and East Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its values, objectives and policies.

Control issues pertaining to the arrangements for the contract monitoring of care homes and the control weaknesses identified throughout the year in GEM CSU have been reported in this Governance Statement together with compensating controls and remedial action to address these weaknesses.

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.

Sam Walters
Accountable Officer
2 June 2014

Statement of Accountable Officer

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

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

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

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

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

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

Sam Walters
Chief Officer
2 June 2014

ANNUAL ACCOUNTS

Chief Financial Officer Commentary

The Summary Financial Statements provide an overview of our performance for 2013/14. These summary statements may not provide sufficient information for a full understanding of our financial position and performance. A copy of the full accounts can be obtained from the Chief Financial Officer at our headquarters.

Nottingham North & East Clinical Commissioning Group has achieved all key financial NHS England Group Requirements for the year, including remaining within resources available, delivering our planned surplus, achieving our agreed year end cash balance and delivering against the Better Payment Practice Code target.

The CCG commenced the year in a challenging financial position, with a reduced surplus target set by NHS England. As such the achievement of these targets is a notable success and thanks go to our staff, managers and members for their support in this achievement. Furthermore, delivery of QIPP (Quality, Innovation, Productivity and Prevention) schemes and targets, plus control on expenditure, has enabled the CCG to agree and achieve a surplus target of £1,013k.

The CCG thus moves into 2014/15 in a solid financial position that reflects the going concern declaration. There are still a number of financial challenges that the CCG will face in 2014/15 and 2015/16 and these are reflected in the detailed two year financial plan for the CCG. Notable challenges are a continued QIPP requirement in order to achieve financial balance and also that of the establishment of the Better Care Fund in 2015/15 whereby CCG resources, together with additional funds from the Department of Health and Local Authority funds, are pooled to be invested in transforming Health and Social Care services.

The CCG will work with all local stakeholders, including the local authorities, healthcare and social care providers and other clinical commissioning groups to ensure resources are used and invested to improve the health and well-being of the residents of Nottingham North and East CCG.

Salaries and Allowances

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
Terry Allen – Lay Member, Financial Management and Audit (from 02/11/2013 to 31/03/2014)	5-10	-	-	-	-	5-10

Paul Johnson - Lay Member, Financial Management and Audit (from 01/04/2013 to 31/10/2013)	5-10	-	-	-	-	5-10
Samantha Walters – Chief Officer	95-100	-	-	-	112.5-115	210-215
Sharon Pickett – Deputy Chief Officer	70-75	-	-	-	75-77.5	150-155
Jonathan Bemrose – Chief Finance Officer	40-45	-	-	-	57.5-60	100-105
Cheryl Crocker – Director of Quality and Patient Safety	30-35	-	-	-	20-22.5	50-55
Andy Hall - Director of Outcomes & Information	40-45	-	-	-	15-17.5	55-60
Tony Marsh – GP Clinical Lead / Chair (01/04/2013 to 31/05/2014)	10-15	-	-	-	-	10-15
Dr Paramjit Panesar – Assistant Clinical Chair	35-40	-	-	-	-	35-40
Dr James Hopkinson – GP Representative	20-25	-	-	-	-	20-25
Dr David Hannah – GP Representative (01/04/2013 to 30/04/2013)	0-5	-	-	-	-	0-5
Dr Paul Oliver- GP Clinical Lead / chair	75-80	-	-	-	-	75-80
Adrian Kennedy – Allied Healthcare Professional Representative	5-10	-	-	-	-	5-10
Mike Wilkins – Lay Member Patient and Public Involvement	0-5	-	-	-	-	0-5
Dr Mohammed Al-Uzri – Secondary Care Doctor	5-10	-	-	-	-	5-10
Paul McKay – Local Authority Representative (01/04/2013 to 30/11/2013)	-	-	-	-	-	-
Jean Lewis – Patient and Public Representative (01/04/2013 to 30/09/2013)	0-5	-	-	-	-	0-5
Stephen Storr – Patient and Public Representative (01/11/2013 to 31/03/2014)	0-5	-	-	-	-	0-5

Caroline Baria (01/12/2013 to 31/03/2014)	-	-	-	-	-	-

The salaries of the Members below were allocated over a number of CCG's. The allocation to Nottingham North and East Clinical Commissioning Group is shown above. Their total remuneration is shown below

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
Jonathan Bemrose – Chief Finance Officer	95-100	-	-	-	140-142.5	235-240
Cheryl Crocker – Director of Quality	75-80	-	-	-	50-52.5	125-130
Andrew Hall – Director of Outcome & Information	95-100	-	-	-	35-37.5	130-135

Pension Benefits

The following Members' pensionable remuneration was allocated over a number of CCGs. Their pension details are as below:

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2014 £000	Cash equivalent transfer value at 31 March 2013 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £00
Samantha Walters – Chief Officer	2.5-5	12.5-15	20-25	70-75	395	305	84	14

Sharon Pickett – Deputy Chief Officer	2.5-5	7.5-10	25-30	80-85	495	422	64	10
Jonathan Bemrose – Chief Finance Officer	5-7.5	15-17.5	30-35	75-80	527	416	102	13
Cheryl Crocker – Director of Quality	0-2.5	5-7.5	20-25	60-65	373	323	43	11
Andrew Hall – Director of Outcomes and Information	0-2.5	0-2.5	35-40	105-110	651	605	33	14

Certain Members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for Lay Members.

Cash Equivalent Transfer Value

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

Real Increase in CETV

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

Financial statements

Our annual report and accounts cover the 12 month period from 1 April 2013 to 31 March 2014 Nottingham North & East Clinical Commissioning Group has achieved all key financial requirements for the year, including remaining within resources available and delivering against the Better Payment Practice Code target.

NHS England Group Requirements	Target £'000	Actual £'000
The national requirement to deliver surplus requirements	surplus	1,018
Remained within cash limit	250	14
Identification of 2% funding committed non recurrently	3,230	3,230
Identification of 0.5% contingency to meet in year cost pressures	802	802
Running cost to be within notified allowances	3,414	3,339

Note 1 *The Notified Running Cost Allowance for Nottingham North & East CCG for 2013/14 was £3,570k. Due to non-recurrent savings a target budget was set for the CCG of £3,414k*

Our accounts have been prepared in accordance with directions given by the Department of Health. They are also prepared to comply with International Financial Reporting Standards (IFRS) and are designed to present a true and fair view of our financial activities.

Going Concern

Our accounts have been prepared on the basis that the clinical commissioning group is a 'going concern'. This means that our assets and liabilities reflect the ongoing nature of our activities. Our Governing Body has considered and declared that:

- 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.

Counter Fraud Activities

We receive a dedicated Local Counter Fraud Specialist Advice Service from 360Assurance and have developed a comprehensive counter fraud work plan in accordance with guidance received from the NHS Protect. We also have a counter fraud policy approved by the Governing Body. Anyone suspecting fraudulent activities within our services should report their suspicions to our Local Counter Fraud Specialist by telephoning the confidential hotline on: 0115 883 5323.

Working Capital and Liquidity

We ended 2013/14 with a cash balance of £14k (0.08%), as directed by NHS England.

Events After Reporting Period

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

Capital Expenditure

There is no capital expenditure during the financial year.

Accounting Policies

We have detailed accounting policies approved by the Audit Committee which comply with the NHS Manual of Accounts and International Financial Reporting Standards (IFRS). Our accounting policies are detailed in the full set of financial accounts.

Efficiency

We generated recurrent efficiency savings and contributions from new initiatives of £3,743k during 2013/14. A summary of our main savings delivered during the year is shown below:

Programme Areas	2013/14 QIPP £'000
Contracting	648
Mental Health	256
Planned Care	601
Prescribing	722
Unplanned Care	893
Balance to full year 2012/13	419
CHP	108
Other	96
Total	**3,743**

Future Financial Performance

The Governing Body has set out a detailed financial plan for the two-year period from 2014/15 to 2015/16. We intend to achieve a surplus of £1.7 million in 2014/15 and £1.8 million in 2015/16.

Our two-year financial plan has assumed that the efficiency requirement will continue to be challenging. We have taken further measures through 2013/14 to improve our financial governance processes to prepare for the more challenging times ahead.

Our Finance and Information Group, which was set up during the year, has become embedded to ensure that a structured process is in place for the delivery of our major change programmes, which will result in future efficiencies. We have also improved our financial reporting to ensure we are more forward looking and have the information to enable us to manage performance proactively. We have developed mitigation plans that will be introduced should the need arise.

Audited Financial Statements

The Audited Financial Statements and Auditor's Report are attached at Appendix 1

NHS Nottingham North & East CCG

Financial Statements for the

Year ended

31st March 2014

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The Primary Statements:

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS NOTTINGHAM NORTH & EAST CCG

We have audited the financial statements of NHS Nottingham North & East CCG for the year ended 31 March 2014 on pages 5 to 57 of Appendix 1. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 88, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2014 and of its net operating costs for the year then ended; and

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

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

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

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

Matters on which we are required to report by exception

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

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

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

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

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report any matters that prevent us from being satisfied that the audited body has put in place such arrangements.

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

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

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

Certificate

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

Tony Crawley, Director for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
St Nicholas House
31 Park Row
Nottingham
NG1 6FQ

5 June 2014

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	Note	2013-14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	4	**2,257**
Other costs	5	**163,807**
Other operating revenue	2	**(2,220)**
Net operating costs before interest		**163,844**
Other operating revenue	2	**-**
Other (gains)/losses	9	**-**
Finance costs	10	**1**
Net operating costs for the financial year		**163,845**
Net (gain)/loss on transfers by absorption		
Net operating costs for the financial year including absorption transfers		**163,845**
Of which:		
Administration Costs		
Gross employee benefits	4	**1,984**
Other costs	5	**1,683**
Other operating revenue	2	**(327)**
Net administration costs before interest		**3,340**
Programme Expenditure		
Gross employee benefits	4	**273**
Other costs	5	**162,124**
Other operating revenue	2	**(1,893)**
Net programme expenditure before interest		**160,504**

Other Comprehensive Net Expenditure	2013-14 £000
Impairments and reversals	**-**
Net gain/(loss) on revaluation of property, plant & equipment	**-**
Net gain/(loss) on revaluation of intangibles	**-**
Net gain/(loss) on revaluation of financial assets	**-**
Movements in other reserves	**-**
Net gain/(loss) on available for sale financial assets	**-**
Net gain/(loss) on assets held for sale	**-**
Net actuarial gain/(loss) on pension schemes	**-**
Share of (profit)/loss of associates and joint ventures	**-**
Reclassification Adjustments	
On disposal of available for sale financial assets	**-**
Total comprehensive net expenditure for the year	**163,845**

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report any matters that prevent us from being satisfied that the audited body has put in place such arrangements.

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

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

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Tony Crawley, Director for and on behalf of KPMG LLP, Statutory Auditor

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St Nicholas House
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5 June 2014

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment	13	-
Intangible assets	14	-
Investment property	15	-
Trade and other receivables	17	-
Other financial assets	18	-
Total non-current assets		-
Current assets:		
Inventories	16	-
Trade and other receivables	17	1,915
Other financial assets	18	-
Other current assets	19	-
Cash and cash equivalents	20	14
Total current assets		1,929
Non-current assets held for sale	21	-
Total current assets		1,929
Total assets		1,929
Current liabilities		
Trade and other payables	23	7,916
Other financial liabilities	24	-
Other liabilities	25	-
Borrowings	26	-
Provisions	30	57
Total current liabilities		7,973
Total Assets less Current Liabilities		(6,044)
Non-current liabilities		
Trade and other payables	23	-
Other financial liabilities	24	-
Other liabilities	25	-
Borrowings	26	-
Provisions	30	-
Total non-current liabilities		-
Total Assets Employed		(6,044)
Financed by Taxpayers' Equity		
General fund	SOCITE	(6,044)
Revaluation reserve	SOCITE	-
Other reserves	SOCITE	-
Charitable Reserves	44	-
Total taxpayers' equity:		(6,044)

The notes on pages 9 to 57 form part of this statement

The financial statements on pages 5 to 57 were approved by the Audit & Governance Committee on 2 June 2014 and signed on its behalf by:

Samantha Walters
Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

	Note	General fund	Revaluation reserve	Other reserves	Total reserves
		£000	£000	£000	£000
Changes in taxpayers' equity for 2013-14					
Balance at 1 April 2013		**-**	**-**	**-**	**-**
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition		-	-	-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies		-	-	-	-
Adjusted CCG balance at 1 April 2013		**-**	**-**	**-**	**-**
Changes in CCG taxpayers' equity for 2013-14					
Net operating costs for the financial year	**SOCNE**	(163,844)	-	-	**(163,844)**
Net gain/(loss) on revaluation of property, plant and equipment		-	-	-	**-**
Net gain/(loss) on revaluation of intangible assets		-	-	-	**-**
Net gain/(loss) on revaluation of financial assets		-	-	-	**-**
Total revaluations against revaluation reserve		**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets		-	-	-	**-**
Net gain (loss) on revaluation of assets held for sale		-	-	-	**-**
Impairments and reversals		-	-	-	**-**
Net actuarial gain (loss) on pensions		-	-	-	**-**
Movements in other reserves		-	-	-	**-**
Transfers between reserves		-	-	-	**-**
Release of reserves to the Statement of Comprehensive Net Expenditure		-	-	-	**-**
Reclassification adjustment on disposal of available for sale financial		-	-	-	**-**
Transfers by absorption to (from) other bodies		-	-	-	**-**
Transfer between reserves in respect of assets transferred under absorption		-	-	-	**-**
Reserves eliminated on dissolution		-	-	-	**-**
Net Recognised CCG Expenditure for the Financial Year		(163,844)	-	-	**(163,844)**
Net funding		157,800	-	-	**157,800**
Balance at 31 March 2014		**(6,044)**	**-**	**-**	**(6,044)**

Statement of Cash Flows for the year ended 31 March 2014

	Note	2013-14 £000
Cash Flows from Operating Activities		
Net operating costs for the financial year		**(163,844)**
Depreciation and amortisation		**-**
Impairments and reversals		**-**
Other gains (losses) on foreign exchange		**-**
Donated assets received credited to revenue but non-cash		**-**
Government granted assets received credited to revenue but non-cash		**-**
Interest paid		**-**
Release of PFI deferred credit		**-**
(Increase)/decrease in inventories		**-**
(Increase)/decrease in trade & other receivables		**(1,915)**
(Increase)/decrease in other current assets		**-**
Increase/(decrease) in trade & other payables		**7,916**
Increase/(decrease) in other current liabilities		**-**
Provisions utilised		**-**
Increase/(decrease) in provisions		**57**
Net Cash Inflow (Outflow) from Operating Activities		**(157,786)**
Cash Flows from Investing Activities		
Interest received		**-**
(Payments) for property, plant and equipment		**-**
(Payments) for intangible assets		**-**
(Payments) for investments with the Department of Health		**-**
(Payments) for other financial assets		**-**
(Payments) for financial assets (LIFT)		**-**
Proceeds from disposal of assets held for sale: property, plant and equipment		**-**
Proceeds from disposal of assets held for sale: intangible assets		**-**
Proceeds from disposal of investments with the Department of Health		**-**
Proceeds from disposal of other financial assets		**-**
Proceeds from disposal of financial assets (LIFT)		**-**
Loans made in respect of LIFT		**-**
Loans repaid in respect of LIFT		**-**
Rental revenue		**-**
Net Cash Inflow (Outflow) from Investing Activities		**-**
Net Cash Inflow (Outflow) before Financing		**(157,786)**
Cash Flows from Financing Activities		
Net funding received		**157,800**
Other loans received		**-**
Other loans repaid		**-**
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		**-**
Capital grants and other capital receipts		**-**
Capital receipts surrendered		**-**
Net Cash Inflow (Outflow) from Financing Activities		**157,800**
Net Increase (Decrease) in Cash & Cash Equivalents		**14**
Cash & Cash Equivalents at the Beginning of the Financial Year		**-**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		**-**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**14**

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 2013-14* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to 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.

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.
For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.5 Charitable Funds

From 2013-14, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies’ own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities’ accounts.

1.6 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
If the clinical commissioning group is in a “jointly controlled operation”, the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group's share of the income from the pooled budget activities.

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

· The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);

- The clinical commissioning group's share of any liabilities incurred jointly; and,
- The clinical commissioning group's share of the expenses jointly incurred.

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

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

- Gross Accounting

The clinical commissioning group has entered into an arrangement with other Nottinghamshire clinical commissioning groups in adopting Gross Accounting in relation to transactions between DH Group Bodies, except transaction deemed to be in the nature of a "recharge". This is consistent with the requirements contained within IAS18.

- Maternity Pathway Costs

The clinical commissioning group prepaying out Maternity Pathway Costs which span the end of the financial year.

1.7.2 Key Sources of Estimation Uncertainty

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

- Partially completed Healthcare Spells

The clinical commissioning group includes estimations for partially completed spells which span the end of the financial year. The provider produces activity information to the clinical commissioning group on which to base the estimation value.

1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

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

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

1.9.2 Retirement Benefit Costs

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

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

1.10 Other Expenses

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

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

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 Valuation

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

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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

1.11.3 Subsequent Expenditure

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

1.12 Intangible Assets

1.12.1 Recognition

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

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

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

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

1.12.2 Measurement

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

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

1.13 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

1.14 Donated Assets

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

1.15 Government Grants

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

1.16 Non-current Assets Held For Sale

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

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

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 Leases

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

1.17.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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

1.17.2 The Clinical Commissioning Group as Lessor

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

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

1.18 Private Finance Initiative Transactions

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

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

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

1.18.1 Services Received

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

1.18.2 PFI Asset

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

1.18.3 PFI Liability

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

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

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

1.18.4 Lifecycle Replacement

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

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

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

1.18.5 Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme

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

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

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

1.19 Inventories

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

1.20 Cash & Cash Equivalents

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

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

1.21 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

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

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

- Legacy Provisions

"Legacy provisions" are defined as those that were provided in the Primary Care Trusts' accounts. This excludes amounts disclosed as contingent liabilities by the Primary Care Trusts. While the clinical commissioning group and NHS England assumed statutory responsibilities for continuing healthcare from the Primary Care Trust from 1 April 2013, movements in legacy provisions will be accounted for by NHS England. Hence any increases or reductions in the value of specific claims will be accounted in NHS England's Income and Expenditure.

1.22 Clinical Negligence Costs

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

1.23 Non-clinical Risk Pooling

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

1.24 Carbon Reduction Commitment Scheme

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

1.25 Contingencies

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

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

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

1.26 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.26.1 Financial Assets at Fair Value Through Profit and Loss

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

1.26.2 Held to Maturity Assets

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

1.26.3 Available For Sale Financial Assets

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

1.26.4 Loans & Receivables

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

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

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.
At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.27 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.
Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.27.1 Financial Guarantee Contract Liabilities

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

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

1.27.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.27.3 Other Financial Liabilities

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

1.28 Value Added Tax

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

1.29 Foreign Currencies

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

1.30 Third Party Assets

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

1.31 Losses & Special Payments

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

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

1.32 Subsidiaries

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

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

1.33 Associates

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

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

1.34 Joint Ventures

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

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

1.35 Joint Operations

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

1.36 Research & Development

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

1.37 Accounting for Legacy Balances

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 1.4 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements."

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013-14, all of which are subject to consultation:

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

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

2 Other Operating Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Recoveries in respect of employee benefits	**-**	-	-
Patient transport services	**-**	-	-
Prescription fees and charges	**-**	-	-
Dental fees and charges	**-**	-	-
Education, training and research	**-**	-	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-	-
Receipt of donations for capital acquisitions: NHS Charity	**-**	-	-
Receipt of Government grants for capital acquisitions	**-**	-	-
Non-patient care services to other bodies	**1,767**	302	1,465
Income generation	**-**	-	-
Rental revenue from finance leases	**-**	-	-
Rental revenue from operating leases	**-**	-	-
Other revenue	**453**	25	428
Total other operating revenue	**2,220**	**327**	**1,893**

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

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

3 Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
From rendering of services	**2,220**	**327**	**1,893**
From sale of goods	**-**	**-**	**-**
Total	**2,220**	**327**	**1,893**

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2013-14 Total	Total Permanent Employees	Other	Total	Admin Permanent Employees	Other	Total	Programme Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	**1,811**	1,811	-	**1,577**	1,577	-	**234**	234	-
Social security costs	**162**	162	-	**147**	147	-	**15**	15	-
Employer Contributions to NHS Pension scheme	**239**	239	-	**215**	215	-	**24**	24	-
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**45**	45	-	**45**	45	-	**-**	-	-
Gross employee benefits expenditure	**2,257**	**2,257**	**-**	**1,984**	**1,984**	**-**	**273**	**273**	**-**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	-	-	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**2,257**	**2,257**	**-**	**1,984**	**1,984**	**-**	**273**	**273**	**-**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**2,257**	**2,257**	**-**	**1,984**	**1,984**	**-**	**273**	**273**	**-**

4.1.2 Recoveries in respect of employee benefits

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

4.2 Average number of people employed

	2013-14 Total	Permanently employed	Other
	Number	Number	Number
Total	**42**	42	-
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	-	-

4.3 Staff sickness absence and ill health retirements

	2013-14 Number
Total Days Lost	974
Total Staff Years	292
Average working Days Lost	3

The numbers above are the total for the old Nottinghamshire County PCT area, of which Nottingham North and East is a part. These figures are unable to be split.

	2013-14 Number
Number of persons retired early on ill health grounds	**-**
Total additional Pensions liabilities accrued in the year	**-**
Ill health retirement costs are met by the NHS Pension Scheme	**-**

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

4.4 Exit packages agreed in the financial year

2013-14	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	**-**	**-**
£10,001 to £25,000	1	10,255	-	-	**1**	**10,255**
£25,001 to £50,000	-	-	1	34,984	**1**	**34,984**
£50,001 to £100,000	-	-	-	-	**-**	**-**
£100,001 to £150,000	-	-	-	-	**-**	**-**
£150,001 to £200,000	-	-	-	-	**-**	**-**
Over £200,001	-	-	-	-	**-**	**-**
Total	**1**	**10,255**	**1**	**34,984**	**2**	**45,239**

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

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	1	34,984
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval*	-	-
Total	**1**	**34,984**

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

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

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

4.5.1 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to 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.
The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

4.5 Pension costs

4.5.3 Scheme Provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:
The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under 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.

5. Operating expenses

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits			
Employee benefits excluding governing body members	1,628	1,355	273
Executive governing body members	629	629	-
Total gross employee benefits	**2,257**	**1,984**	**273**
Other costs			
Services from other CCGs and NHS England	19,515	289	19,226
Services from foundation trusts	6,649	-	6,649
Services from other NHS trusts	97,473	-	97,473
Services from other NHS bodies	-	-	-
Purchase of healthcare from non-NHS bodies	11,886	-	11,886
Chair and lay membership body and governing body members	-	-	-
Supplies and services – clinical	-	-	-
Supplies and services – general	250	109	141
Consultancy services	100	100	-
Establishment	561	434	128
Transport	50	2	48
Premises	1,262	215	1,047
Impairments and reversals of receivables	-	-	-
Inventories written down	-	-	-
Depreciation	-	-	-
Amortisation	-	-	-
Impairments and reversals of property, plant and equipment	-	-	-
Impairments and reversals of intangible assets	-	-	-
Impairments and reversals of financial assets	-	-	-
· Assets carried at amortised cost	-	-	-
· Assets carried at cost	-	-	-
· Available for sale financial assets	-	-	-
Impairments and reversals of non-current assets held for sale	-	-	-
Impairments and reversals of investment properties	-	-	-
Audit fees	79	79	-
Other auditor's remuneration			
· Internal audit services	-	-	-
· Other services	-	-	-
General dental services and personal dental services	-	-	-
Prescribing costs	21,110	-	21,110
Pharmaceutical services	-	-	-
General opthalmic services	-	-	-
GPMS/APMS and PCTMS	425	-	425
Other professional fees excl. audit	416	397	19
Grants to other public bodies	-	-	-
Clinical negligence	1	1	-
Research and development (excluding staff costs)	-	-	-
Education and training	27	27	-
Change in discount rate	-	-	-
Other expenditure	4,003	31	3,972
Total other costs	**163,807**	**1,683**	**162,124**
Total operating expenses	**166,064**	**3,667**	**162,397**

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

6.1 Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	1,326	18,861
Total Non-NHS Trade Invoices paid within target	1,290	18,216
Percentage of Non-NHS Trade invoices paid within target	97.29%	96.58%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,381	123,649
Total NHS Trade Invoices Paid within target	1,347	122,069
Percentage of NHS Trade Invoices paid within target	97.54%	98.72%

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

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2013-14 £000
Amounts included in finance costs from claims made under this legislation	**1**
Compensation paid to cover debt recovery costs under this legislation	**-**
Total	**1**

7 Income Generation Activites

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

The following provides details of income generation activities whose full cost exceeded £1m or was otherwise material:

	Income £'000	Full cost £'000	Surplus (deficit) £'000
Aggregate of all Schemes	**-**	**-**	**-**
Aggregate of all Schemes whose full cost exceeds £1m	**-**	**-**	**-**
Description			
0	-	-	-
0	-	-	-
0	-	-	-
0	-	-	-
0	-	-	-
0	-	-	-
0	-	-	-
0	-	-	-
0	-	-	-

8. Investment revenue

	2013-14 £000
Rental Revenue	
PFI finance lease revenue (planned)	-
PFI finance lease revenue (contingent)	-
Other finance lease revenue	-
Total rental revenue	-
	-
Interest Revenue	-
LIFT: equity dividends receivable	-
LIFT: loan interest receivable	-
Bank interest	-
Other loans and receivables	-
Impaired financial assets	-
Other financial assets	-
Total interest revenue	-
	-
Total investment revenue	-

9. Other gains and losses

	2013-14 £000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	-
Gain/(loss) on disposal of intangible assets other than by sale	-
Gain/(loss) on disposal of financial assets other than held for sale	-
Gain/(loss) on disposal of assets held for sale	-
Gain/(loss) on foreign exchange	-
Change in fair value of financial assets carried at fair value through the statement of comprehensive net expenditure	-
Change in fair value of financial liabilities carried at fair value through the statement of comprehensive net expenditure	-
Change in fair value of investment property	-
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	-
Total	-

10. Finance costs

	2013-14 £000
Interest	
Interest on loans and overdrafts	-
Interest on obligations under finance leases	-
Interest on obligations under PFI contracts:	
· Main finance cost	-
· Contingent finance cost	-
Interest on obligations under LIFT contracts:	
· Main finance cost	-
· Contingent finance cost	-
Interest on late payment of commercial debt	1
Other interest expense	-
Total interest	1
Other finance costs	-
Provisions: unwinding of discount	-
Total finance costs	1

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

Nil

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	Land	Buildings	Other	2013-14 Total
	£000	£000	£000	£000
Payments recognised as an expense				
Minimum lease payments	-	1,259	-	1,259
Contingent rents	-	-	-	-
Sub-lease payments	-	-	-	-
Total	-	1,259	-	1,259

12.1.2 Future minimum lease payments

	Land	Buildings	Other	2013-14 Total
	£000	£000	£000	£000
Payable:				
No later than one year	-	-	-	-
Between one and five years	-	-	-	-
After five years	-	-	-	-
Total	-	-	-	-

Nottingham North and East CCG occupies property managed by Community Health Partnerships and NHS Property Services.
For 2013-14, a transitional occupancy rent based on annual property allocations was agreed. This is reflected in Note 12.1.1 .
While our arrangement with CHC/NHS PS falls within the definition of operating leases, the rental charge for future years has not yet been agreed.
Consequently, this note includes only the known future minimum lease payments for 2014/15

12.2 As lessor

12.2.1 Rental revenue

	2013-14
	£000
Recognised as income	
Rent	-
Contingent rents	-
Total	-

12.2.2 Future minimum rental value

	2013-14
	£000
Receivable:	
No later than one year	-
Between one and five years	-
After five years	-
Total	-

13 Property, plant and equipment

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-
Adjusted Cost or valuation at 1 April 2013	-	-	-	-	-	-	-	-	-
Addition of assets under construction and payments on account	-	-	-	-	-	-	-	-	-
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	-	-	-	-	-
Depreciation 1 April 2013	-	-	-	-	-	-	-	-	-
Adjusted depreciation 1 April 2013	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	-	-	-	-	-
Net Book Value at 31 March 2014	-	-	-	-	-	-	-	-	-
Purchased	-	-	-	-	-	-	-	-	-
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2014	-	-	-	-	-	-	-	-	-
Asset financing:									
Owned	-	-	-	-	-	-	-	-	-
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total PFI & LIFT assets	-	-	-	-	-	-	-	-	-
Total at 31 March 2014	-	-	-	-	-	-	-	-	-

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	-	-	-	-	-

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

	2013-14 £000
Land	-
Buildings excluding dwellings	-
Dwellings	-
Plant & machinery	-
Transport equipment	-
Information technology	-
Furniture & fittings	-
Total	**-**

13.2 Donated assets

Nil

13.3 Government granted assets

Nil

13.4 Property revaluation

	2013-14 £000
The major constituents of the upward revaluation are as follows:-	
Previously charged to the Statement of Comprehensive Net Expenditure and now reversed:	
	-
	-
	-
	-
	-
	-
	-
	-
	-
	-
Other [balancing figure to get to annual total]	-
Total	-
Credited to the Revaluation Reserve:	
	-
	-
	-
	-
	-
	-
	-
	-
	-
	-
Other [balancing figure to get to annual total]	-
Total	-
The major constituents of the downward revaluation are as follows	
Charged to the Statement of Comprehensive Net Expenditure:	
	-
	-
	-
	-
	-
	-
	-
	-
	-
	-
	-
Other [balancing figure to get to annual total]	-
Total	-
Charged to the Revaluation Reserve:	
	-
	-
	-
	-
	-
	-
	-
	-
	-
	-
	-
Other [balancing figure to get to annual total]	-
Total	-

13 Property, plant and equipment cont'd

13.5 Compensation from third parties

Nil

13.6 Write downs to recoverable amount

Nil

13.7 Temporarily idle assets

The net book value of temporarily idle assets was as follows:

	2013-14 £000
Land	-
Buildings excluding dwellings	-
Dwellings	-
Plant & machinery	-
Transport equipment	-
Information technology	-
Furniture & fittings	-
Total	-

13.8 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2013-14 £000
Land	-
Buildings excluding dwellings	-
Dwellings	-
Plant & machinery	-
Transport equipment	-
Information technology	-
Furniture & fittings	-
Total	-

13.9 Economic lives

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

14 Intangible non-current assets

2013-14	Computer Software: Purchased £000	Computer Software: Internally Generated £000	Licences & Trademarks £000	Patents £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2013	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-
Adjusted Cost or valuation at 1 April 2013	-	-	-	-	-	-
Additions purchased	-	-	-	-	-	-
Additions internally generated	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-
Cumulative amortisation adjustment following revaluation	-	-	-	-	-	-
At 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**
Amortisation 1 April 2013	-	-	-	-	-	-
Adjusted amortisation 1 April 2013	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-
Cumulative amortisation adjustment following revaluation	-	-	-	-	-	-
At 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**
Net Book Value at 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**
Purchased	-	-	-	-	-	-
Donated	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-
Total at 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**

Revaluation Reserve Balance for intangible assets

	Computer Software: Purchased £000's	Computer Software: Internally Generated £000's	Licences & Trademarks £000's	Patents £000's	Development Expenditure (internally generated) £000's	Total £000's
Balance at 1 April 2013	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-
Impairments	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-
Other movements	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	-	-

14 Intangible non-current assets cont'd

14.1 Donated assets
Nil

14.2 Government granted assets
Nil

14.3 Revaluation

	2013-14 £000
The major constituents of the upward revaluation are as follows:-	
Previously charged to the Statement of Comprehensive Net Expenditure and now reversed:	
	-
	-
	-
Other [balancing figure to get to annual total]	-
Total	-
Credited to the Revaluation Reserve:	
	-
	-
Other [balancing figure to get to annual total]	-
Total	-
The major constituents of the downward revaluation are as follows	
Charged to the Statement of Comprehensive Net Expenditure:	
	-
	-
	-
Other [balancing figure to get to annual total]	-
Total	-
Charged to the Revaluation Reserve:	
	-
	-
	-
Other [balancing figure to get to annual total]	-
Total	-

14 Intangible non-current assets cont'd

14.4 Compensation from third parties

Nil

14.5 Write downs to recoverable amount

Nil

14.6 Non-capitalised assets

Nil

14.7 Temporarily idle assets

The net book value of temporarily idle assets was as follows:

	2013-14 £000
Computer software: purchased	-
Computer software: internally generated	-
Licences & trademarks	-
Patents	-
Development expenditure (internally generated)	-
Total	-

14.8 Cost or valuation of fully amortised assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2013-14 £000
Computer software: purchased	-
Computer software: internally generated	-
Licences & trademarks	-
Patents	-
Development expenditure (internally generated)	-
Total	-

14.9 Economic lives

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

15 Investment property

The clinical commissioning group had no investment property as at 31 March 2014

	2013-14 £000
Fair value balance at 1 April 2013	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-
Adjusted fair value balance at 1 April 2013	-
Additions through subsequent expenditure	-
Other acquisitions	-
Reclassified as held for sale and reversals	-
Disposals other than by sale	-
Loss from fair value adjustments: Impairments	-
Gain from fair value adjustments: Reversal of impairments	-
Gain from fair value adjustments	-
Transfer (to) from other public sector body	-
Other changes	-
At 31 March 2014	-

15.1 Investment property

	2013-14 £000
Capital revenue	-
Capital expenditure	-
Net revenue (expenditure)	-

16 Inventories

The clinical commissioning group had no inventories as at 31 March 2014

	Drugs £'000	Consumables £'000	Energy £'000	Work in Progress £'000	Loan Equipment £'000	Other £'000	Total £'000
Balance at 1 April 2013	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-
Additions	-	-	-	-	-	-	-
Inventories recognised as an expense in the period	-	-	-	-	-	-	-
Write-down of inventories (including losses)	-	-	-	-	-	-	-
Reversal of write-down previously taken to the statement of comprehensive net expenditure	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	-	-	-

17 Trade and other receivables

	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	**1,256**	**-**
NHS receivables: Capital	**-**	**-**
NHS prepayments and accrued income	**168**	**-**
Non-NHS receivables: Revenue	**62**	**-**
Non-NHS receivables: Capital	**-**	**-**
Non-NHS prepayments and accrued income	**342**	**-**
Provision for the impairment of receivables	**-**	**-**
VAT	**88**	**-**
Private finance initiative and other public private partnership arrangement prepayments and accrued income	**-**	**-**
Interest receivables	**-**	**-**
Finance lease receivables	**-**	**-**
Operating lease receivables	**-**	**-**
Other receivables	**(1)**	**-**
Total	**1,915**	**-**
Total current and non current	**1,915**	
Included above:		
Prepaid pensions contributions	**-**	

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.

17.1 Receivables past their due date but not impaired

	2013-14 £000
By up to three months	**73**
By three to six months	**-**
By more than six months	**-**
Total	**73**

£73k of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2014.

17.2 Provision for impairment of receivables

	2013-14 £000
Balance at 1 April 2013	**-**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**-**
Adjusted balance at 1 April 2013	**-**
Amounts written off during the year	**-**
Amounts recovered during the year	**-**
(Increase) decrease in receivables impaired	**-**
Transfer (to) from other public sector body	**-**
Balance at 31 March 2014	**-**

	2013-14 £000
Receivables are provided against at the following rates:	
NHS debt	**-**

18 Other financial assets

18.1 Current

	2013-14 £000
Balance at 1 April 2013	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-
Adjustment balance at 1 April 2013	-
Additions	-
Revaluation	-
Impairments	-
Impairment reversals	-
Transferred from non-current financial assets	-
Disposals	-
Transfer (to)/from other public sector body	-
At 31 March 2014	-

18.2 Non-current

	2013-14 £000
Balance at 1 April 2013	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-
Adjustment balance at 1 April 2013	-
Additions	-
Revaluation	-
Impairments	-
Impairment reversals	-
Transferred from non-current financial assets	-
Disposals	-
Transfer (to)/from other public sector body	-
At 31 March 2014	-

18.3 Non-current: capital analysis

	2013-14 £000
Capital revenue	-
Capital expenditure	-

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2014.

20 Cash and cash equivalents

	2013-14 £000
Balance at 1 April 2013	**-**
Net change in year	**14**
Balance at 31 March 2014	**14**
Made up of:	
Cash with the Government Banking Service	**14**
Cash with Commercial banks	**-**
Cash in hand	**0**
Current investments	**-**
Cash and cash equivalents as in statement of financial position	**14**
Bank overdraft: Government Banking Service	**-**
Bank overdraft: Commercial banks	**-**
Total bank overdrafts	**-**
Balance at 31 March 2014	**14**
The CCG does not hold any Patients Money	**-**

21 Non-current assets held for sale

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-	-
Adjustment balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Plus: assets classified as held for sale in the year	-	-	-	-	-	-	-	-	-	-
Less: assets sold in the year	-	-	-	-	-	-	-	-	-	-
Less: impairment of assets held for sale	-	-	-	-	-	-	-	-	-	-
Plus: reversal of impairment of assets held for sale	-	-	-	-	-	-	-	-	-	-
Less: assets no longer classified as held for sale, for reasons other than disposal by sale	-	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	-
Revaluation	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	-	-	-	-	-	-	-

Liabilities associated with assets held for sale at 31 March 2014

22 Analysis of impairments and reversals

22.1 Analysis of impairments and reversals: property, plant and equipment

	2013-14 £000
Impairments and reversals charged to the statement of comprehensive net expenditure	
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Total charged to departmental expenditure limit	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total charged to annually managed expenditure	-
Total impairments and reversals charged to the statement of comprehensive net expenditure	-
Impairments and Reversals charged to the revaluation reserve	
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total Impairments and reversals charged to the revaluation reserve	-
Total impairments and reversals of property, plant and equipment charged to the revaluation reserve	-
Total impairments and reversals of property, plant and equipment	-

22.1 Analysis of impairments and reversals: Intangible assets

	2013-14 £000
Impairments and reversals charged to the statement of comprehensive net expenditure	
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Total charged to departmental expenditure limit	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total charged to annually managed expenditure	-
Total impairments and reversals charged to the statement of comprehensive net expenditure	-
Impairments and Reversals charged to the revaluation reserve	-
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total Impairments and reversals charged to the revaluation reserve	-
Total impairments and reversals of property, plant and equipment charged to the revaluation reserve	-
Total impairments and reversals of intangible assets	-

22 Analysis of impairments and reversals cont'd

22.3 Analysis of impairments and reversals: investment property

	2013-14 £000
Impairments and reversals charged to the statement of comprehensive net expenditure	
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Total charged to departmental expenditure limit	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total charged to annually managed expenditure	-
Total impairments and reversals charged to the statement of comprehensive net expenditure	-
Impairments and Reversals charged to the revaluation reserve	-
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total Impairments and reversals charged to the revaluation reserve	-
Total impairments and reversals of property, plant and equipment charged to the revaluation reserve	-
Total impairments and reversals of investment property	-

22.4 Analysis of impairments and reversals: inventories

	2013-14 £000
Impairments and reversals charged to the statement of comprehensive net expenditure	
Loss or damage resulting from normal operations	-
Total charged to departmental expenditure limit	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total charged to annually managed expenditure	-
Total impairments and reversals charged to the statement of comprehensive net expenditure	-
Total impairments and reversals of inventories	-

22 Analysis of impairments and reversals cont'd

22.5 Analysis of impairments and reversals: financial assets

	2013-14 £000
Impairments and reversals charged to the statement of comprehensive net expenditure	
Loss or damage resulting from normal operations	-
Total charged to Departmental Expenditure Limit	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total charged to Annually Managed expenditure	-
Total impairments and reversals charged to the statement of comprehensive net expenditure	-
Impairments and Reversals charged to the revaluation reserve	-
Loss or damage resulting from normal operations	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total impairments and reversals charged to the revaluation reserve	-
Total impairments and reversals of property, plant and equipment charged to the revaluation reserve	-
Total impairments and reversals of financial assets	-

22.6 Analysis of impairments and reversals: non-current assets held for sale

	2013-14 £000
Impairments and reversals charged to the statement of comprehensive net expenditure	
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Total charged to departmental expenditure limit	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total charged to annually managed expenditure	-
Total impairments and reversals charged to the statement of comprehensive net expenditure	-
Impairments and Reversals charged to the revaluation reserve	-
Loss or damage resulting from normal operations	-
Over-specification of assets	-
Abandonment of assets in the course of construction	-
Unforeseen obsolescence	-
Loss as a result of catastrophe	-
Other	-
Change in market price	-
Total Impairments and reversals charged to the revaluation reserve	-
Total impairments and reversals of property, plant and equipment charged to the revaluation reserve	-
Total impairments and reversals of intangible assets	-

22 Analysis of impairments and reversals cont'd

22.7 Analysis of impairments and reversals: totals

	2013-14 £000
Impairments and reversals charged to the statement of comprehensive net expenditure	
Departmental expenditure limit	-
Annually managed expenditure	-
Total impairments and reversals charged to the statement of comprehensive net expenditure	-
Impairments and reversals charged to the revaluation reserve	-
Total impairments	-
Of the above:	
Impairment on revaluation to “modern equivalent asset” basis	-
Impairments and reversals of donated and government granted assets charged to the statement of comprehensive net expenditure included above:	
Property, plant & equipment charged to departmental expenditure limit	-
Intangible assets charged to departmental expenditure limit	-
Total charged to departmental expenditure limit	-
Property, plant & equipment charged to annually managed expenditure	-
Intangible assets charged to annually managed expenditure	-
Total charged to annually managed expenditure	-
Total impairments and reversals of donated and government granted assets charged to the statement of comprehensive net expenditure	-

23 Trade and other payables

	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	-	-
NHS payables: revenue	3,383	-
NHS payables: capital	-	-
NHS accruals and deferred income	271	-
Non-NHS payables: revenue	3,624	-
Non-NHS payables: capital	-	-
Non-NHS accruals and deferred income	434	-
Social security costs	21	-
VAT	-	-
Tax	26	-
Payments received on account	81	-
Other payables	74	-
Total	7,916	-
Total payables (current and non-current)	7,916	

Included above are liabilities of £nil, for people, due in future years under arrangements to buy out the liability for early retirement over 5 years

Other payables include £nil outstanding pension contributions at 31 March 2014

24 Other financial liabilities

	Current 2013-14	Non-current 2013-14
Embedded derivatives at fair value through the statement of comprehensive net expenditure	-	-
Financial liabilities carried at fair value through profit and loss	-	-
Amortised cost	-	-
Total	-	-
Total current and non-current	-	

25 Other liabilities

	Current 2013-14	Non-current 2013-14
Private finance initiative/LIFT deferred credit	-	-
Lease incentives	-	-
Other	-	-
Total	-	-
Total current and non-current	-	

26 Borrowings

	Current 2013-14 £000	Non-current 2013-14 £000
Bank overdrafts:		
· Government banking service	-	-
· Commercial banks	-	-
Total overdrafts	-	-
Loans from:	-	-
· The Department of Health	-	-
· Other entities	-	-
Total loans	-	-
Private finance initiative liabilities:	-	-
· Main liability	-	-
· Lifecycle replacement received in advance	-	-
Total private finance initiative liabilities	-	-
LIFT liabilities:	-	-
· Main liability	-	-
· Lifecycle replacement received in advance	-	-
Total LIFT liabilities	-	-
Finance lease liabilities	-	-
	-	-
Total	-	-
Total current and non-current	-	

26.1 Repayment of principal falling due

	Department of Healt £000	Other £000	Total £000
Within one year	-	-	-
Between one and two years	-	-	-
Between two and five years	-	-	-
Between one and five years	-	-	-
After five years	-	-	-
Total	-	-	-

27 Private finance initiative, LIFT and other service concession arrangements

27.1 Off-Statement of Financial Position private finance initiative and other service concession arrangements

	2013-14 £000
Within one year	-
Between one and five years	-
After five years	-
Total	-

27.1.1 Payments committed to in respect of off-statement of financial position LIFT schemes

	2013-14 £000
Within one year	-
Between one and five years	-
After five years	-
Total	-

27.2.1 Imputed “finance lease” obligations for on-statement of financial position private finance initiative and other service concession arrangements

	2013-14 £000
Within one year	-
Between one and five years	-
After five years	-
Sub-total	-
Less: Interest element	-
Total	-

27.2.2 Imputed “finance lease” obligations for on-statement of financial position LIFT schemes

	2013-14 £000
Within one year	-
Between one and five years	-
After five years	-
Sub-total	-
Less: Interest element	-
Total	-

27 Private finance initiative, LIFT and other service concession arrangements cont'd

27.3.1 In respect of private finance initiative and other service concession arrangements

	2013-14 £000
Off-Statement of financial position arrangements	-
Service element of on-statement of financial position arrangements	-
Total	-

27.3.2 In respect of LIFT schemes

	2013-14 £000
Off-Statement of financial position arrangements	-
Service element of on-statement of financial position arrangements	-
Total	-

27.4.1 In respect of on-statement of financial position private finance initiative and other service concession arrangements

	2013-14 £000
Within one year	-
Between one and five years	-
After five years	-
Total	-

27.4.2 In respect of on-statement of financial position LIFT schemes

	2013-14 £000
Within one year	-
Between one and five years	-
After five years	-
Total	-

28 Finance lease obligations

	Present value of minimum lease payments			
	Land 2013-14 £000	Buildings 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Within one year	-	-	-	-
Between one and five years	-	-	-	-
After five years	-	-	-	-
Less: future finance charges	-	-	-	-
Present value of minimum lease payments	-	-	-	-
Included in:	-	-	-	-
Current borrowings	-	-	-	-
Non-current borrowings	-	-	-	-
Total	-	-	-	-

	Minimum lease payments			
	Land 2013-14 £000	Buildings 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Within one year	-	-	-	-
Between one and five years	-	-	-	-
After five years	-	-	-	-
Less: future finance charges	-	-	-	-
Present value of minimum lease payments	-	-	-	-
Included in:	-	-	-	-
Current borrowings	-	-	-	-
Non-current borrowings	-	-	-	-
Total	-	-	-	-

28.1 Finance leases as lessee

	2013-14 £000
Nil	-

29 Finance lease receivables

	Present value of minimum lease payments			
	Land 2013-14 £000	Buildings 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Within one year	-	-	-	-
Between one and five years	-	-	-	-
After five years	-	-	-	-
Less: future finance charges	-	-	-	-
Present value minimum lease payments	-	-	-	-
Less: allowance for uncollectible lease receivables	-	-	-	-
Total finance lease receivables recognised in the statement of financial position	-	-	-	-
Included in:	-	-	-	-
Current finance lease receivables	-	-	-	-
Non-current finance lease receivables	-	-	-	-
Total	-	-	-	-

	Gross investment in leases			
	Land 2013-14 £000	Buildings 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Within one year	-	-	-	-
Between one and five years	-	-	-	-
After five years	-	-	-	-
Less: future finance charges	-	-	-	-
Present value minimum lease payments	-	-	-	-
Less: allowance for uncollectible lease receivables	-	-	-	-
Total finance lease receivables recognised in the statement of financial position	-	-	-	-
Included in:	-	-	-	-
Current finance lease receivables	-	-	-	-
Non-current finance lease receivables	-	-	-	-
Total	-	-	-	-

29.1 Finance leases as lessor

	2013-14 £000
Unguaranteed residual value accruing	-
Accumulated allowance for uncollectible lease receivables	-

29.2 Rental revenue

	2013-14 £000
Contingent rent	-
Other	-
Total	-

30 Provisions

	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	-	-
Pensions relating to other staff	-	-
Restructuring	-	-
Redundancy	-	-
Agenda for change	-	-
Equal pay	-	-
Legal claims	-	-
Continuing care	57	-
Other	-	-
Total	57	-
Total current and non-current	57	

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Agenda for Change £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Arising during the year	-	-	-	-	-	-	-	57	-	57
Utilised during the year	-	-	-	-	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-	-	-	-	-
Unwinding of discount	-	-	-	-	-	-	-	-	-	-
Change in discount rate	-	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	-	-	-	-	57	-	57
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	57	-	57
Between one and five years	-	-	-	-	-	-	-	-	-	-
After five years	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	-	-	-	-	57	-	57

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £1,939k

31 Contingencies

	2013-14 £000
Contingent liabilities	
Continuing Care	57
	-
	-
	-
Amounts recoverable against contingent liabilities	-
Net value of contingent liabilities	57
Contingent assets	
	-
	-
	-
	-
Amounts payable against contingent assets	-
Net value of contingent assets	-

32 Commitments

32.1 Capital commitments

	2013-14 £000
Property, plant and equipment	-
Intangible assets	-
Total	-

32.2 Other financial commitments

The clinical commissioning group and consolidated group had entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2013-14 £000
In not more than one year	-
In more than one year but not more than five years	-
In more than five years	-
Total	-

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 the 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 clinical commissioning group's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group's internal auditors.

33.1.1 Currency risk

The 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 clinical commissioning group has no overseas operations. The 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 clinical commissioning group's revenue comes parliamentary funding, the clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, from NHS England, as the need arises. The 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'	Loans and Receivables	Available for Sale	Total
	2013-14 £000	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	1,256	-	1,256
· Non-NHS	-	62	-	62
Cash at bank and in hand	-	14	-	14
Other financial assets	-	(1)	-	(1)
Total at 31 March 2014	-	1,331	-	1,331

33.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-
Payables:	-	-	-
· NHS	-	3,654	3,654
· Non-NHS	-	4,098	4,098
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	-	-
Other financial liabilities	-	-	-
Total at 31 March 2014	-	7,752	7,752

34 Operating segments

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

35 Pooled budgets

The clinical commissioning group entered into a pooled budget arrangement for Integrated Community Equipment Schemes on 1st April 2013 ending 31 March 2014 with Nottinghamshire County Council. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for Integrated Community Equipment Scheme activities.

The pool is hosted by Nottinghamshire County Council. As a commissioner of healthcare services the clinical commissioning group makes contributions to the pool, which is then used to purchase healthcare services

The memorandum account for the pooled budget is:

	2013-14
Income from Partnership	
Nottingham City Council	**1,286**
Nottinghamshire County Council	**2,313**
Bassetlaw CCG	**466**
Nottinghamshire County CCGs	**2,210**
Nottingham City CCG	**1,314**
Other	**968**
	8,557
Expenditure	
Partnership Management & Administration Costs	**287**
Contract Management Fee	**1,091**
ICES Equipment	**5,545**
Continuing Healthcare Specialist Equipment	**286**
Minor Adaptations	**804**
Project Provision Expenditure	
	8,013
Remaining Balance under/(overspend)	**544**

The Nottingham North and East CCG contribution to the pool is £477k.

36 NHS Lift investments

	Loan 2013-14 £000	Share Capital 2013-14 £000	Total 2013-14 £000
Balance at 1 April 2013	-	-	-
Transfer of investments from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-
Adjusted balance at 1 April 2013	-	-	-
Additions	-	-	-
Disposals	-	-	-
Loan repayments	-	-	-
Revaluations	-	-	-
Loans repayable within 12 months	-	-	-
Balance at 31 March 2014	-	-	-

37 Intra-government and other balances

	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	87	-	82	-
· Local Authorities	-	-	-	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	629	-	2,794	-
· NHS Trusts and Foundation Trusts	795	-	860	-
Total of balances with NHS bodies:	1,424	-	3,654	-
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	404	-	4,180	-
Total balances at 31 March 2014	1,915	-	7,916	-

38 Related party transactions

IAS 24 applies to material transactions between NHS bodies and related parties. Related Party transactions for CCG relate to payments made to GP Practices which have a GP who sits on the CCG Governing Body.

Details of related party transactions with individuals are as follows:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
The Ivy Medical Group	21		2	
The Peacock Practice	15		13	
The Calverton	103		7	
Torkard Medical Centre	78		11	

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. Details follow:-

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
• NHS England;	19,821	2,140	2,769	629
• NHS Foundation Trusts;	6,907	12	294	106
• NHS Trusts;	97,474	37	589	689
• NHS Litigation Authority;	5	0	0	0
• NHS Business Services Authority.	137	0	0	0
• NHS Property Services/Community Health Partnerships	1,259	0	0	0

39 Events after the end of the reporting period

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

40 Losses and special payments

40.1 Losses

The total number of clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Administrative write-offs	-	-
Fruitless payments	-	-
Store losses	-	-
Constructive loss	-	-
Cash losses	-	-
Claims abandoned	-	-
Other losses	-	-
Total	-	-

The CCG has recorded no losses or special payments in 2013/14

40.2 Special payments

	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Compensation payments	-	-
Extra contractual Payments	-	-
Ex gratia payments	-	-
Extra statutory extra regulatory payments	-	-
Special severance payments	-	-
Total	-	-

41 Third party assets

The clinical commissioning group held cash and cash equivalents which relate to monies held by the clinical commissioning group on behalf of other parties. This has been excluded from the cash and cash equivalents figure reported in these financial statements.

	2013-14 £'000
Third party assets held by the clinical commissioning group	-

42 Financial performance targets

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended). The clinical commissioning group's performance against those duties was as follows:

National Health Service Act Section	Duty	Maximum	2013/14 Performance	Duty Achieved?
		£000	**£000**	
223H(1)	Expenditure not to exceed income	167,083	166,065	YES
223I(2)	Capital resource use does not exceed the amount specified in Directions	-	-	YES
223I(3)	Revenue resource use does not exceed the amount specified in Directions	164,862	163,844	YES
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	YES
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	YES
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	3,414	3,339	YES

43 Impact of IFRS

	2013-14 £'000
Depreciation charges	-
Interest expense	-
Impairment charge: Annually Managed Expenditure	-
Impairment charge: Departmental Expenditure Limit	-
Other Expenditure	-
Revenue receivable from subleasing	-
Total IFRS Expenditure (IFRIC 12)	-
Revenue consequences of private finance initiative/LIFT schemes under UK GAAP/ESA95 (net of any sublease revenue)	-
Net IFRS Change (IFRIC 12)	-
Capital Consequences of IFRS: private finance initiative/LIFT and other service concession arrangements under IFRIC 12	
Capital expenditure 2013-14	-
UK GAAP capital expenditure 2013-14 (reversionary interest)	-

44 Analysis of charitable reserves

	2013-14 £'000
Unrestricted funds	-
Restricted funds	-
Endowment funds	-
Total	-