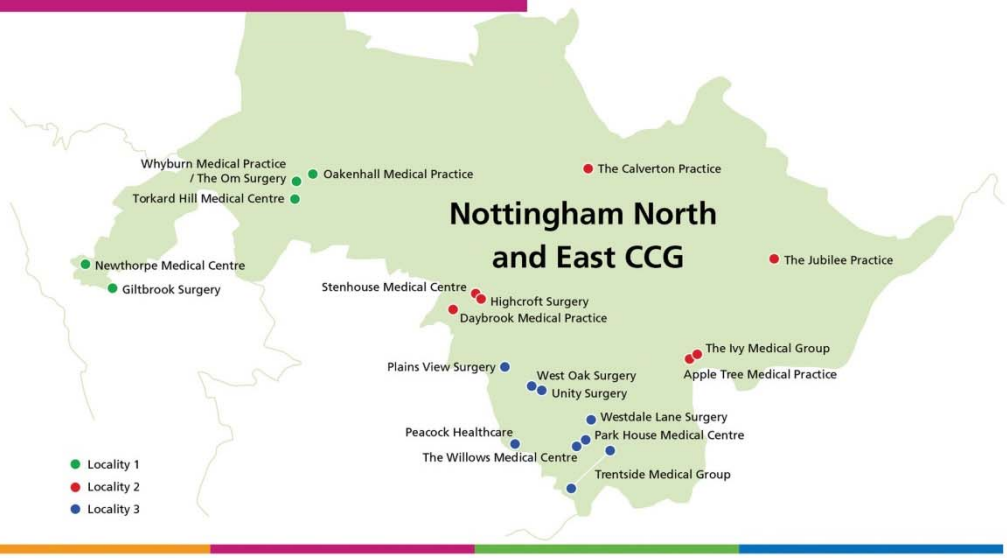
NHS
Nottingham North and East
Clinical Commissioning Group

Putting good health *into practice*

Our Annual Report and Accounts 2014/15



NHS Nottingham North and East Clinical Commissioning Group

Annual Report and Accounts 2014/2015

This is the Annual Report and Accounts for NHS Nottingham North and East Clinical Commissioning Group 2014/15. It includes information about the organisation and its activities during 2014/15.

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

For more details about any of the information included within this document please contact us:

Nottingham North and East Clinical Commissioning Group
Civic Centre
Arnot Hill Park
Arnold
Nottingham
NG5 6LU

Tel: 0115 883 1838
Email: info@nottinghamnortheastccg.nhs.uk
Website: www.nottinghamnortheastccg.nhs.uk
Twitter: @NHSNNE

Chair and Chief Officer Statement

As Clinical Lead and Accountable Officer, we are pleased to report that 2014/15 saw good progress in our second year as a Clinical Commissioning Group (CCG). Whilst it was a year of consolidation of business operations, it was also a year of continued growth and development both as a CCG and as a key organisation within the wider health and social care economy. The Better Care Fund, Transformation Partnership and system resilience have been fundamental areas of collaboration during 2014/15 and the CCG have stepped up to the responsibilities with the appropriate culture and management strategy.

The Governing Body are committed to the ongoing reshaping of the CCG in order to meet local health care needs and ensure a sustainable future. A sustainable future includes addressing difficult financial conditions and we were pleased to have delivered against our financial duties during 2014/15. We recognise that 2015/16 will be even more challenging and feel the CCG is in a strong position due to the hard work and ongoing development of the business model. For this reason, with support from member practices, we have taken on the responsibility for delegated authority of GP primary care services as we feel this provides us with greater opportunity to deliver the benefits of working as a CCG to improve local health services and address health inequalities.

We would like to thank our member practices for their continued commitment to the CCG and to our employees and partners for their hard work. We would also like to thank all our patients, particularly those on our Peoples Council, who ensure that the patient voice is at the centre of everything that we do.

Sam Walters
Chief Officer

Dr Paul Oliver
Clinical Lead and Chair

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Strategic Report

Introduction

Welcome to Nottingham North and East Clinical Commissioning Groups 2014/2015 Annual Report. This document fulfils our duty to produce an Annual Report on how we have discharged our functions and details our annual financial accounts for 2014/2015.

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 Annual Report will be presented with our Annual Accounts which directions are determined by NHS England under the Health & Social Care Act 2012, which amended the NHS Act 2006 and approved by the Department of Health (Secretary of State)

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

Who is NHS Nottingham North and East Clinical Commissioning Group (NNE CCG)

Nottingham North and East Clinical Commissioning Group (NNE CCG) is co-located with Gedling Borough Council at the Gedling Civic Centre in Arnot Hill Park. We are one of seven Clincal Commissioning Groups in Nottinghamshire, including Nottingham City and Bassetlaw. The CCG is a clinically led membership organisation made up of 21 general practices covering a population of approximately 149,000, organised collectively to commission health services for the patient population living in Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield and Newthorpe.

Image 1

Our Vision

NNE CCG's vision is:

"Putting Good Health into Practice"

This vision will be delivered through:

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

Our Population

Demographics

The population of NNE CCG is spread across a mix of urban areas and rural villages and has a registered population of approximately 149,000. The majority of patients registered with GP practices in the CCGs area live within three districts: Gedling Borough, Ashfield Districts (mainly Hucknall), 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, see Graph 1 below. An increase of 33% is expected in the older population by 2025, particularly in the 75-79 age groups. This would see a rise of 8,500 from 26,000 to 34,500 people aged 65 or older across NNE CCG with a greater number of females than males. The highest proportions of older people live in Eastwood, Burton Joyce and Newstead.

The adult population is expected to increase by 9.7% by 2025 compared with 8.9% increase for Nottinghamshire's registered population average.

Graph: 1

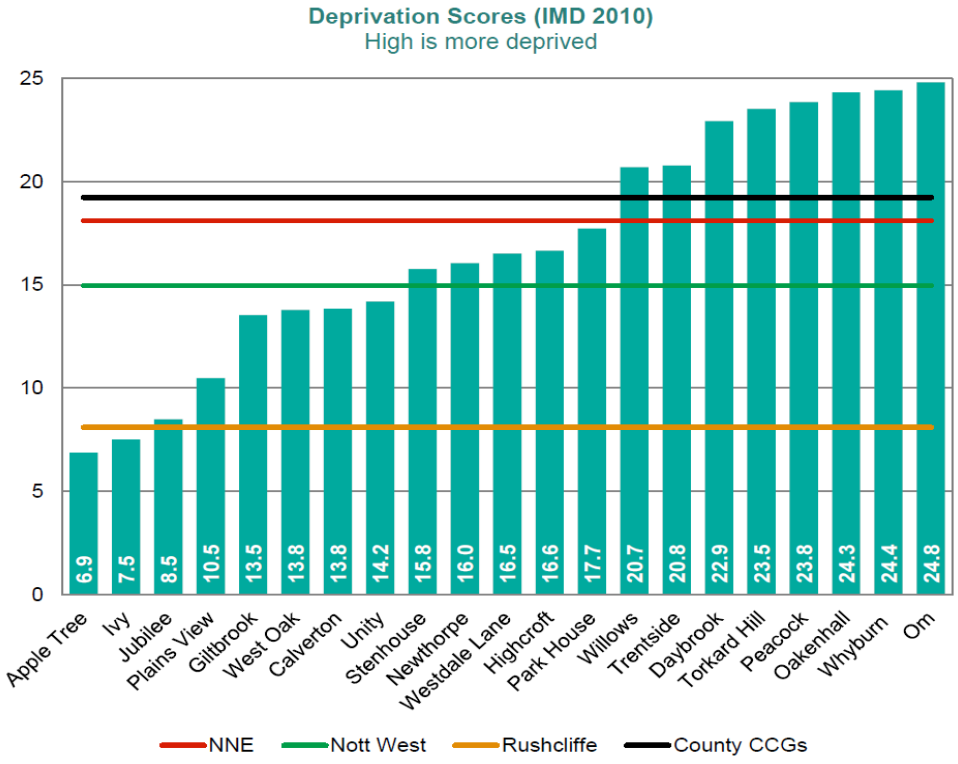
Health, Health Inequalities and Deprivation

The Index of Multiple Deprivation (IMD) score for the CCG is 18.2 (2012, UK averages is 21.5). The higher the score, the more deprived the area. NNE CCG has mix of deprivation that ranges from a level of 25.1 in Hucknall to 6.7 in Burton Joyce.

In Gedling, deprivation is lower than the national average; however, 3420 children and 1 in 7 pensioners live in poverty. Life expectancy for men is 79.5 and 83 for women which is higher than the England average.

In Ashfield, deprivation is higher than the national average and 5,300 children live in poverty. Areas of Ashfield where NNE CCG registered populations live, such as Hucknall, include some of the most deprived 20% of areas nationally. Life expectancy for both men and women is significantly lower than the England average. Life expectancy is 8.7 years lower for men and 10.6 years lower for women in the most deprived areas of Ashfield compared with the least deprived.

See Graph 2 for the CCG's deprivation score by practice, as a CCG as whole and in comparison to neighboring CCG's.



Graph: 2

Long Term Conditions

The prevalence of long term conditions among adults is similar to the national average. In NNE CCG the most common long term conditions are hypertension (38,439 individuals), common mental health disorders (17,460), asthma (10,560), chronic kidney disease (11,201), diabetes (8587), chronic back pain (7,062) and coronary heart disease (7,063) and cancer (5,207).

An estimated 1,407 women are living with Breast cancer in NNE CCG; this is the most common cancer in women. For men, the most common cancer is prostate cancer, with an estimated 692 living with this disease in the CCG. Gedling district has a significantly higher incidence of malignant melanoma than the England average. However, the numbers are small with approximately 22 new cases a year.

The unmet need (measured as those whose illness is undiagnosed) is also particularly high for some of the long term conditions noted above. Across NNE CCG, there is a relatively high proportion of unmet need for dementia, hypertension, COPD, chronic kidney disease and diabetes.

There are currently expected to be 1822 people living with dementia in NNE CCG. In 2010/2011, 53% of people were undiagnosed in NNE CCG, this was comparable with the average diagnosis rate across Nottinghamshire. The number of people newly diagnosed with dementia across Nottinghamshire is expected to almost double between 2010 and 2030. This is a significant challenge for health and social care delivery, with direct costs to the NHS predicted to treble by 2030.

Carers

Nottinghamshire has a high proportion of unpaid carers across the County compared to England. Gedling has an estimated 12,460 residents who provide unpaid care; this is the second-highest number for all the districts in Nottinghamshire. Ashfield has the highest number of residents providing unpaid care with an estimate of 12,631.

Mental Health

In 2008, NNE CCG had an estimated 17,460 adults with a common mental disorder; 14.7% of the adult population compared with 13.6% across Nottinghamshire County. In 2007-2009, Gedling district had the second highest suicide rate in Nottinghamshire. This was almost 50% higher than the Nottinghamshire rate, but is not statistically significant. Areas of Arnold are in the highest 20% nationally for rates hospital stay for self-harm across the NNE CCG area.

Specialist Children and Adolescent Mental Health Services (CAMHS) in Gedling are delivered through a locality based team, which has only 1% of the County caseload. Emotional disorders and problems make up 80% of presentations, and 20% are eating disorders. Gedling has the second lowest specialist CAMHS admission rate in Nottinghamshire (44.8 per 100,000).

Ashfield scores poorly in relation to six indicators associated with increased risk of a child developing mental health problems. As of 2009, children in Ashfield were more at risk of poor mental health than the East Midlands as a whole. There are also significantly higher levels of deprivation, drug use and mental illness compared to the regional average.

Specialist CAMHS in Ashfield district are delivered through a locality based team, with the highest County caseload. They also have the highest number of children waiting to access the service, and the highest number of staff. There are a relatively high number of children on the caseload with additional needs (including those with a learning disability, young offenders, or children looked after). Almost 40% of cases present with hyperkinetic disorders. There are low levels of eating disorders, substance misuse and self-harm.

Smoking

Smoking is the primary cause of preventable illness and premature death in England, and the single biggest cause of inequalities in death rates. Smoking is responsible for around 1300 deaths across the County every year. Smoking prevalence in the adult population is lower in Gedling (19.3%) and Broxtowe (17.1%) but higher across Ashfield (25.9%) than England (20.8%) or the East Midlands (21.1%).

Obesity

The percentage of obese adults in Gedling district is expected to be slightly lower than the England average, but not significantly so. Gedling district has a significantly lower percentage of the adult population who are physically active. Children in Gedling have significantly lower levels of obesity than the England average.

Adult obesity is expected to be significantly higher than the national average in Ashfield, with areas of Hucknall in the top 20% nationally. Ashfield district also has the highest prevalence of obese year 6 children in the County; however none of the areas of Ashfield district which are included in the NNE CCG area are in the top 20% nationally. Reception year children in areas of Hucknall and Bestwood are in the top 20% nationally for obesity. Ashfield district also has the lowest level of participation in sport and physical exercise in the County (in the 5-16 year old age group).

Immunisation and Vaccinations

NNE CCG has achieved the 95% recommended coverage for primary immunisations. The CCG is below the recommended 90% coverage for preschool immunisations (MMR) but is above the national average of 78%. Nottingham North and East achieved the national target of uptake for flu vaccinations for people aged 65 and older in 2011/12 (75.3% compared to the target of 75%).

Teenage Pregnancy

The teenage conception rate for Gedling district is comparable with the County average; however teenage conception rates for Ashfield are higher than the County average. Below district level, pockets of Ashfield relevant to NNE CCG in Hucknall have rates in the top 20% across Nottinghamshire. Within Gedling district, in areas within Carlton and Arnold, teenage conception rates are in the top 20% in the County.

Access to Services

NNE CCG's population has relatively good access to health services although some rural areas around Newstead and Lowdham experience poorer access to health services.

Causes of Death

The main causes of death for all ages in the CCG are Cardiovascular Disease, Cancer and Respiratory Illness. Death rates under the age of 75 are mainly linked to cancer (lung and prostate in men, breast and lung in women).

Across Nottinghamshire, the trend in death rates overtime is reducing. However, the gap between those experiencing the best health and those who have the worst health is not narrowing as quickly as it should.

In order to tackle the root causes of ill health and health inequalities across the area, NNE CCG is committed to working in partnership with both Nottinghamshire County Council and the relevant District Councils, the police, schools, voluntary sector, and other local organisations and groups as appropriate. Joint approaches to tackling issues will aim to have a positive impact on the long-term health of the population.

Table 1 shows the Public Health Profiles for the NNE population compared with the Nation

Indicator	Period	NNE CCG %	National Average %	High or lower than national average
% aged 65+ years	2014	19.5	16.9	
% aged 75+ years	2014	8.8	7.8	
% aged 85+ years	2014	2.5	2.2	
% aged under 18 years	2014	19.7	20.7	
Deprivation score (2012)	2012	18.2	21.5	
% with a long standing health condition	2013/14	54.8	54.0	
% with a caring responsibility	2013/14	20.0	18.4	
Nursing home patients	2010/11	0.5	0.5	
Life expectancy – Male	2008 - 2012	79.3	78.9	
Life expectancy – Female	2008 – 2012	82.4	82.8	
A&E – Emergency admissions (per 1000)	2012/2013	93	88	
Long term conditions bed days (per 1000)	2012/2013	533	458	
Estimated smoking prevalence (QOF)*	2013/2014	16.5	17.1	
Long term mental health problem	2013/2014	5.0	4.8	
Alzheimer's disease or dementia	2013/2014	0.6	0.6	
Chronic Kidney Disease: QOF prevalence (18+)	2012/2013	8.5	4.3	

*QOF – Quality Outcomes Framework

Table: 1

Population and health inequalities information supports NNE in identifying the health needs of the population, and therefore impacts on the services commissioned for the area, for example, higher than average numbers of older people within the area suggest that there will be higher than average levels of long term and life threatening conditions.

In response to our local population and their health needs identified in the Joint Strategic Needs Assessment the CCG's health priorities for 2014/2015 were focused on the;

- High rates of teenage conceptions in small populations across the NNE CCG area
- Mental health: highest rates of common mental health disorders in NNE CCG, high suicide rates (though not significantly different for national average), rates in highest 20% nationally for hospital stays for self-harm for small areas within the NNE CCG
- Average number of decayed, missing or filled teeth per young child in Gedling is the highest in Nottinghamshire
- Carers: Gedling and Ashfield have the highest number of carers in the County
- Improved identification of people with long-term conditions, especially dementia.

Social, Community and Human Rights

NNE 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, leaders of the CCG and in working with our partners. As such, NNE also recognises the benefits of working within local communities themselves and supporting them to change. NNE CCG actively supports the PANEL principles[1] in ensuring a human rights approach - **P**articipation in one's own development; **A**ccountability of duty bearers to rights-holders; **N**on-discrimination and prioritisation of vulnerable groups; **E**mpowerment of rights holders; **L**egality: the express application of a human rights framework. There are examples throughout the Annual Report and specific elements are provided below. Organisational detail can be found in the section on strategic objectives.

Community Projects – Participation, Accountability and Empowerment

Working alongside local partners, member practices and local communities, NNE CCG are supporting community projects that work to address the needs of the local population and help residents to make changes.

With the support of Gedling Borough Council and Ashfield District Council NNE are actively working with partners and the residents in Daybrook and Hucknall East. This is being achieved through C2 Connecting Communities.

Designed by a community nurse, a GP and researchers from the University of Exeter, the integrated C2 approach has a consistent track record of breaking through longstanding barriers to transform the health and wellbeing of communities across the UK, by seeing local residents as the solution, not the problem. It works with and releases the latent strengths inherent in all neighbourhoods and is grounded in 20 years of 'practice based evidence'. C2 is also based on compelling biological evidence that the lack of any sense of influence or control over one's immediate environment, coupled with poor social networks, causes catastrophic health behaviours.

Not only has the approach supported working directly with local residents, it has also had a direct impact on better working relationships with local agencies and partners. This is because C2 works by delivering a lasting culture shift and an enabling environment at strategic, community and frontline service delivery levels. The focus is on collaborative health creation to harness the collective creative powers of residents working as equals with Police, Education and Local Authority services across the spectrum. The end result is self-managing, well supported, stronger and healthier communities.

Taking forward C2 has aligned with the CCG responsibilities on the Community Safety Partnership and has resulted in an increased opportunity to work with local communities on priorities through member practices.

Patient Safety – Accountability, Legality, Non-discrimination and Prioritisation

The last decade has seen a number of key publications that have informed and shaped the patient safety agenda. These include the recent Francis Report and subsequent landmark publications from Professor Don Berwick and Sir Bruce Keogh examining patient safety in the NHS. As a response to the Francis Report in November 2013, the Government's final response was published which accepted the majority of the 290 recommendations. We established a task and finish group with specific responsibility for reviewing the recommendations and undertaking a gap analysis. As a result an action plan was implemented during 2014 to ensure we are fully compliant as a commissioning organisation.

[1] A guide to evaluating human rights-based interventions in health and social care, Alice Donald, London Metropolitan University, Human Rights & Social Justice Research Institute

The safety and welfare of children and vulnerable adults is a priority for clinical commissioning groups across all commissioned and contracted services. Under our arrangements with other local clinical commissioning groups, Safeguarding Committees for Children and Vulnerable Adults have been established which have embedded safeguarding governance and accountability arrangements across the clinical commissioning groups in Nottinghamshire. The Multi Agency Safeguarding Hub (MASH) has also been developed which secured commitment from all local clinical commissioning groups to work in partnership with the local authority and other agencies to ensure prompt information sharing across the health community. MASH is the first point of contact for new safeguarding concerns and has significantly improved the sharing of information between agencies, helping to protect the most vulnerable children and adults from harm, neglect and abuse. We are also statutory members of the Nottinghamshire Safeguarding Adults Board.

The Department of Health's review of Winterbourne View Hospital sets out specific actions for the care of patients with learning disabilities and provides a salutary reminder of the failings in care for this group of vulnerable people. A county-wide Winterbourne View Project Group was established which reports to the Safeguarding Committee. A team of experts was commissioned to review all individuals who were inpatient at 1 April 2013 and determine whether they were ready to move from hospital accommodation. Individual plans were then put in place to move those ready for discharge by the end of May 2014. Care and treatment reviews continue for individuals admitted after 1 April 2013 and we are committed to commissioning more community based services for this cohort of individuals.

Nationally and locally, the quality of care delivered to individuals in care homes has had a high profile. Clinical commissioning groups in Nottinghamshire together with the local authority and the Care Quality Commission (CQC) have set up a strategic review of the care home sector in Nottinghamshire. One of the group's aims is to establish the details on current care home provision and identify any gaps in provision. We have jointly developed a quality assurance framework with our local authority colleagues so that we can monitor the quality of services provided and support continual improvement. Locally, we have established a Care Homes Group which proactively monitors standards in care homes. Using a suite of tools the group is able to identify early warning signs of deteriorating standards and collect intelligence from clinicians enabling resources to be targeted appropriately. Links with the local authority team have been strengthened allowing for joint visits, pooling of resources and information sharing, which enables effective timely interventions for care homes of concern.

With our main providers of health services we have developed our capability to proactively scan quality data and have redeployed staff to bring added rigour to this process. We combine business intelligence, survey results, patient feedback, complaints, incidents and Patient Advice and Liaison Service (PALS) contacts to give us an overall picture of provider hotspots. We hold providers to account for quality through regular quality scrutiny panels and quality visits. We actively encourage patient representatives and lay members to take part through the use of a bank of lay members who attend quality reviews and quality visits, as they provide an invaluable patient perspective on quality. We take patient stories to every Governing Body meeting to understand the human factors in harm and error and the real impact on patients and their families, as well as acknowledging where services performed well and met their needs effectively.

Clinical Effectiveness – Accountability and Empowerment

Clinical effectiveness is about delivering the best possible care for patients through timely and appropriate treatments but also ensuring the right outcome for patients – "right person, right place, right time". Clinical effectiveness is made up of a range of quality improvement activities and initiatives including evidence, guidelines and standards to identify and implement best practice and quality improvement tools such as clinical audit to review and improve treatments and services. These are based on:

- The views of patients, service users and staff
- Evidence from incidents, near-misses, clinical risks and risk analysis
- Outcomes from treatments or services
- Measurement of performance to assess whether the team/department/organisation is achieving the desired goals
- Identifying areas of care that need further research
- Information systems to assess current practice and provide evidence of improvement
- Assessment of evidence as to whether services/treatments are cost effective
- Development and use of systems and structures that promote learning and learning across the organisation.

By using these systems and processes there has been a significant reduction in harm from falls and pressure ulcers as a result of using targeted interventions based on thematic review and key learning. A co-ordinated approach to healthcare acquired infection is evident as a result of multi-organisational working and analysis across the healthcare economy. As part of the response to the Francis recommendations providers are reviewing their workforce transparently to ensure effective skill mix and staff in place to deliver services. The regular Quality Scrutiny panels with providers ensure that it is possible to discuss and determine action required to acknowledge or enhance the clinical effectiveness of specific services.

Children's Services – Accountability, Legality, Non-discrimination and prioritisation

NNE and the local authority are working in partnership to commission services jointly for children and young people, including for those with special education needs and disabilities. This ensures effective provision, relevant to need and clear education, health and care plans.

Health Services for Looked After Children

Nottinghamshire CCGs are working with the Local Authority and provider organisations to support a whole system review of current pathways and service provision for looked after children's health. The aim of the review is to understand whether the services being commissioned are fit for purpose, link effectively with each other and provide value for money. Actions include reviewing service provision, auditing the accuracy of data, analysing current and forthcoming legislation, and undertaking a full-scale health needs assessment.

Children and Families Act 2014 – Special Educational Needs and Disability Reforms

The Special Educational Needs and Disability (SEND) reforms outlined in the Children and Families Act 2014 are focused on outcomes for children and young people with SEND and how education, health and social care work together to help children and young people aged 0-25 achieve their outcomes.

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.

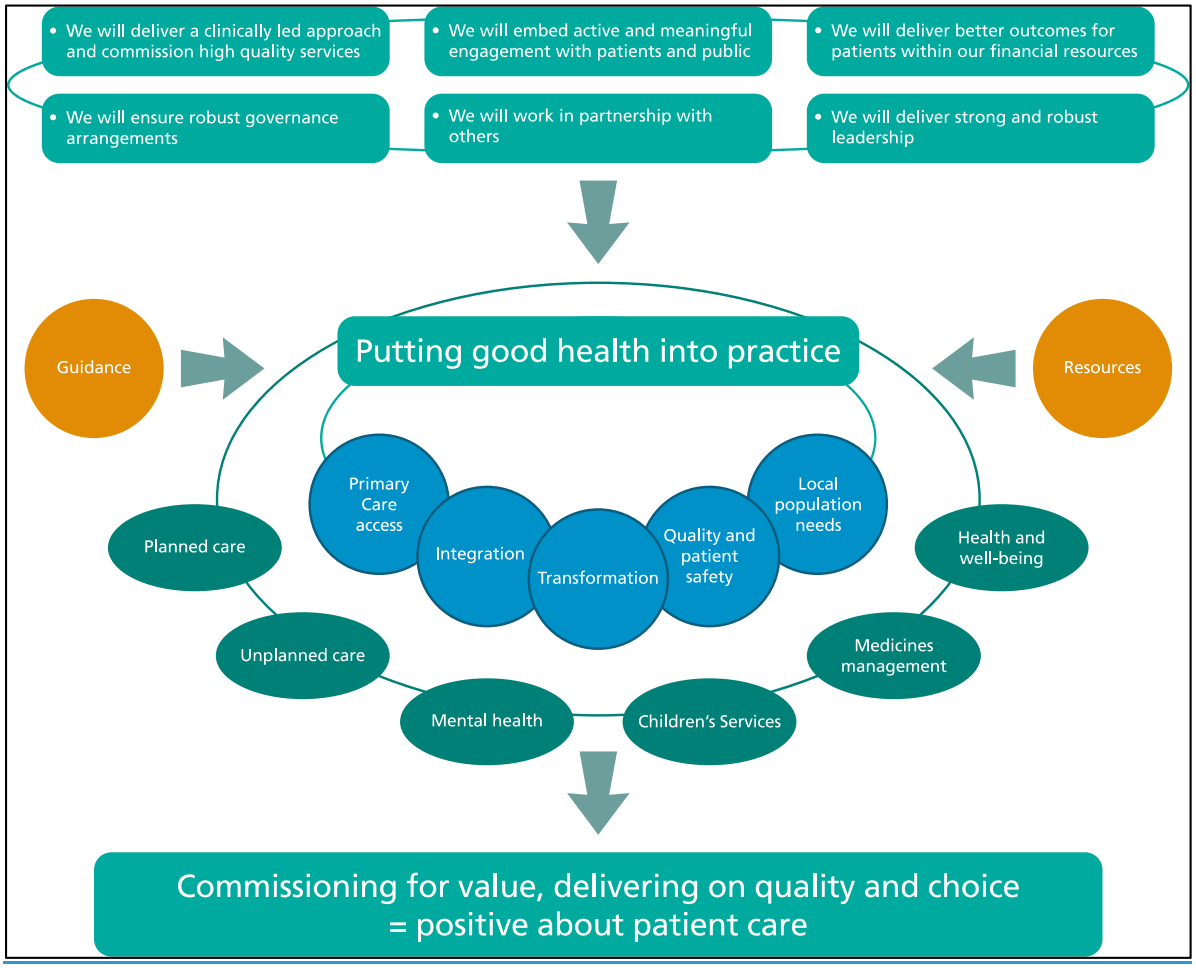


Image 2

Our Resources

Our Structure and Employees

NNE CCG can be classed as a small organisation, with 46.48 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. NNE CCG shares a number of teams with NHS Nottingham West and NHS Rushcliffe CCG and are the host employing organisation for the finance, quality and transformation services. Information and Outcomes and Contracting directorates are hosted by NHS Rushcliffe CCG and NHS Nottingham West CCG respectively, we also commission other back office functions from Greater East Midlands Commissioning Support Unit.

We have a flat structure and strongly support teams working together to provide a comprehensive approach to all activities. We review, make, share and 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.

The Governing Body has responsibility for ensuing that the Clinical Commissioning Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Clinical Commissioning Groups principles of good governance, further details can be found in the members report.

Table 2 below shows NNE CCG's gender distribution in relation to; Members of the Governing Body, all other senior managers, including those classed as very senior managers (VSM) not included in the Governing Body and all other employees.

	Member of Governing Body	Senior Management	All Other Employees	Grand Total
Female	3*	13	20	36
Male	9*	4	8	21
Grand Total	12	17	28	57

*Includes 1 Female and 1 Male that are present in the capacity of an observer for the Governing Body

Table: 2

Equal Opportunities

The CCG wholeheartedly supports the principles of Equal Opportunities in employment and opposes all forms of unfair or unlawful discrimination. Accordingly it is the CCG policy that no employee or job applicant receives less favourable treatment on the grounds of his or her gender, religion and belief, age, disability, race, gender reassignment, marriage and civil partnership, pregnancy and maternity or sexual orientation (the nine protected characteristics). Our aim is that our workforce should reflect the diverse communities we work in.

The CCG has carried out an initial review of how the organisation compares against the Workforce Race Equality Standard and recognises the need to progress against the indicators. Our population is approximately 6% BME and our workforce is representative at approximately 11%. The CCG has approximately 5% BME staff and Governing Body members at bands 8-9 and VSM. The Governing Body is representative of the CCG BME population as well as other protected characteristics, with the opportunity to further enhance through appointments over the coming year.

The CCG continues to strive to be representative of the community it serves, and takes pride in being an equal opportunities employer. The CCG treats all job applicants and employees (including trainees, agency workers, those on Government employment schemes and students) equitably. The CCG has been accredited for the 'Positive about disabled people 'two tick' scheme, and 'Mindful Employer', which promote positive attitudes to disability and mental health respectively. The CCG 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 CCG's efforts to promote equality and eliminate discrimination will only succeed if its staff fully understand the principles of inclusion, exclusion, equality and discrimination. To that end the CCG continues to ensure all staff has access to learning and development opportunities. The CCG has invested in 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.

Sources of Finance

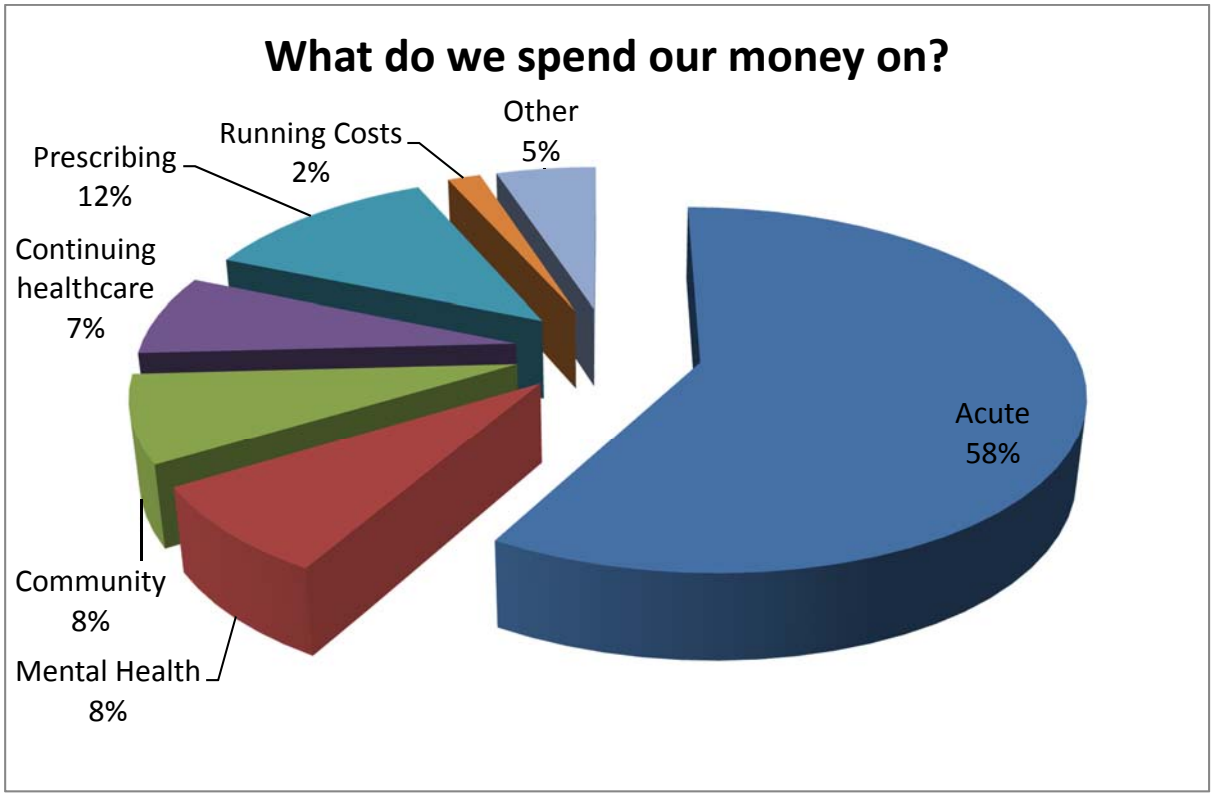
Nottingham North and East CCG are set an allocation by the Department of Health (DH), via NHS England, for each financial year. For 2014/15 and 2015/16 allocations have been set and notified to the CCG for both years, aiding the financial planning process.

The allocation is split into two main components. These are the programme allocation, out of which the CCG purchases the healthcare it requires for its population, and the running costs allocation against which all CCG operational costs are funded.

For 2014/15 the CCG received 2.14% uplift over its 2013/14 programme allocation (with a further 4.71% in 2015/16). Running cost allocations remain broadly static in 2014/15 but in 2015/16 are reduced by 10% reflecting the DH squeeze on running costs.

In 2015/16 the CCG will also receive a further allocation of £3.1m in relation to establishing the Better Care Fund. This fund is a national initiative for NHS monies to be pooled with local authority resources to enable better working and integration of health and social care services. The development of the Better Care Fund is described in 'Our Future Developments' section.

How We Spend Our Money



Graph 3

Our Stakeholders

Working in partnership with our stakeholders is fundamental to our success and NNE CCG recognises the invaluable input that our stakeholders contribute to commissioning of our services. We would like to take this opportunity to thank our stakeholders for their contributions and hard work throughout 2014/2015, here is a list of some of our stakeholders and how we engage with them;

Our Local Population

- Peoples council – patients from our member practices
- Holding NNE Voice for Health Events
- Attending community fairs and events
- Meeting with local groups
- Supporting district/ borough council events
- Having a patient representative on the Governing Body
- Engagement and involvement on service changes and new services
- Information and support for self-management
- Community projects

NHS England

- Working collaboratively on quality in primary care
- Working collaboratively in supporting our member practices
- Joint patient and public engagement
- Sharing best practice in planning
- Support in developing NNE as an organisation

Our Providers

- Working as a health and social care community on transformation
- Collaboratively reviewing services and making changes
- Building clinical relationships
- Working jointly on patient and public involvement

Our CCG partners

- Ensuring efficiencies and added value through shared services and resources
- Working together within the local health and social care community
- Expanding on joint commissioning
- Working individually and collaboratively on plans to suit the needs of our local populations
- Sharing innovation

Our local voluntary sector and local agencies

- Commissioning local services
- Promoting local services
- Engaging with local agencies and developing community projects
- Joint working

Local Authorities

- Partnership working on transformation and the better care fund
- Joint commissioning of children's services
- Joint working on improving services and support for carers
- Working jointly on communicating to our local populations
- Integrating services
- Working directly with local communities, including on human rights

Our Duties

The statutory duties and powers of the CCG are set out within NHS England's "The functions of Clinical Commissioning Groups (March 2013) and are in our Constitution which can be found on our website.

We have maintained a strong focus on the delivery of our duties alongside our strategic objectives and how this has been achieved is illustrated in the table below

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

Table 3 provides an overview of how we have met our duties in 2014/15.

Our duty	How we have met this duty
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 • Dedicated team supporting delivery of safety, effectiveness and experience • Promotion of NHS Constitution on intranet and internet • Five Year Forward View Plan – Effective operational, activity and financial planning
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 • Member practices on the Clinical Cabinet • Worked jointly with NHS England and the Care Quality Commission 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 • Taking forward Patients in Control including self-management and shared decision making
Enabled patients to make choices with respect to the aspects of health services provided to them.	• Continued work with Right Care and Commissioning for Value packs • Considered choice in all service changes • Actively taken on board feedback from patients and public about more information on self-care which is supported through all commissioning activities • NNE MyHealth smartphone app and patient information available through NNE site on digital TV channels • Campaign and information on making the right choices when using local services

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 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
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
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 NHS England 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 • Carried out a self-assessment and received accreditation from NHS England
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 Nursing and Quality 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 • Utilised specific chapters to inform engagement as well as business proposals

Table 3

Sustainability Report

What is meant by sustainability?

Sustainability in this context is about the smart and efficient use of natural resources, to reduce both immediate and long term social, environmental and economic risks. The cost of all natural resources is rising and there are increasing health and wellbeing impacts from the social, economic and environmental costs of natural resource extraction and use.

Performance and achievements

We are committed to using sustainable approach in commissioning healthcare services and working within the available environmental and social resources, protecting and improving health now and for future generations. To this effect, we will be working to reduce carbon emissions, minimising waste & pollution, making the best use of scarce resources, building resilience to a changing climate and nurturing community strengths and assets.

We have established 2013/14 as a baseline for our emissions. We have calculated our corporate emissions baseline to be 40.88 tCO_2e which is equivalent to 0.99 tCO_2e per full time employee and carbon influence through contracts for commissioned healthcare services and procurement of non-healthcare products and services to be 48,965 tCO_2e. Our corporate emissions encompass energy, waste, water and travel. Having established this baseline, we have set an ambitious target of 28% carbon reduction by 2020.

We have adopted an environmental policy and have a board approved Sustainable Development Management Plan (SDMP) with accompanying action plans on how to achieve our ambitious target of 28% reduction by 2020. We have appointed NetPositive to work with us and support us to implement this plan

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. The CCG has engaged with its local community to encourage a healthier lifestyle, where possible used local businesses.

How We Support Sustainability:

Governance

- Have appointed the Director of Operations as the 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
- Have a board approved Sustainable Development Management Plan (SDMP)
- Have included climate change adaptation planning as an action in the SDMP

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, Brian Hancock 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
- Have calculated baseline emissions as s result of commissioned healthcare activities
- Have 3 of our provider organisation that regularly report their environmental performance and 67.4% of commissioned spending was with these organisations; they are Nottingham University Hospitals, Nottinghamshire Healthcare Foundation Trust and East Midlands Ambulance Services
- Will require our suppliers to have a simple environmental management systems and will report annually % of suppliers who have an environmental management system (EMS) in place or routinely publicly report the carbon footprint for their organization

Procurement

- Have calculated baseline emissions as a result of the organisation procuring non-health care products and services, based on this, we will embed sustainability into our procurement policy and require that our suppliers have a simple environmental management systems
- Will report annually, % of procurement spend where suppliers have an EMS in place or routinely publicly reports the carbon footprint for their organization
- Have monitored the quantity of paper used and calculated the associated emissions and based on this, plans on how to reduce paper usage has been included in our SDMP
- Have changed printing settings on all computers, so that defaults to double sided black and white, regularly communicate to staff to stop printing to reduce the need to procure paper
- Have calculated also the emissions associated with data transmission online.

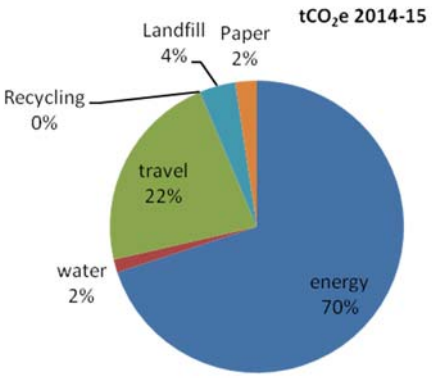
The CCG has joined the Investors in the Environment Network that supports organisations to reduce their direct reliance on increasingly expensive energy and natural resources organisations, cutting costs and emissions, while gaining a visible externally verified quality mark to evidence their progress.

The CCG will be receiving the Investors in the Environment Silver Award Accreditation in May 2015 to demonstrate our commitment to improving our environmental performance and ensuring environmental management - an integral part of healthcare provision.

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 health social enterprise NetPositive to support.

Summary of sustainability performance

Area (totals)		2013/14	2014/15
GHG emissions (tCO2e gross)		42.25	44.99
Energy in buildings	**Use (kWh)**	77,230	80,379
	tCO_2e	28	31
	tCO_2e/ WTE	0.68	0.69
Water	**Consumption (m^3)**	636	704
	tCO_2e	0.58	0.64
	tCO_2e/ WTE	0.014	0.014
Transport	**Mileage (Km)**	48,754	43,805
	tCO_2e	11	10
	Expenditure (£)	20,297	18,237
Waste	**Recycling (tonnes)**	0.809	0.89
	Recycling (tCO_2e)	0.017	0.019
	Landfill (tonnes)	7.29	7.29
	landfill (tCO_2e)	1.782	1.782
Paper	**A4 Sheets**	165000	216000
	A3 Sheets	5000	4800
	tCo_2e	0.83	1.07



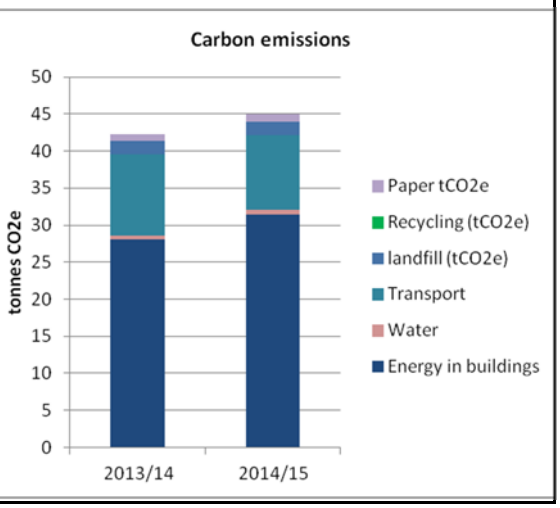


Table: 4

Our Strategic Objectives

Our strategic objectives drive our success as a CCG both in response to our responsibilities as a public body in the NHS and to the needs of our local population.

Strategic Objective 1: We will deliver a clinically led approach and commission high quality services

We continue to experience the benefits of a clinically led approach for our local health community. This is championed by our Clinical Lead and Chair, Dr Paul Oliver and 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.

Clinical commissioning groups are in a unique position to improve the quality of services they both provide and commission for their patients. GPs have direct access to feedback from their patients and can use this to identify areas for improvement, improve health and change lives.

The work streams for 2014/15 included planned and unplanned care, mental health, prescribing and children's services. The Commissioning Plan provides detail on all these projects, and below are achievements during 2014/15.

Patient Experience

The NHS Constitution states that the delivery of high quality care is dependent on feedback and those organisations that welcome feedback from patients and staff are able to identify and drive areas for improvement.

Within our quality team we have staff that are skilled in seeking and responding to complaints and patient experience. These staff analyse complaints, compliments, stories and patient satisfaction surveys. We have implemented the Patient Association standards and peer review methodology for the management of complaints and during 2014 have implemented a Commissioning for Quality and Innovation (CQUIN) scheme across all our providers to improve complaints management using peer review. Furthermore, we have implemented an electronic issues log which enables GPs and other clinicians to capture real time feedback from patients. All issues recorded are analysed for trends or patterns and this can then be incorporated into the quality and contract meetings with our providers.

Patient and public involvement and feedback is embedded by aligning patient experience and patient engagement teams to ensure a comprehensive understanding of the quality of services.

Below are specific projects carried out in 2014/15 which have improved the quality of services. More detail on how we will commission high quality services is detailed in a later section.

COPD and Up Skilling Nurses

In 2012 a review was undertaken of spirometry across NNE covering 30 nurses across 20 practices which found that 15 nurses had failed to reach an acceptable standard, through ongoing education, training and support NNE's Respiratory Nurse Educator was able to up skill the nurses. A follow up audit was completed in 2014, which involved 23 nurses and resulted in an 87% pass rate and 6 nurses now also hold the Association for Respiratory Technology & Physiology Spirometry qualification.

Parkinson's

The CCG secured two years funding from Parkinson's UK to fund a Community Parkinson's Specialist Nurse across NNE. Our Nurse has been in post since August 2014 and currently has a case load of over 200 patients

The aim of the service is to provide specialist support from a Parkinson's Specialist Nurse to patients with Parkinson's in a community setting. This role will be to provide seamless support throughout all stages of the disease and act as a key point of communication in order to coordinate multidisciplinary support for people with Parkinson's.

Electronic Palliative Care Co-ordination Service

The pilot project started in August 2014 and is installed in all 21 NNE CCG GP practices. The aim of the service is to improve the quality of care for patients with end of life needs. The service ensures that information on preferred place of care is known and shared with all those involved in their care. The service will improve patient and carer experience, improve clinical outcomes and reduce hospital admissions for our patients with palliative care needs.

Pathway Developments

The CCG has been working with colleagues from our local hospitals to develop pathways of care. These pathways will promote consistent management by GP's prior to referring patients to the hospital and cover conditions in gynaecology (for heavy menstrual bleeding) and orthopaedics (hip and knee pain patient pathway and carpal tunnel pathway).

Training GP's in Heart Conditions

The CCG successfully secured funding from the East Midlands Strategic Clinical Network to up-skill our GP's in the detection and management of Atrial Fibrillation and Heart Failure. More than 30 GP's from 20 of our practices attended the training sessions held in November 2014 and February 2015. These events have improved the clinical knowledge of attendees and will increase the number of patients who are cared for (with these heart conditions) by our GP's.

Acute and Chronic Kidney Disease

The CCG successfully secured funding from the East Midlands Strategic Clinical Network, to participate in the Acute and Chronic Kidney Disease Quality Improvement Programme. As part of this programme educational sessions for GP's and Practice Nurses will be delivered in 2015 to support health care staff to develop action plans to improve their management of patients with kidney disease.

Strategic Objective 2: We will embed active and meaningful engagement with patients and public

Over the last year, our engagement and communications plans have developed at a pace and we have made good progress with engaging different groups of patients, involving more people with the decision making process and raising our profile throughout the area.

We have made significant steps to develop a robust approach to communications and engagement and have worked with our patient representatives and stakeholders to develop relationships and deliver communications and engagement activity which has had an impact on both strategy and public perception.

Involvement embedded in CCG structures

- 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.

Events and consultations

- We hold regular 'Voice for Health' events, which are open presentations and discussions on the local NHS and the progress of the CCG. Topics covered over the last year include: urgent care, co-commissioning, budgetary choices and decision making. They have been held in: Arnold, Killisick, Papplewick, Hucknall, Netherfield and Lowdham.
- We have facilitated a number of workshops in Hucknall working with GPs and Hucknall patient representatives to discuss the impact of new housing developments on the local primary care services. Patients and GPs worked together to arrive at some possible solutions.

We actively promote individual participation in care and treatment through commissioning activities by involving patients and public in all service design and redesign work. Through these activities, NNE CCG ensures that it listens and acts upon patient and carer feedback at all stages of the commissioning cycle. In 2014/15, we have conducted a number of targeted consultations to help inform CCG strategy.

The issues we have covered are:

- Urgent care, gluten free prescribing, diabetes services, community health services, feedback on the Musculoskeletal Assessment and Treatment Service, IAPTs, Shared Decision Making, Parkinsons services, cancer care, Stroke care and transformation. We have also have ongoing, more general consultation about what people love and would improve about the care they receive.
- The CCG also involve patients and public in the ongoing contract monitoring through quality panels, patient stories and lessons learnt.
- We held out Annual Public Meeting in September, which was well attended and looked back on our year but also attempted to explain the pressures and opportunities through drama
- 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.

Communications

- We are using technology as an enabler for engagement and deliver patient information and services on a range of digital channels, including the CCG website, social media, regular e-bulletins via Mailchimp, an integrated healthcare App, Sky TV, Virgin TV, games consoles and social media.

- We are utilising social media much more as a way to engage with patients and deliver our messages. Our social media has grown over the last 12 months (from 200 – 1,000 followers on Twitter and most recently from 15 to 300 on Facebook). We also manage the NHS South Notts Facebook page, which we have grown from 0-1,200 followers from December - March 2015. We utilise these social media channels to push our messages out but also to allow people to engage with these messages, comment and feedback.
- We involve patients with the development of our communications campaigns, which this year have included Urgent Care, Choose Well, IAPT and Shared Decision Making.
- We have produced a quarterly Patient Participation Group newsletter – Connected – which provides one page of CCG engagement news and opportunities and is set up so the patient groups can use the template to fill in other pages to promote their engagement news at their practice – thus empowering and enabling patients.
- We deliver regular branded bulletins to the patients on our member databases to let them know about training and involvement opportunities and our local events.
- We publish evidence on our website on what activity has taken place and how the feedback has been used.
- We send out regular media releases to ensure that the public know about any involvement opportunities available and are kept up-to-date with CCG developments.

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

During 2014/2015 the CCG have implemented a number of projects, campaigns and service developments to deliver better outcomes for patients within our financial resources, the following are some of our achievements.

Diabetes and Education in Diabetes

During 2014/ 15, primary care staff from six practices completed the Year of Care training programme. The programme aims to improve care for diabetic patients by focusing on patient centered care planning and self-management. The training has demonstrated that where care planning and support for self-management are implemented there can be improvements for patients with regards to professional experience, care processes and clinical outcomes. All practices have signed up to complete the Year of Care Training Programme for 2015/2016.

Dementia

In March 2014, NHS England set a national target of 67% to ensure those patients who have dementia receive a formal diagnosis and access to support and NNE reached a target of 68%. All practices completed an exercise which resulted in 270 potential patients being identified for a dementia review and assessment. The CCG produced a comprehensive dementia communication plan to support practices in the identification process and provided information of a range of services that are available in the community.

Nottingham Musculoskeletal Assessment and Treatment Service

From February 2015 the service (for patients with more complex musculoskeletal conditions) has started to perform minor surgery for patients with carpal tunnel syndrome in a community setting this allows patients to have their assessment and surgery without going into hospital.

Care Home Community Model

The Care Home Community Model service is available to all registered residents in residential care homes across the NNE area. The model focuses on providing a proactive case management approach. The service started in June 2014 with the recruitment of three nurses covering the three localities. The objectives of the service is to reduce unplanned hospital attendances/admissions and the associated unnecessary distress to residents and their relatives. Patients in residential care settings have benefited from ward rounds, which identify residents of clinical concern and deteriorating health issues. In addition, holistic reviews have been undertaken on all new residents and those identified as being of concern. As a result, residents' physical and mental wellbeing is being supported and their life experience improved.

The care home team have developed good working relationships across the health community, having regular meetings with GPs, Community Geriatrician and Adult Social Care. Moreover, the team have engaged a number of care homes including those with high unplanned acute activities. Targeted training according to the needs of the care homes has been delivered to support care home staff to become competent and confident in managing the health of their residents.

Proactive Care Management

During 2014/15 NNE CCG had a 16% increase in patients aged 75 and older being admitted into hospital, over the past 12 months we have been working with our GP practices to analyse the increase and improve the quality of care and reduce the risk of emergency admission for this cohort of patients. Practices have been identifying those patients that are most at risk of admission and putting in place a care plan. Care plans are discussed and agreed with the patient and their carers (where applicable) to ensure that proactive management of care is provided and a management plan is in place should the patients' health deteriorate. Patient feedback of proactive case management has been very positive and will continue throughout 2015-2016.

Map of Medicine

The CCG has developed a number of clinical pathways that improve the patient experience, reduce waiting time and reduce costs by preventing avoidable readmissions. Clinical pathways are one of the main tools used by GPs to manage the quality in healthcare concerning the standardisation of care processes. These pathways promote organised and efficient patient care, based on evidence based practice. 2015/2016 will see the implementation of Map of Medicine that will support the clinicians to identify the most appropriate care pathway for their patients'. Clinicians will have instant access to locally customised pathways, centrally controlled referral forms and clinical information during a consultation allowing for detailed discussions to take place with the patient.

Medicines Management

Medicines Management Team is in place to ensure good quality, evidence based cost-effective prescribing and therefore acts as a resource for prescribers in order to implement processes and provide advice to improve prescribing.

In the last year this has included working with practices to implement the Royal College of GPs indicators which have been shown to reduce the risk of errors when prescribing. Many GP practices now have a Medicines Management Facilitator (MMF) in place who is a member of the practice's own staff. The role of the MMF is to implement processes within the practice which improve cost-effective prescribing.

The team is being proactive in providing care more those who are most vulnerable. A programme of education and medication use reviews has been developed with Gedling Homes in order that we can reach out individuals who are in sheltered accommodation. The programme is both for wardens and residents. Also the CCG has recruited a pharmacist whose role focuses on medication management within care homes.

Improving Outcomes for Children and Young People

Health services for children and young is supported by the work of the Children's Integrated Commissioning Hub, funded by CCGs, Public Health and Children's Services and hosted by Nottinghamshire County Council.

Mystery Shopper

The CCG has supported the development of the mystery shopper programme to assess services against accessibility and being young people friendly. Young people were trained to go under cover into primary care services and universal acute settings to assess services against the national 'you're welcome quality criteria'.

Child and Adolescent Mental Health Services Review

The CCG has been actively engaged in the review of child and adolescent mental health services (CAMHS) across Nottinghamshire. The review, led by the Integrated Commissioning Hub, has reported a range of strengths but has also identified significant challenges. A new service model has been developed and the CCG is working closely with the Integrated Commissioning Hub to agree implementation and investment plans for 2015/16.

Maternity Services Review

A joint review of NUH Maternity Services has been carried out by the Rushcliffe, Nottingham North and East, Nottingham West and Nottingham City CCGs. This has provided assurance regarding the quality of services locally, but has also identified areas for improvement. An implementation plan and steering groups has been established to drive the improvements.

Integrated Community Children and Young People's Healthcare Programme (ICCYPH)

The ICCYPH is integrating 14 services into 1 to improve the commissioning and delivery of services to children and young people with acute and additional health needs. The vision is to enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met wherever they are. The services will support the child's life choices rather than rather than restrict them and improve the quality of life for children and their families. Work to date has included a range of engagement with service users, providers and other stakeholders to co-produce outcomes and an integrated service specification. A new integrated service will be in place following the procurement as part of the community services tender by April 2016.

Strategic Objective 4: We will ensure robust governance arrangements

The CCG continues to work within robust governance arrangements and this has been demonstrated through the developments achieved during 2014/15. We are confident that our governance arrangements will support us in the challenges, trends and factors for 2015/16 namely transformational change, sustainable financial recovery, delegated authority of GP primary care, integration and partnership working and the management of the urgent care system as a health community.

During 2014/15 the CCG has achieved all key financial duties for the year, including remaining within revenue allocation, remaining within running cost target and planning for a reduction in spend of 10%, delivering our planned surplus and achieving our agreed year end cash balance.

The CCG was authorised to manage delegated authority of GP contracts. The CCG has established and implemented robust governance arrangements in order to ensure that conflicts of interest are managed effectively and processes are aligned to existing responsibilities. The CCG has established a Primary Care Commissioning Committee and a Primary Care working group to support decision making. The CCG has also established a close working relationship with NHS England and neighbouring CCGs in order to provide further learnings and assurance as well as achieving added value. The CCGs Constitution was also approved during 2014/15 with the relevant changes.

The CCGs robust governance arrangements have supported the alignment of the transformation programme. This is particularly important since the programme is being managed through twelve different organisations and has to adhere to their statutory responsibilities. During 2014/15 the Transformation Partnership have committed to the establishment and maintenance of robust accountability and governance arrangements for the Transformation Programme. This includes working together as a 'network of leaders' in a South Nottinghamshire Transformation Board which is the overarching strategic governing group for the programme.

The CCG's 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.

Public Sector Equality Duty and the Equality Act

During 2014/15 the CCG has enhanced on its decision making and business practices which directly support due regard to the Public Sector Equality Duty and the Equality Act. The following are steps that have been taken to eliminate discrimination, advance equality of opportunity and foster good relations.

The CCG have the following equality objectives which will be carried forward into 2015/16:

- Equality of opportunity - Improve staff equality monitoring data and use it to inform future succession planning processes
- Eliminate discrimination – Have due regard to the Workforce Race Equality Standard as a CCG and as part of the local health economy

- Foster good relations – Improve patient and public communication by taking into consideration the needs of protected characteristics and by improving information on how and when to use health care services
- Advance equality of opportunity – Improving an understanding of how individuals fare within primary care by expanding on our project to collect equality data through GP member practices
- Eliminate discrimination – Improve on the decision making process through effective use of Equality Impact Assessments
- Foster good relations – Enhance on engagement processes as a local health community by working closely with neighbouring CCGs and the Acute Trust to ensure a wider understanding of how protected characteristics fare against outcomes

Through the use of the Equality Delivery System (EDS) over the past three years, the CCG have continued to deliver against its action plan during 2014/15 and this will be taken forward into 2015/16. Working in partnership with neighbouring CCGs in south Nottinghamshire including NHS Rushcliffe CCG and NHS Nottingham West CCG a forum has been established to ensure accountability in advancing and mainstreaming equality and to make effective use of resources. The forum forms part of the overall governance structure as a sub-group of the Quality and Risk Committee, chaired by a Lay Member.

During 2014 creative thinking to align the patient journey through primary and secondary care resulted in an arguably unique commissioner-provider partnership between the CCGs and the main acute trust - Nottingham University Hospitals (NUH). This saw NUH's Head of Equality and Diversity seconded to provide strategic direction across the three south CCGs and aligned with NUH.

This partnership approach is unique and fundamentally different to the approach taken by most organisations for two key reasons. Firstly, it involves commissioners and a provider working together. Secondly, it enables equality and diversity as a discipline to really come to life as a reality, affecting the day-to-day work of NHS professionals, linking existing processes directly to the EDS2, enabling the EDS2 to become a living process, rather than just a table-top exercise.

Specific achievements during 2014/15 include:

- Signing up to the British Deaf Association British Sign Language Charter to improve services for deaf/ deafened and hard of hearing service users.
- A new Equality and Diversity policy
- The creation of an Equality and Trans* policy
- A new flexible working policy
- Effective recording of engagement linked to protected characteristic groups
- Improved equality data collection - GP practices taking part in a pilot scheme to collect patient equality monitoring data and surveying patients in the Emergency Department
- The implementation of Equality Engagement Surveys to ensure a balanced approach to patient engagement
- Being awarded the 'two ticks' positive about disability symbol by Jobcentre Plus to show commitment to employ, keep and develop the abilities of disabled staff.

The linking of engagement activities to the EDS2 grading and objective setting process, has enabled the partnership to gather a true perspective of how individuals fare and the thoughts, issues and priorities of people from protected characteristic and the Inclusion Health groups which undoubtedly would not have been achieved working as separate entities. Events such Nottinghamshire Pride, Caribbean Carnival, Muslim Women's Festival and Nottingham MELA have provided one-stop-shop opportunities to gather expert public and patient opinion on current service provision and delivery at the point of care.

Through this process, each organisation has learned the benefits of putting individual organisational issues aside and focusing more on patient and employee equality outcomes. By seeing similarities rather than differences, each organisation has been able to retain its' own principles, values and culture whilst still being able to fully contribute to the wider partnership goal of a joint approach to the EDS2 and principles of the NHS Constitution.

The Equality Delivery Scheme and Action Plan and the EDS2 Grading Report are published on the CCG's website including the objectives detailed above.

Strategic Objective 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. The CCG have actively engaged with local communities, agencies and partners and have developed a strong foundation for a truly local approach and commitment to its residents.

As highlighted in the section on Human Rights, the CCG has sponsored two community projects that directly support partnership working. The community projects have provided an opportunity to learn how health commissioning can work effectively with the police, local schools, district/borough councils, local groups, councillors and housing associations.

The CCG is an active member of the Community Safety Partnership which has further developed improved relationships with local agencies, including an alignment of priorities (see section on Communities). The CCG works closely with District and Borough Councils and has welcomed the opportunity to link resources on specific projects including warm homes, domestic violence, dementia, road gritting. NNE CCG is a member of both the Gedling Health Forum and Broxtowe Health Partnerships. During 2014/15 NNE has also welcomed the opportunity to work with Gedling Homes on a project to support their residents who are carers and to provide education and clinics on medicines management.

A major focus in relation to 2014/15 was the Better Care Fund. NNE CCG, alongside the other Nottinghamshire CCGs, has successfully developed plans, funding and governance arrangements for the Better Care Fund. Working in partnership with local authorities, CCGs, police, practices and citizens a vision and supporting plan has been achieved 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 Chief Officer of NNE is the executive lead for the Transformation programme and has dedicated considerable resource to the partnership and strengthening relationships. The Transformation Partnership outlined above has provided an ideal opportunity in 2014/15 to strengthen partnership working with our local provider partners in particular.

The CCG works closely with the Children's Integrated Commissioning Hub to ensure locally-commissioned services best meet the needs of children and young people in the NNE area. Considerable work has been undertaken to understand the needs of children with specialist needs, including extensive engagement with children, young people, and families. As a result, the Nottinghamshire Integrated Community Children and Young People's Healthcare Programme has been developed and will be procured during 15/16.

Strategic Objective 6: We will ensure strong and robust leadership

Our achievements during 2014/2015, continue to demonstrate our strong and robust leadership. Whilst 2014/15 has been a year of consolidation it has also been a year of building partnerships, contributing to the strength of the whole local health and social care community, managing a difficult financial position and amalgamating additional responsibilities.

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. During 2014/15 the Governing Body was demonstrably more confident in working both individually and collectively both internally and in partnership with the local health and social care economy. After experiencing two full years as a CCG and achieving a greater understanding of the complexities, the Governing Body are in a good position to translate the Five Year Forward View into local delivery and achievements.

Through its commitment to working in partnership and with local communities, alongside putting the patient at the centre and listening, the Chief Officer, Governing Body and in turn the executives demonstrate how organisational priorities align and fit with human rights.

During 2014/15 the CCG encouraged and supported employees and Governing Body members in achieving their full potential by providing a range of learning and development programmes, including gold membership in the East Midlands Leadership Academy. The CCG are also able to support employees with accredited management development programmes and NVQs through Gedling Borough Council. The CCG welcomed the organisational development opportunities provided by GEM commissioning support unit.

Key Performance Indicators

We worked hard throughout the year to meet the national targets that were set. Specific details of our performance during 2014/15 are as follows:

18 Weeks from Referral to Treatment

The patient right ‘to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer patients a range of alternative providers if this is not possible’ remains a key element of the NHS Constitution in England.

During 2014/15 we met or exceeded all the national targets for elective waiting times set by the Department of Health.

In the year to 31 March 2015:

- 95.02 per cent of admitted patients were treated within 18 weeks (national standard 90 per cent).
- 97.92 per cent of non-admitted patients were treated within 18 weeks (national standard 95 per cent).
- 92 patients waited more than six weeks for a diagnostics test, which is within the one per cent national tolerance.
- 97.79 per cent of patients who were still waiting for their treatment had been waiting less than 18 weeks (national standard 92 per cent).

Cancer

Achieving the national standards for cancer can lead to earlier diagnosis, enhanced patient experience and improved cancer outcomes.

In the year to 31 March 2015:

- 92.37 per cent of patients with suspected cancer were seen by a consultant within 14 days of referral by their GP (national standard 93 per cent).
- 97.65 per cent of patients received their first treatment within 31 days following a diagnosis of cancer (national standard 96 per cent).
- 86.80 per cent of patients diagnosed with cancer were treated within 62 days of a referral from their GP (national standard 85 per cent).

The CCG continues to work with hospitals to reduce the waiting times for patients in receiving their cancer treatment following diagnosis. Action plans are in place with major hospitals to:

- Streamline processes for patients
- Increase the numbers of clinical staff available to treat them.
- Reduce waiting times for diagnostic tests for patients suspected of having cancer
- Increase clinical capacity in anticipation of forthcoming Cancer campaigns
- Expedite patients referred for treatment into tertiary centres from other Trusts

Accident and Emergency

The national threshold for performance against this standard is that 95 per cent of patients should wait no more than four hours in Accident and Emergency from arrival to admission, transfer or discharge.

In the year to 31 Mach 2015:

- 86.60 per cent of patients were treated within four hours of attending Accident and Emergency (national standard 95 per cent).

The local health community has faced significant challenges in delivering the Emergency Department performance standard at Nottingham University Hospitals NHS Trust. We are continuing to work with the wider Nottingham health community to improve performance for our population. NHS England has put in place a programme to support all partners in the South Nottinghamshire locality and will continue to review the assurance level until a sustained period of delivery has been achieved. We recognise this remains a high priority going forward in 2015/6.

Ambulance – East Midlands Ambulance Service

In the year to 31 March 2015:

- 71.61 per cent of calls assigned as Red 1 (immediately life threatening cases where a defibrillator is required) were responded to within 8 minutes (national standard 75 per cent).
- 70.20 per cent of calls assigned as Red 2 (immediately life threatening cases) were responded to within 8 minutes (national standard 75 per cent).
- 70.28 per cent of all calls assigned as Red were responded to within 8 minutes (national standard 75 per cent).

Cancelled Elective Operations – Nottingham University Hospitals

In the year to 31 March 2015:

- 9 elective operations were cancelled for non-clinical reasons and not rebooked within 28 days (national standard is zero).

Dementia Diagnosis Rate

In April 2014, NHS Nottingham North & East CCG was required to submit dementia diagnosis rate targets, against which we will be monitored, as part of our formal planning submission to the NHS England. The diagnosis rate target for 2014/15 is 67%. This will enable the CCG to ascertain the Prime Minister's target of 2 thirds of the CCG's dementia prevalence number be identified by March 2015.

During March 2015:

- 62.26 per cent of patients estimated to have dementia within the CCG have been diagnosed as having dementia

Improving Access to Psychological Therapies (IAPT)

As part of NHS England's national programme on Parity of Esteem, we worked hard to meet the national ambition on IAPT. The aim was that by the end of March 2015, at least 15 per cent of people with anxiety or depression would have access to a clinically proven talking therapy service, and that those services would achieve 50 per cent recovery rates.In the quarter to 31 March 2015:

- 3.56 per cent of patients estimated to have depression and/or anxiety disorders within the CCG have received Psychological Therapies (National target is 3.75 per cent i.e. 15% by March 2015).
- 56.15 per cent of patients who have completed treatment are moving to recovery (national standard 50 per cent).

The recovery rate is the number of people who are moving to recovery, divided by the number of people who have completed treatment, minus the number of people who have completed treatment who were not at "caseness" at initial assessment. An individual is said to be at caseness when their outcome score exceeds the accepted threshold for a standardised measure of symptoms.

Risk Overview

What might challenge the delivery of our strategic objectives?

Table 5 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

Risk	Specific risks we face
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

Risk	Specific risks we face
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

Table 5

Our Future Developments

Operational Plans

The CCGs future developments planned or implemented during 2014/15 directly fit with the Five Year Forward View. Further information can be found in our Operational Plan. Details of how NNE will implement in the measures are below

Achieving Parity for Mental Health

There is a dedicated mental health commissioning team and a mental health clinical lead who work closely together, engaging with key stakeholders to strengthen local services.

In 2015/16 the CCG has planned:

- New investment in 111 mental health project, Personality Disorder Services, and CAMHS Eating Disorder Service
- 24/7 crisis care for adults established via service transformational change
- Joint working with Nottinghamshire Police to eradicate detentions in police cells for children and adults detained under section 136
- Physical health CQUIN building on developments in 14/15 to improve take-up of health screening to improve health outcomes
- Delivery and continued improvement of take-up of Primary Care Psychological Therapies

There are further developments planned, including:

- Improvement of the crisis care offer for children and young people
- Review of care pathways across clusters 1-4

Following a comprehensive assessment of need and a CAMHS pathway review during 2014-15, working with partner CCGs, the local authority, providers and other stakeholders, a new service model will be implemented in 2015/16.

Integral to the model is:

- Effective support for universal services to improve identification of children and young people with mental health problems
- The development of a 'One CAMHS' service with a single point of access to improve access to effective support and reduce waiting times
- Responsive rapid response and crisis care for young people
- In addition, there is planned additional investment in a specialist community CAMHS Eating Disorder Service in 2015/16.

Transforming Care of People with Learning Disabilities

The CCG will continue to ensure that people with a learning disability receive appropriate and regular assessment and are cared for in the most appropriate setting, and will look to commission services that enable them to remain in their community and close to friends and family.

Winterbourne/Transforming Care

A cross-agency Project Board is in place and will continue during 2015/16. Regular meetings take place to monitor progress and focus on any blockages. This group reports to the Integrated Commissioning Group which is a sub-group of the Health and Wellbeing Board. All individual care reviews have taken place and plans are in place to monitor progress towards discharge. A patient tracker is reviewed at each meeting; this details key milestones and is RAG rated. The Local Authority has secured additional funding for developing additional local accommodation.

Antibiotic Prescribing

Joint guidelines for antimicrobial prescribing have been developed across primary and secondary care.

The prescribing of antibiotics within practices will continue to be monitored on a quarterly basis during 2015/16. The following data is analysed:

- Total volume of antibiotics prescribed
- Volume of cephalasporins prescribed
- Volume of quinolones prescribed
- Volume of co-amoxiclav prescribed

Practices where excessive prescribing has occurred are contacted and their prescribing audited. These practices can then be supported through the medicines management team to review their prescribing where appropriate.

Better Care Fund

The Health and Wellbeing Board is responsible for developing, approving and delivering plans associated with the Better Care Fund (BCF). The BCF was announced in June 2013 within the Government's spending review. It was described as creating a national £3.8 billion pool of NHS and local authority monies intended to support an increase in the scale and pace of integration and promote joint planning for the sustainability of local health and care economies. The fund is 'a single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities'.

A better care fund plan has been developed between the following parties:

- NHS Nottingham North and East CCG
- Nottinghamshire County Council
- NHS Bassetlaw CCG
- NHS Mansfield and Ashfield CCG
- NHS Newark and Sherwood CCG
- NHS Nottingham West CCG
- NHS Rushcliffe CCG

The Nottinghamshire Better Care Fund plan was signed off by NHS England as "Approved" in December 2014 following further work to provide assurance around programme governance in relation to monitoring and delivery of the plan.

The Better Care Fund will:

- Provide an opportunity to transform care so that people are provided with better integrated care and support
- Help deal with demographic pressures in adult social care
- Assist in taking the integration agenda forward at scale
- Support a significant expansion in care in community settings.

The pooled budget is managed under a section 75 agreement between the above parties which was signed on 31 March 2015. The pooled budget will be hosted by Nottinghamshire County Council.

A governance structure is in place for monthly reporting of delivery of the BCF Plan against performance metrics, scheme delivery, risk register and financial expenditure and savings.

The schemes funded by the partner organisations;

- Seven day working
- GP access
- Community care coordination
- Support for carers
- Reablement/rehabilitation services
- Transformation programme
- Protecting social care services

In 2015 Nottinghamshire County was announced as a Wave 2 Pioneer site, one of eleven areas to join the existing fourteen sites in the national Pioneer programme. The pioneer covers Nottinghamshire County Council, the two Mid Notts CCGs and the three CCGs in the south of the County. Pioneer status recognises the innovative and transformational work that has already been undertaken within the region to develop integrated services improving outcomes for the population. As a pioneer, Nottinghamshire will have access to tailored support to implement our plans including system leadership, freedoms to develop new commissioning models and flexibilities with information sharing between partner agencies.

Primary Care Co-commissioning

From 1 April 2015 NNE CCG has been approved to take on Level 3 delegated responsibility for NHS England-specified general medical care commissioning functions.

The CCG's vision and strategy for general practice is to deliver equitable, high quality, efficient and accessible primary care services that are clinically effective and patient-centred.

The CCG believes that co-commissioning under delegated arrangements will facilitate improved performance, access and quality in primary care, and enable primary care commissioning to be more responsive and sensitive to local needs and priorities. The opportunity to commission locally sensitive services, rather than nationally specified enhanced services is therefore particularly appealing.

In addition, co-commissioning will strengthen the CCG's ability to deliver whole system integration of services and implement alternative models such as an Accountable Care Organisation, a Multispecialty Community Provider or Prime Provider/Primary & Acute Service. More specifically, co-commissioning will enable the CCG to work with its member practices as providers, to explore, develop, and implement new ways of working both within and between practices, to ensure the sustainability of general practice so that it can continue to support patients in the context of increasing demand and limited resources.

In respect of the intended benefits to patients, co-commissioning will support the CCG to:

- Develop new models within primary care that provide more proactive, holistic and responsive services for the local population, particularly for frail older people and those with complex health needs
- Ensure services are 'wrapped around the patient', patient-centred and delivered in an integrated manner integrate/federate general practice and improve collaborative working across the whole health care system in order to ensure patient care is delivered in a 'joined up' manner improve quality in general practice to ensure patients have the best possible experience of care

- Reduce unwarranted clinical variation between practices in the CCG
- Reduce unwarranted variation between practices in terms of health outcomes for patients
- Develop systems, processes and pathways that empower patients (and their carers) to take more control of their care through self-management
- Ensure patients and carers are more fully involved in the development of primary care services
- Reduce health inequalities
- Promote healthy lifestyles, well-being and independence
- Maximise the use of existing and new technology systems to support information sharing, and improved co-ordination of patient care
- Reduce the number of avoidable hospital attendances and emergency admissions.

Transformation

NNE are part of the South Nottinghamshire Transformation Partnership which includes membership from commissioners and providers of health with the aim to work in partnership to transform services, to deliver improved health and wellbeing for the citizens they serve by creating sustainable, high quality health and social care system for everyone through new ways of work together, improving communication and finding better ways of using the resources entrusted in them in combination.

During 2014/2015, the partner organisations have specifically been coming together to improve the urgent care system, with a focus on:

- Ensuring citizens get timely access to care and don't have long waits in the local Nottingham University Hospitals NHS Trust Emergency Department
- Ensuring service users are only cared for in a hospital setting if this is appropriate for their needs.

Work will continue during 2015/2016 on the following priorities:

- Developing effective collaborative working arrangements.
- Developing a new system based on the accountable care philosophy;
- Optimising and improving the current system

Urgent Care

Our growing population and ageing population has meant that here is a continued increase in demand on ours services and we must ensure that we continue to deliver high quality care whilst meeting our financial obligations.

NHS urgent and emergency care services provide life-saving care for patients who need medical help quickly or perhaps unexpectedly. However, with our A&E departments under increasing pressure, we need to change behaviours and look at alternative ways people can get urgent care in the community. By urgent care, we mean everything from pharmacies, same day GP appointments and GP weekend and evening appointments to accessing out of hours health services (delivered in Nottingham by NEMS – Nottingham Emergency Medical Services – calling NHS 111, walk in centres and A&E (A&E provides urgent care but should be used in emergencies only).

Research

The CCG is a member of the East Midlands Clinical Research Network and is aware of its statutory responsibilities in this area and for example, together with partner CCGs in Nottinghamshire, has a process for considering and approving Excess Treatment Costs (ETCs). Throughout 2015/16 the CCG will continue to support research, in particularly looking at opportunities to develop research capacity and capability in primary care. As at the end of Quarter 3 2014/15 1919 patients had been recruited to participate across 15 new research projects across the Nottinghamshire CCGs. This is a significant increase on previous years and evidences the commitment of the CCG member practices to on-going participation in research. Research has taken place in areas such as Dementia, Medicines Management and Musculoskeletal Disorders.

Financial Plans

The CCG's financial plans for 2015/16 and beyond seek to fulfil the broader strategic objectives, whilst retaining a sound financial position. NNE CCG will receive 4.71% growth in 2015/16 and the CCG's financial plan delivers all recurrent outturn pressures. In addition the CCG's long-term financial strategy:-

- Plans to make a 1% recurrent surplus each year from 2015/16 onwards.
- Sets aside a 1% recurrent Transformational Reserve which will be used on a non-recurrent basis, therefore planning to have a recurrent underlying surplus of 2%.
- Provides for a non-recurrent contingency of 0.5%.
- Plans to remain within the CCG's Running Cost Allocation.
- Sets aside a risk reserve each year which will mitigate against any contract/in-year risks.

Transformational Fund

The 1% non-recurrent Transformational Fund will be invested in-year, together with the re-admissions and Marginal Rate Emergency Tariff (MRET) resources. The CCG will continue to invest in a strategic manner including the continuation of QIPP pump priming, primary care developments, community care beds and home care investment. Investments will focus on increasing community support provision to enable reduced inappropriate acute admissions and stays to support the achievement of the CCG's objectives.

Better Care Fund

The Better Care Fund (BCF) will become a pooled budget in 2015/16 (NNE's required level of investment is £9.1m) which brings together local NHS organisations with Local Government and provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses funding to redefine the resource mix between acute sector services and services in the community and preventative setting. The BCF initiative therefore provides an opportunity to support the reconfiguration of local healthcare provision over the coming years and exists within the context of tight financial pressures for both health and local government.

Mental Health

In line with parity of esteem and the 2015/16 planning guidance, Nottingham North & East CCG is planning real-term increases in Mental Health spend in line with the CCG's overall real term funding increase.

Quality, Innovation, Productivity and Prevention (QIPP)

During 2015/16 the CCG will need to meet an increased Quality, Innovation, Productivity and Prevention (QIPP) target of £7.1m (4% of expenditure) in order to ensure a stable underlying financial position is maintained. The CCG has developed robust recurrent QIPP plans for 2015/16 which will be closely scrutinised by the Service Improvement Group. The QIPP schemes are all recurrent and the intention to have all planned schemes operational by 01st April 2015 to ensure maximum delivery of savings. There are a large number of schemes but many are common across the South Nottinghamshire CCGs in line with the strategic footprint of healthcare provision.

Risk

The main risks to the delivery of the 2015/16 plan remain the delivery of the challenging QIPP target including the delivery of non-elective savings from the BCF investment and the containment of the Continuing Healthcare Provision spend in line with plans. The risk in terms of the BCF investment is that the majority of the CCG's QIPP will need to be delivered from the investment in the Better Care Fund (BCF) as the Transformational Fund is reduced in 2015/16. Key risks to the financial plan will continue to be acute spend (for both NHS and non NHS providers), continuing healthcare costs and prescribing. Acute spend linked to winter pressures remains a particular risk. Prescribing costs have been successfully managed over the past few years, delivering relatively large QIPP savings however the scope for such savings has, however, been diminishing over the past 12 months. The plan aims to deliver all key financial duties of the CCG

Signature of the Chief Officer

I certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the NHS Act 2006 (as amended). Signed on behalf of Sam Walters, Chief Officer

Sharon Pickett, Deputy Chief Officer

Signature: S Pickett

Date: 27 May 2015

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

The Governance Structure

The Governing Body has responsibility for ensuing that the Clinical Commissioning Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Clinical Commissioning Groups principles of good governance.

Throughout 2014/2015 our Clinical Lead and Chair was Dr Paul Oliver and our Chief Officer was Sam Walters.

The following is a diagram of the governance structure and committees of 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.

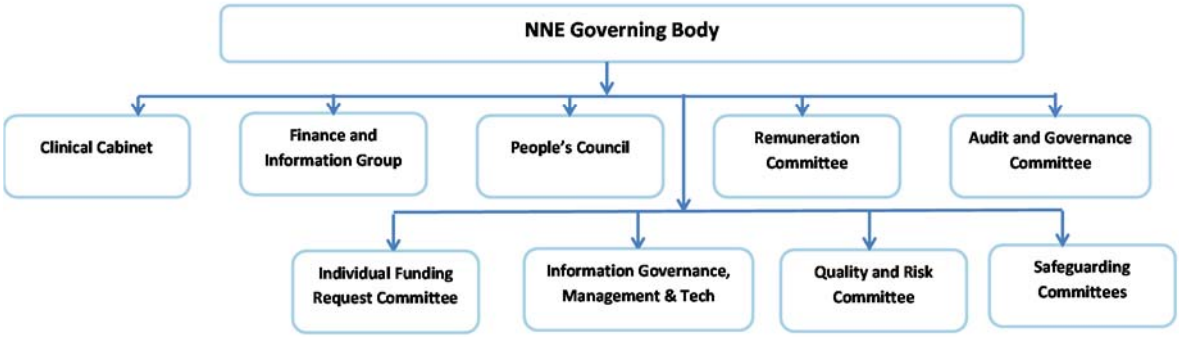


Image 3

The Governing Body

The Governing Body membership – 2014/2015

Dr Paul Oliver	Chair
Sam Walters	Chief Officer
Dr Paramijit Panesar	Assistant Clinical Chair
Jonathan Bemrose	Chief Finance Officer
Dr James Hopkinson	GP Member
Adrian Kennedy	Allied Health Professional Member
Nichola Brammhall	Registered Nurse
Dr Mohammed Al-Uzri	Secondary Care Doctor
Mike Wilkins	Lay Member – Patient and Public Involvement
Terry Allen	Lay Member – Finance and Governance
Caroline Baria	Observer
Stephen Storr	Observer

Table 6

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.

The Governing Body has been effective in discharging the functions of the CCG. 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.

Governing Body Member Biographies

Dr Paul Oliver – Clinical Lead

Dr Oliver is the Chair of the Governing Body and Clinical Lead for Nottingham North and East Clinical Commissioning Group. 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.

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.

Sam Walters – Chief Officer

Sam, a qualified physicist, joined the NHS in 1992 from the private sector. During her career, Sam has held positions in a wide range of disciplines including public health, finance and community nursing management, as well as senior roles in primary care commissioning and leading one of the country's largest cancer networks.

In her previous role as Executive Director of Strategy and Governance 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 working with local people to design health services for local people. She applies her knowledge, expertise and vision to help deliver innovative health solutions to our local communities. Her overriding passion is to gather patient experience and stories and use them to make positive changes to the NHS.

Sam is also a keen outdoors enthusiast, enjoying climbing, hiking, skiing, windsurfing, running and indulging in the occasional extreme obstacle course race.

Dr Parm Panesar – Assistant Clinical Chair

Dr Paramjit Singh Panesar trained at the University of Birmingham Medical School and has been working within the NHS for 15 years. He graduated from the Nottingham GP training scheme and became a GP in 2004. He also become a member of The Royal College of General Practitioners with Merit in 2004 (MRCGPm) and holds a diploma with Royal College of Obstetricians and Gynaecologists (DRCOG). At the end of training he developed his own innovate training post for 6 months within Soft Tissue Medicine and Rheumatology.

In 2006, along with colleagues he successfully won a competitive tender run by Gedling PCT for a local practice and became one of the founders and a senior partner at The Ivy Medical Group in Burton Joyce. Since then he has contributed, as senior partner, to the development of the practice into a clinically highly performing practice and an engaged member of the commissioning group. He is also completing his Post Graduate Certificate in Medical Education (PGCME) and will be developing GP training at the practice as a trainer. Clinically, Dr Panesar has a keen interest and experience within Rheumatology and Cardiology.

Dr Panesar joined the NNE Governing body in October 2011 and is passionate about Commissioning and opportunities to improve quality of care for patients by redesigning pathways and promoting innovation. During his time with NNE Dr Panesar has provided leadership and implemented successful initiatives within planned care and diabetes as well holding the position of innovation lead and sitting on the Audit and Governance committee. He also has a keen interest in primary care development and collaborative working. He has completed training within medical leadership and international Health and Social Care Leadership. Over the past year he has also taken up the position of Deputy Clinical Lead/Chair for NNE.

Jonathan Bemrose – Chief Finance Officer

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 roles include; Director of Resources for Nottingham CityCare Partnership where he was responsible for finance, workforce, training, organisational development, support services, estates and IT, Finance Manager at Nottingham Emergency Medical Services (NEMS) which provided him with additional business exposure and experience and Deputy Director of Finance for NHS Nottingham City Primary Care Trust.

Dr James Hopkinson – GP 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.

Adrian Kennedy – Allied Health Professional Member (Pharmacist)

Adrian joined the NNE Governing Body in October 2011 and has been a practice Pharmacist at Calverton Medical Practice for 7 years

His previous roles include a Pharmacy Superintendent, a Business Development Manager for a large healthcare provider, consultancy support to Nottingham North and East Consortium Practice Based Commissioning, Community Pharmacy Manager and a Professional Executive Committee member for Gedling Primary Care Trust.

Terry Allen – Lay Member, Finance and Governance

Terry 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.

Previous roles 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.

Nichola Bramhall – Registered Nurse, Director of Nursing and Quality

Nichola joined us in September 2014 from East Midlands Ambulance Service where she was Deputy Director of Nursing and Quality for two and a half years. Prior to this Nichola was Deputy Director of Nursing at Chesterfield Royal Hospital where she worked for eleven years in a number of roles including Clinical Teacher, Head of Workforce Review and Head of Nursing.

Nichola trained at Guy's and Lewisham School of Nursing, qualifying as a Registered General Nurse in 1991. After qualifying she worked at Lewisham, Dulwich and King's College Hospitals holding a number of roles including Ward Sister and Vascular Clinical Nurse Specialist until relocating to the Nottingham area in 2000. During this time Nichola obtained a BA (HONS) in Nurse Education and also qualified as a Registered Nurse Teacher.

Nichola is the Governing Body Registered Nurse and leads the quality team who have responsibility for monitoring the quality (including patient safety, experience and outcomes) of commissioned services for all three of the South Nottingham CCGs. Nichola is the executive lead for Patient Safety and Experience, Safeguarding, Infection Prevention and Control, Continuing Health Care, Nursing and Health and Safety. She is also Caldicott Guardian.

Dr Mohammed Al-Uzri – Secondary Care Consultant

Dr Al-Uzri joined the Governing Body in August 2012 and 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.

Mike Wilkins – Lay Member, Patient and Public Involvement

Mike Wilkins has been a member on the Governing Body since October 2011. He was initially recruited as a Non-Executive Director and now holds 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 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.

Caroline Baria – Observer, Service Director – Nottinghamshire County Council

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 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.

Stephen Storr – Observer, Patient and Public Representative

Stephen 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 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 customer at all levels were paramount.

Stephen 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.

Audit and Governance Committee

The Audit Committee is established in accordance with NNE Clinical Commissioning Group's constitution. The committee is a non-executive committee of the Governing Body and has no executive powers, other than those delegated in the terms of reference.

The committee consists of all the Lay Members of the clinical commissioning group. The Lay Member on the Governing Body, with a lead role in overseeing key elements of financial management and audit, will chair the Audit Committee.

The Audit and Governance Membership throughout 2014/ 2015 were:

- Terry Allen: Lay Member – Financial Management & Audit
- Mike Wilkins: Lay Member – Patient & Public Engagement

Membership may also be drawn from other Governing Body members.

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

Financial reporting

The Committee monitors the integrity of the financial statements of the CCG and any formal announcements relating to the CCGs' financial performance. It ensures 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 has reviewed the annual report and financial statements before submission to the CCG Governing Body.

Internal control and risk

The committee reviews 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.

Remuneration Committee

Please see the Remuneration Report for details of the membership of the Remuneration Committee, and the Governance Statement for details of and membership of all other Governing Body and Membership Body Committees.

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 themselves aware of any relevant audit information and to establish that the CCGs auditor is aware of that information.

Pension Liabilities

For information about how pension liabilities are treated in the accounts and statements on the relevant pension scheme(s) please see accounting policy note 1.9 Employee Benefits and the remuneration report further on in this report.

Director/ Members Interests

NNE is responsible for the stewardship of significant public resources when making decisions about the commissioning health and social care services. In order to ensure and evidence that these decisions secure the best possible services for the population it serves, the CCG must demonstrate accountability to relevant stakeholders, probity and transparency in the decision making process. This will become even more important where CCGs become involved in delegated co-commissioning.

A key element of this assurance involves management of conflicts of interest with respect to any decisions made. Although such conflicts of interest are inevitable, having processes to appropriately identify and manage them is essential to maintain the integrity of the NHS commissioning system and protect the CCG, its employees, its Governing Body and associated GP practices for allegations and perceptions of wrong-doing.

NNE actively maintains a conflicts of interest register which is publically available on the NNE website and can be provided upon request.

External Auditors Remuneration

Our external auditors are KPMG. During 2014/15, 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 2014/15 was £72,000 in respect of the completion of the statutory audit work.

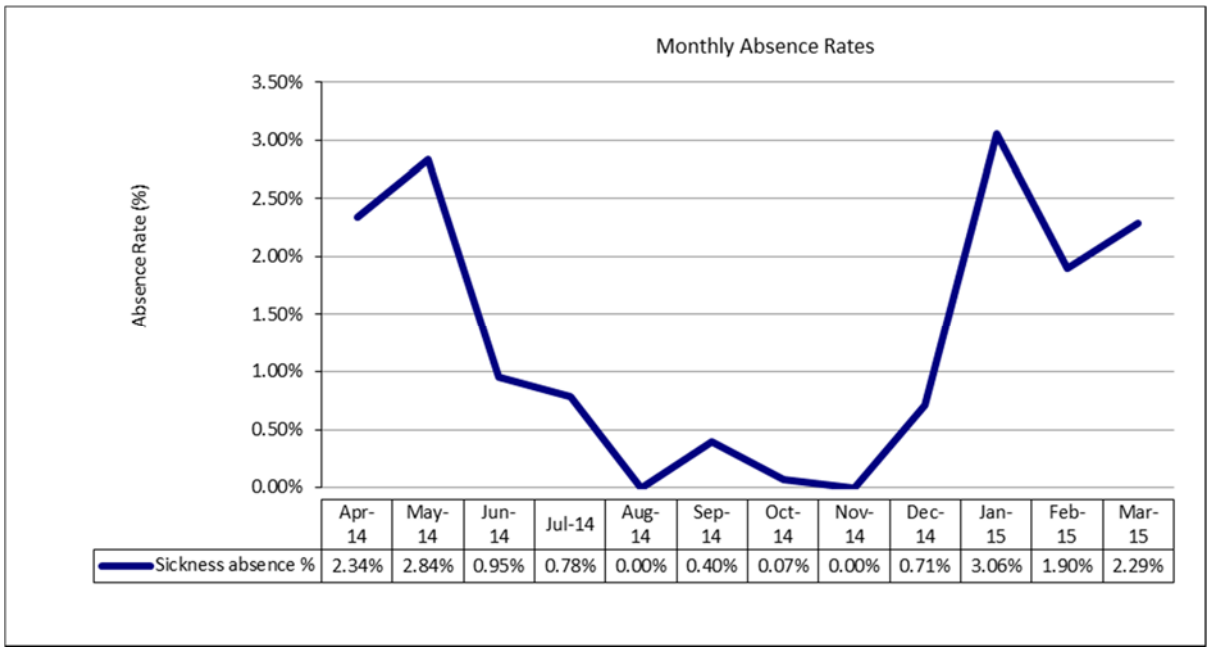
Political and Charitable Donations

We did not make any political or charitable donations from our exchequer during 2014/15.

Sickness Absence Data

Sickness absence can be problematic for small organisations as it is more difficult to cover the absence of key individuals or disseminate the work between teams.

The graph below provides details of the CCGs monthly absence rates for the period April 2014 to March 2015.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Sickness absence %	2.34%	2.84%	0.95%	0.78%	0.00%	0.40%	0.07%	0.00%	0.71%	3.06%	1.90%	2.29%

Graph: 4

The CCGs monthly absence rate demonstrates a generally decreasing pattern of sickness absence. Rises in absence rates are expected over the winter mother due to seasonal illness.

The CCG's sickness absence of 1.28% is much lower than the national average for Infrastructure support staff (which includes clerical, estates and managerial staff) that had a sickness absence rate of 3.58 in 2013/2014 (*data from HSCIC).*

The staff sickness and ill health retirements for the Nottinghamshire County Clinical Commissioning Groups as a collective are detailed in the table below.

	2013/2014	2014/2015
Total Days Lost	974	702
Total Staff Years	292	156
Average working Days Lost	3.34	4.50

Table 7

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.

Cost Allocation and Charges for Information

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

Disclosure of Personal Data Related Incidents

NHS Nottingham North and East CCG are committed to reporting, managing and investing 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.

During 2014/2015 there have been no disclosure of personal data related incidents recorded.

Employee Consultations

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, Internet and Email

The CCG's website and internet are both used to share information both within the CCG and further afield. The internet incorporates a GP portal section with hosts information and documents specifically aimed at our GPs. All important information is also emailed to employees.

Staff Survey

An annual staff survey is also undertaken to ensure that our employees have the opportunity to provide an anonymous opinion of how they feel the CCG treat their staff. The CCG encourage participation and take on board the results to improve relationships.

Equality Disclosures

The CCG has an Equality and Diversity Policy that includes disabled employees and the CCGs commitment to equal opportunities. The Policy sets out how the CCG will meet the statutory duties which it views as crucial to the success of the CCG as a developing and dynamic organisation. It will achieve delivery of the duties by:

- ensuring all employees, volunteers, patients, service users and lay members understand their own responsibilities for working towards an equal and diverse community
- ensuring the CCG's commitment to equality and diversity is strongly visible to all who engage with the CCG at all levels; and
- outlining the framework for promoting the equality and diversity agenda within the CCG

The CCG aspires to be representative of all the communities it serves and takes pride in being an equal opportunities employer, opposing all forms of unfair or unlawful discrimination. Accordingly it is the CCG policy that no employee or job applicant receives less favourable treatment on the grounds of his or her gender, religion and belief, age, disability, race, gender reassignment, marriage and civil partnership, pregnancy and maternity or sexual orientation (the nine protected characteristics). This is achieved through inclusive and transparent recruitment and selection processes for short-listing and interviewing.

The CCG recognises the mutual benefits to both the organisation and its employees with regard to the implementation of flexible working. The CCG has a Flexible Working Policy offering several ways of working flexibly, including part-time working, job share, annual hours, flexible working time, flexible location and flexible retirement.

The CCG Mandatory Training Policy identifies the need for all staff to complete equality and diversity training every three years. The CCG has 100% compliance for this training achieved largely through e-learning. Governing Body and Patient Cabinet members completed their training through a tailored face to face training session. In addition, members of the Active Group (chairs of all GP Practices' patient participation groups) were invited to attend the Equality Conference in February 2015.

NNE CCG will continue to adhere to the Brown's Principles below;

- Decision maker must be aware of their duty to have a 'due regard'
- 'Due regard' must be fulfilled before and at the time a particular decision is considered
- The duty must be exercised in substance, with rigour and an open mind
- The duty is non delegable
- The duty is a continuing one; and
- It is good practice to keep an adequate record showing the duty has been considered

Health and Safety

The CCG has established a shared Health and Safety sub-group of the Quality and Risk Committee with NHS Nottingham West and NHS Nottingham North and East to co-ordinate activities required for each CCG to comply with the Health and Safety Act 1974 and other statutory provisions; and to provide a healthy and safe environment for all people who work in, use or visit their premises.

The CCG has a Governing Body approved Health and Safety Policy and a procedure for reporting incidents and near misses which includes RIDDOR requirements.

Over the last year the sub-group has continued to review and re-write health and safety policies relevant for CCGs and has approved the following policies:

- Working with Display Screen Equipment (DSE)
- Young Persons at Work
- New and Expectant Mothers

The group also monitors the mandatory training uptake figures for Health and Safety and Fire Safety which were 91% and 93% respectively. Each CCG has an IOSH trained health and safety lead who promotes training, reporting of incidents and undertakes risk assessments.

Over the last year, there have been no incidents have been reported.

The CCGs work closely with NHS Property Services and receive a quarterly building compliance report which identifies the status of all health and safety requirements and any high risk areas.

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.

In accordance with its constitutional framework, the clinical commissioning group is required to have adequate arrangements in place for countering fraud, corruption and bribery. The CCG has produced a fraud, bribery and corruption risk assessment and developed a Work plan across 4 areas of work:

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

Counter Fraud reports are received at Audit Committees. These reports inform the Committee of the work carried out by the Counter Fraud Specialist (CFS) and provide an update of progress against the Work plan.

Staff have received Counter Fraud training via presentations and eLearning and Counter Fraud surveys are regularly conducted, the results of which form an action plan which is considered when developing the Clinical Commissioning Group's Counter Fraud Risk Assessment and Work plan. Regular bulletins are issued to staff which raise awareness, vigilance and reporting and the CFS reviews policy and process to ensure adequate preventative measures are in place.

Better Payments Practice Code

The Better Payment Practice Code requires the Clinical Commissioning Group to aim to 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 2014/15 financial year, we achieved all four targets in this area as summarised below:

2014/15 Better Payment Practice Code Performance	NHS	Non NHS
Value	99.51%	99.59%
Volume	98.56%	98.75%

Table: 8

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.

Emergency Preparedness, Resilience and Response

The CCG is a Category 2 responder for major incidents and is therefore not required statutorily to have major incident plans in place, however. In the event of a major incident, the CCG would support NHS England as Category 1 responders and work with them to implement the shared incident response plan for which they hold responsibility for the local health community.

During 2014/15, core standards for EPRR were developed nationally. NHS England required all relevant organisations to complete a RAG (red, amber, green) rated self-assessment against the standards. A statement of compliance approved by the Governing Body confirmed the CCG's responsibility in emergency planning and that the necessary processes and infrastructure were in place in relation to the core standards of a Category 2 responder.

In October 2014, as part of the annual assurance process for EPRR Category 1 and 2 responders, the CCG took part in a confirm and challenge meeting which examined the plans and arrangements put in place to provide assurance that the CCG was able to respond appropriately.

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.

Business Continuity

The CCG has its own business continuity plans which would be enacted in the event of any incident that impacted on the day to day running of the organisation. The CCG conducted a Business Continuity Plan exercise in October 2014 to test the plan by simulating a disruption caused by access denial to the work area or utility failure as set out in the Business Continuity Plan. An audit tool was developed to test the information in the plan and that appropriate procedures were in place. The exercise and review highlighted that the Rushcliffe CCG Business Continuity Plan was fit for purpose and would be effective in the event of a disruption. Some minor changes were identified and improvements to communication with other buidling users would be improved.

The Governing Body noted the conclusions from the exercise and approved the CCG's Business Continuity Plan at its meeting in March 2015.

Principles for Remedy

The Parliamentary and Health Service Ombudsman (PHSO) have produced guidance on how public bodies provide remedies for injustice or hardship resulting from their maladministration or poor service. The six 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 of 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 organisations 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.

Exit packages and severance payments

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 2014/15 for Nottingham North & East CCG.

Off payroll engagements

Following the *Review of Tax Arrangements of Public Sector Appointees* published by the Chief Secretary to the Treasury on 23 May 2012 Clinical Commissioning Groups must publish information on their highly paid and/or senior off-payroll engagements.

Name of Supplier	Date	Rate per Day £	Total £	Number of Invoices
Hewitt Communications	Sept 2014 – Mar 2015	396.00	27,477.00	7
Mike Farrar Consulting Ltd	Sept 2014 – Mar 2015	1,250.00	9,523.08	5
Parasol Ltd	Apr 2014 – Nov 2014	*280	26,754.00	7

*£35 per hr based on 8 hrs per day

Table: 9

Signature of the Chief Officer

I certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the NHS Act 2006 (as amended). Signed on behalf of Sam Walters, Chief Officer.

Sharon Pickett, Deputy Chief Officer

Signature: S Pickett

Date: 27 May 2015

Remuneration Report

As Accountable officer, I have reviewed the definition of 'Senior Manager' and can confirm that this covers the members of the Governing Body only.

Remuneration Committee Report (not subject to audit)

NNE CCG has established a Remuneration Committee which is a key committee of the Governing Body. The Committee has delegated responsibility to review and set the remuneration and terms of service of the Directors. The committee which comprises of Lay Members met twice during the year and attendance is detailed in the table below:

During 2014/2015 the following people were members of the Remuneration Committee

Name	Committee Role	Possible	Actual
Terry Allen	Lay Member Chair	2	2
Mike Wilkins	Lay Member Patient & Public Involvement	2	2
In Attendance			
Jonathan Bemrose	Chief Finance Officer	2	1
Hazel Buchanan	Director of Operations	2	2

Table: 10

Remuneration of Senior Managers

The definition of "Senior Mangers" is:

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

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 staff members including Senior Managers are required to undertake an annual appraisal to discuss their role and performance and consider any personal development and whether they have any particular career aspirations that the CCG may be able to support.

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 2014/15 financial year.

Salaries and Allowances (subject to audit)

Name	Title	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Bonus payments (bands of £5,000) £000	Benefits in kind (rounded to the nearest £00) £00
Terry Allen	Lay Member – Financial Management and Audit	10-15	-	-	-
Samantha Walters	Chief Officer	100 - 105	-	-	-
Jonathan Bemrose	Chief Finance Officer	40 - 45	-	-	-
Nichola Bramhall (From Sept 2014)	Director of Nursing and Quality	15 - 20	-	-	-
Dr Paramjit Panesar	Assistant Clinical Chair – Governing Body	40 - 45	-	-	-
Dr James Hopkinson	GP Representative – Governing Body	20 - 25	-	-	-
Dr Paul Oliver	GP Clinical Lead/Chair	90 - 95	-	-	-
Adrian Kennedy	Allied Healthcare Professional Representative – Governing Body	5 - 10	-	-	-
Mike Wilkins	Lay Member Patient and Public Involvement	10 - 15	-	-	-
Dr Mohammed Al-Uzri	Secondary Care Doctor – Governing Body	5 - 10	-	-	-

Table: 11

The salaries of the Members below were allocated over a number of CCGs. The allocation to Nottingham North And East Clinical Commissioning Group is shown above. Their total remuneration is shown below:

Name	Title	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Bonus payments (bands of £5,000) £000	Benefits in kind (rounded to the nearest £00) £00
Jonathan Bemrose	Chief Finance Officer	95 - 100	-	-	-
Nichola Bramhall*	Director of Nursing and Quality	40 - 45	-	-	-

*Nichola Bramhall started post 30th September 2014

Table: 12

Pension Benefits (subject to audit)

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
Jonathan Bemrose	2.0-2.5	5.0-7.5	35-40	105-110	584	527	57	14
Samantha Walters	0-2.5	2.5-5.0	25-30	75-80	428	395	33	15
Nichola Bramhall*	5.0-7.5	15.0-17.5	25-30	80-85	448	353	95	6
Adrian Kennedy	2.5-5.0	10.0-12.5	10-15	20-24	149	71	78	0

*Nichola Bramhall started post 30th September 2014 Table: 13

As Lay (Non-Executive) Members do not receive pensionable remuneration, 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

The Government Actuary Department factors for the calculation of Cash Equivalent Transfer Values (CETVs) assume that benefits are indexed in line with the Consumer Prices Index which is expected to be lower than the Retail Prices Index which was used previously and hence will tend to produce lower transfer values.

We have used CETVs provided by NHS Pensions. The CETVs have been calculated using different actuarial factors (provided by the Government Actuary's Department) at the beginning and the end of the period. This is contrary to guidance provided in the NHS Manual for Accounts, which states that common market factors should be used at the beginning and end of the period.

Pay Multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in the financial year 2014/15 was £105-110k. This was 2.90 times the median remuneration of the workforce, which was £37,921.

'The figure used for the highest paid member of the Governing Body in NNE CCG in the financial year 2014/15 is not consistent with the previous year as there was an error in the prior year whereby a GP's pro-rated salary was used instead of the figure for the highest paid executive director.'

In 2014/15 no employee received remuneration in excess of the highest paid director. 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.

Relationship between the remuneration report and exit packages, severance payments and off-payroll engagements disclosures

There have been no exit packages or severance payments during 2014/2015, details of our off-payroll engagements can be found in the Members Report.

Statement of the Accountable Officers Responsibilities

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

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

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

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

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

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

Signature of the Chief Officer

I certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the NHS Act 2006 (as amended). Signed on behalf of Sam Walters, Chief Officer.

Sharon Pickett, Deputy Chief Officer

Signature: S Pickett

Date: 27 May 2015

Annual Governance Statement

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

Introduction and Context

As at 1 April 2014, the clinical commissioning group was licensed without conditions.

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.

NHS Nottingham North and East CCG is one of seven Clinical Commissioning Groups in Nottinghamshire, including Nottingham City and Bassetlaw. The CCG is made up of 21 GP practices covering a population of approximately 149,000, organised collectively to commission health services for the patient population living in Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield, and Newthorpe

Scope of responsibility

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

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. Also in order to ensure capability and capacity, I work closely neighbouring Nottinghamshire CCGs, as part of the unit of planning and also to ensure efficiencies and effectiveness through the shared resources. NNE CCG had a revenue resource of £169.8 million for 2014/15 and a workforce of 55, equating to 46.48 whole time equivalent staff.

Compliance with the Corporate Governance Code

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

The detailed findings have been reviewed by the CCG's internal auditors and have been reported in the governance review audit which is part of this year's internal audit plan. This was reported to the Audit Committee in March 2015 and will be reported to the Governing Body as part of the Committee's annual report.

Whilst the report made some recommendations, it can be confirmed that for the financial year ended 31 March 2015, and up to the date of signing this statement there were no departures from the provisions of the UK Corporate Governance Code.

The Clinical Commissioning Group Governance Framework

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

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

The CCG governance framework has remained robust during 2014/15 ensuring that the CCG delivered its functions and duties with the Governing Body collectively taking responsibility for the long-term success of the CCG. As well as the CCG progressing as a statutory body, during 2014/15 the robustness of the governance framework has also been challenged through the capability to support the wider health and social care economy and system, in particular the advancement of the unit of planning, transformation and the introduction of the five year forward view.

The Nottingham North and East Constitution

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.

The Constitution has been updated during 2014/15 in order to align it with developments relevant to the management of the CCG and to reflect the delegated functions for co-commissioning. The scheme of reservation and delegation has remained relevant and has also been updated to reflect delegation from NHS England.

The CCG has a Governing Body which ensures that the CCG discharges its constitutional requirements effectively. The Governing Body leads on the delivery of the organisation's strategic and business objectives, supporting GP practices to work together with local people and other stakeholders to develop and deliver services to improve health and wellbeing to the population served. The Membership Body has reserved responsibilities in relation to regulation and control and how they make decisions, constitution changes, approval of the scheme of delegation. The Membership Body also has reserved responsibilities for final approval of Governing Body members.

The Membership Body, Governing Body and Committee Structure

The Membership Body and Practice Forum

The Membership Body is composed of the following 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

Each has a commissioning lead and the role description is outlined in the Constitution. The Membership Body have a Practice Forum which is convened as required to discuss reserved responsibilities.

The Governing Body

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 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 met whilst quorate 9 times during 2014/2015, they also met for development sessions. Membership of the Governing Body and their attendances are recorded below.

Name	Position	Possible	Actual
Dr Paul Oliver	Chair	7	6
Dr Paramijit Panesar	Assistant Clinical Chair	7	7
Sam Walters	Chief Officer	7	7
Jonathan Bemrose	Chief Finance Officer	7	7
Dr James Hopkinson	GP Member	7	5
Adrian Kennedy	Allied Health Professional Member	7	5
Nichola Bramhall*	Registered Nurse	3	3
Dr Mohammed Al-Uzri	Secondary Care Doctor	7	7
Mike Wilkins	Lay Member – Patient and Public Involvement	7	5
Terry Allen	Lay Member – Finance and Governance	7	6

*Nichola Bramhall started post 30th September 2014

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The Governing Body has been effective in discharging the functions of the CCG. 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 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.

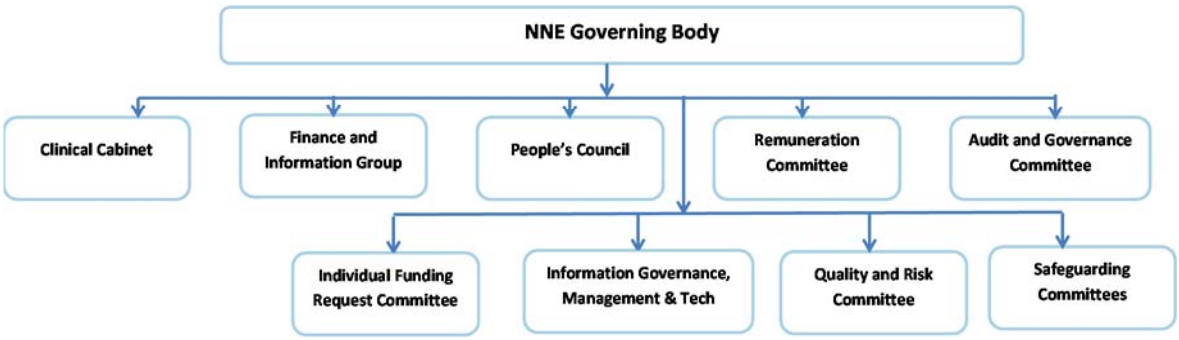

Image:3

The established Governing Body committees, alongside their respective delegated responsibilities are detailed below.

Clinical Cabinet

The Clinical Cabinet is established in accordance with Nottingham North and East Clinical Commissioning Group's Constitution.

The Chair of the Governing Body has taken on the position as Chair of the Clinical Cabinet. In the event of a conflict of interest for the Chair, the Deputy Chair deputises for the meeting or for the relevant agenda item.

The Clinical Cabinet which is accountable to the Governing Body will be given defined delegated responsibilities (within limits and subject to appropriate scrutiny and oversight by the Governing Body) for certain clinical matters. The Governing Body has conferred or delegated the following functions to the Clinical Cabinet

- 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.

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

- Prioritisation Panel – sacral neural modulation
- GP cover during the Christmas period
- Review of over the counter prescribing
- County Health Partnerships responsibilities
- Approval of Service Improvement Group Terms of Reference
- Development of the Community Geriatrician Service
- Mental Health Services – ongoing updates and recommendations
- Gluten Free Prescribing – consultation and product choice decision
- Review of Commissioning Priorities 2015/2016
- Maternity Services Review

- Reports delivered: Referral Activity and Finance Report, NNE Performance Report, Finance Report NNE Information Report
- Urgent Care Centre Procurement
- Hip and Knee Pathway
- End of Life Services Re-procurement
- Falls Rapid Response Project
- Primary Care Strategy
- Co-Commissioning of Primary Care
- Palliative Care Coordination Service
- Integrated Health and Social Care

Cumulative record of the Clinical Cabinet Membership and Attendance 2014/2015

Name	Committee Role	Possible	Actual	Name	Committee Role	Possible	Actual
Dr Paramjit Panesar	Asst Chair/GP Rep (ivy)	6	6	Sam Walters	Chief Officer	6	6
Dr Paul Oliver	Chair	6	5	Finance Representative	Finance Reps	6	5
Sharon Pickett	Deputy Chief Officer	6	5	Dr James Hopkinson	GP Rep (Calverton)	6	5
Dr Arun Shetty	GP Rep (Apple Tree)	6	5	Dr Jacques Ransford	GP Rep (Giltbrook)	6	4
Dr Gerry Gallagher	GP Rep (Daybrook)	6	5	Dr Claire Hatton	GP Rep (Jubilee)	6	1
Dr Smita Jobling	GP Rep (Highcroft)	6	4	Dr Nick Gilmore	GP Rep (Oakenhall)	6	5
Dr Sarah Bamford	GP Rep (Newthorpe)	6	2	Dr Luke Louca	GP Rep (Park House)	6	0
Dr Suman Mohindra	GP Rep (Om)	6	4	Dr Chic Pillai	GP Rep (Plains View)	6	6
Dr Elaine Maddock	GP Rep (Stenhouse)	6	6	Dr David Hannah	GP Rep (Torkard)	6	6
Dr Caitriona Kennedy	GP Rep (Trentside)	6	5	Dr Azim Khan	GP Rep (Unity)	6	6
Dr Graham Cox	GP Rep (West Oak)	6	6	Dr Raian Sheikh	GP Rep (Westdale)	6	4
Dr Amelia Ndirika	GP Rep (Whyburn)	6	5	Dr Sylvester Nyatsuro	GP Rep (Willows)	6	5
Adrian	H/C	6	4	Caroline Baria	LA Rep	6	2

Name	Committee Role	Possible	Actual	Name	Committee Role	Possible	Actual
Kennedy	Professional			(Observer)			
Dr Mohammed Al-Uzri	Secondary Care Consultant	6	4	Stephen Storr	PPI Rep	6	5
Mike Wilkins	Lay Member	6	5	Colleen Mulvany	Practice Nurse	6	6
Pam Husband	Practice Manager	6	5	Dr John Tomlinson	Public Health	6	4

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Peoples' Council

The People's Council, which is accountable to the Governing Body as a Committee with delegated responsibility, is established to provide assurance to the NNE CCG Governing Body that all decisions made by the NNE CCG have been informed by the appropriate level of input from patients, carers' and communities.

The People's Council is responsible to the patients and communities within NNE by supporting the CCG to deliver against its duties as listed below.

The People's Council will actively promote the CCG. Following the Francis report, the Council will provide assurance against the recommendations relevant to patient and public engagement.

Membership:

- 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 duties that the NNE CCG Governing Body has partly delegated to the People's Council include:

- To make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements
- To promote the involvement of individual patients and their carers about their healthcare
- To promote the involvement of the public and local communities in decisions relating to the prevention or diagnosis of illness, service delivery and care pathways.
- To support arrangement to promote patient and public involvement having regard for the need to reduce inequalities, promote innovation, improve access and promote and protect patient choice.

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
- 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

The Council will ensure that the statutory requirements for engagement have been met in relation to Section 242(1B) of the NHS Act 2006 and also ensure compliance with the core values of the NHS Constitution.

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

- Prescribing Strategy
- Prime Ministers Challenge Fund – Urgent Care Model
- Integrated Health and Social Care, Community Projects, Adult Community Care Team, IAPT, Everyone Counts, Dementia Action Plan, Stroke Services Review, procedures of limited clinical value
- Transforming General Practice
- Care data
- Falls – Rapid Response Team
- Patient and Public Feedback
- Equality and Diversity
- 2014/2015 Budget
- NHS England Restructure

Cumulative Record of the Peoples Council Members Attendance 2014/2015

Name	Committee Role	Possible	Actual
Apple Tree	PPG Rep	12	6 (No rep from Aug)
Calverton	PPG Rep	12	12
Daybrook	PPG Rep	12	0 (no rep)
Giltbrook	PPG Rep	12	12
Highcroft	PPG Rep	12	9
Ivy	PPG Rep	12	12
Jubilee	PPG Rep	12	12
Newthorpe	PPG Rep	12	5
Oakenhall	PPG Rep	12	10
Om	PPG Rep	12	12
Park House	PPG Rep	12	11
Peacock	PPG Rep	12	7
Plains View	PPG Rep	12	10
Stenhouse	PPG Rep	12	11
Torkard	PPG Rep	12	10
Trentside	PPG Rep	12	12
Unity	PPG Rep	12	12
West Oak	PPG Rep	12	0 (no rep)
Westdale Lane	PPG Rep	12	10
Whyburn	PPG Rep	12	10
Willows	PPG Rep	12	12
Hazel Buchanan	Director of Operations	12	10
Stephen Storr	Patient and Public Rep NNE Governing Body and Chair	12	11

Mike Wilkins	Chair	12	6
Mariea Kennedy	Patient Advice & Liaison	12	10
Michael Ellis	Patient & Public Engagement	12	11
Dr Paul Oliver	Clinical Lead		6
Sam Walters	Chief Officer	12	3
Patient Rep		12	7

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Finance and Information Group

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
- Consider topic specific issues as required

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

- Activity Trends and Reports
- Finance Performance Reports
- QIPP Highlight Report
- Finance Risk Register
- Resource Allocations 2014/15 and 2015/16
- Service Reviews and non-recurrent funding
- NHS England Cash Regime
- Co-Commissioning

Cumulative Record of Finance and Information Group Members attendance during 2014/2015

Name	Committee Role	Possible	Actual
Terry Allen	Lay Member Chair	8	8
Dr Paul Oliver	Clinical Lead	8	6
Sam Walters	Chief Officer	8	7
Sharon Pickett	Deputy Chief Officer	8	7
Jonathan Bemrose	Director of Finance	8	7
Ian Livsey	Deputy Chief Finance Officer	8	5
Hazel Buchanan	Director of Operations	8	4
Sergio Pappalettera	Data Analyst	8	8

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Audit and Governance Committee

The Audit Committee is established in accordance with NNE Clinical Commissioning Group's constitution. The committee is a non-executive committee of the Governing Body and has no executive powers, other than those delegated in the terms of reference.

The committee consists of all the Lay Members of the clinical commissioning group. The Lay Member on the Governing Body, with a lead role in overseeing key elements of financial management and audit, will chair the Audit Committee.

Membership:

- NNE CCG Lay members
    - Financial Management and Audit
    - Patient and Public Involvement
- GP Member Governing Body Membership may be drawn from other Governing Body members.

The Committee shall critically review the Clinical Commissioning Group's financial reporting, risk and internal control principles and ensure 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 reviews 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 dovetails with that of any quality Committees, 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

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the Clinical Commissioning Group.
- The underlying assurance processes that indicate the degree of achievement of Clinical Commissioning Group objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.
- Compliance with Standing Orders, the Scheme of Delegation and Standing Financial Instructions.
- Corporate and governance structures.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions including any reviews by Department of Health arm's length bodies or regulators/inspectors (for example Care Quality Commission and NHS Litigation Authority), but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

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

- Annual Report and Annual Governance Framework
- Internal Audit Reports
- Consistency Statement
- Counter Fraud annual plan and progress against plan
- Governing Body Assurance Framework
- Conflicts of Interests
- CCG Finance Items

Cumulative Record of Audit and Governance Committee Members attendance 2014/2015

Name	Committee Role	Possible	Actual
Terry Allen	Lay Member Chair	5	5
Mike Wilkins	Lay Member Patient & Public Involvement	5	3
Dr Paramjit Panesar	Membership from other Governing Body members - GP Member	1	1
Mohammed Al-Uzri	Membership from other Governing Body members -Secondary Care Consultant, Governing Body	1	1

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Remuneration Committee

The Remuneration Committee is established in accordance with Nottingham North and East Clinical Commissioning Group's constitution, standing orders and scheme of delegation.

The Remuneration Committee, which is accountable to the Group's Governing Body, 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 Committee acts as a point of appeal for decisions against job responsibilities, job matches and the agenda for change pay scale.

The Remuneration Committee also acts as an arbiter where agreement cannot be reached for procurement decisions and fees 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.

The Committee applies best practice in its decision making processes. When considering individual remuneration the Committee:

- Complies with current disclosure requirements for remuneration
- Seeks independent advice about remuneration for individuals when required
- Ensures that decisions are based on clear and transparent criteria

The members of the Remuneration Committee may be drawn from:

- Lay Member for Financial Management and Audit (Chair)
- Lay Member for Patient and Public Involvement

Other members will be drawn from where conflicts exist for Lay Members:

- Governing Body Secondary Care Consultant
- Governing Body GPs.

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

- Salary rates for Director of Nursing, Chief Officer, Chief Finance Officer
- Employment Tribunal – Settlement

Cumulative Record of Remuneration Committee Members attendance 2014/2015

Name	Committee Role	Possible	Actual
Terry Allen	Lay Member Chair	2	2
Mike Wilkins	Lay Member Patient & Public Rep	2	2

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Quality and Risk Committee

The clinical commissioning group has established a joint Quality and Risk Committee under a memorandum of understanding with NHS Nottingham North & East CCG and NHS Nottingham West 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, and to promote 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 three 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

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

- Responding to actions and recommendations from key National reports and inquiries (including the Francis, Keogh and Berwick Reports)
- Managing the clinical risk register for the CCGs and escalating risks to the Assurance Framework as appropriate.
- Triangulating data relating to commissioned services to provide assurance that quality of services is being maintained or where there are concerns about quality ensuring that appropriate remedial action is being taken
- Monitoring CQUIN progress for the three main providers with whom contracts are held (Circle, Nottingham, Nottingham University Hospitals NHS Trust and County Health Partnership
- Receiving updates on the work of the sub-groups which have included: Health and Safety, Equality and Diversity Forum, Care Homes, and Primary Care Quality and reviewing progress on mandatory training
- Reviewing reports and data including the Director of Quality's bi-monthly Quality Report, Serious Incidents for main providers, Quality Accounts, Quality dashboards from main providers and associate commissioned providers

- Receiving feedback from the NHS England Area Team Quality Surveillance Group and reviewing Internal Audit reports (during 2014/15 the follow up report into contract and quality monitoring in care homes was received which provided significant assurance in relation to the quality monitoring aspect- the action plan delivery continues to be monitored)
- Developed the South Nottingham CCGs Quality Strategy and Sign up to Safety Campaign.
- During 2014/15 the Committee has received a number of reviews including a review of the Quality Team (including a review of the Quality and Risk Committee), a review of primary care quality monitoring and a review of maternity services.
- Lay Member and Lay Representative involvement in scrutiny of main providers
- Review and ratification of policies and procedures.

Cumulative Record of Quality and Risk Committee Members attendance 2014/2015

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)	4	2	Hazel Buchanan	Director of Operations, NNE CCG	4	3 +1 (deputy)
Dr Cheryl Crocker	Director of Quality and Patient Safety, NNE, NW and Rushcliffe CCGs	1	1	Sheila Hyde	Lay Member, Rushcliffe CCG	4	1
Craig Sharples	Head of Quality, Engagement and Governance, NW CCG	2	2	Rebecca Stone	Assistant Director of Quality and Patient Safety, NNE, NW and Rushcliffe CCGs	4	2
Max Booth	Patient Representative, Rushcliffe CCG	4	4	Dr. John Tomlinson	Consultant in Public Health	4	4
Shirley Inskip	Patient Representative, NW CCG	4	1	Dr Mohammed Al-Uzri	Consultant Psychiatrist, Leicestershire Partnership NHS Trust/ NNE CCG Clinical representative	1	0

Lynne Sharp	Head of Governance and Integration, Rushcliffe CCG	4	4	Dr. Ian McCulloch Dr. Ram Patel	GP Representative – Rushcliffe CCG Shared Role	4	1
Nichola Bramhall	Director of Nursing and Quality NNE, NW and Rushcliffe CCGs	2	2				

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Information Governance, Management and Technology (IGM&T)

NHS Nottingham North and East CCG has a memorandum of understanding with, NHS Nottingham West CCG, NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG for the Information Governance, Management and Technology Committee which is hosted by NHS Rushcliffe 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.

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

- Continued progression of the implementation of the necessary changes to ensure compliance with statutory legislation. This has built on the work carried out during 2013/14 and has confirmed the Accredited Safe Haven (ASH) stage 1 status of the CCG. The CCGs are also authorised as Controlled Environments for Finance (CEfF) under the section 251 of the Health and Social Care Act 2012.
- Monitoring the CCGs' progress of completion of and compliance with the Information Governance Toolkit.
- Maintaining an information governance risk register for the CCGs.
- Re-commissioned the Information Governance Service provided to CCGs. This is now from February 2015 provided by NHS Nottingham City CCG through a specification and 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 agreeing the priority of those projects
- Agreed relevant information governance, information management and information technology policies with amendments as necessary reflecting changes in legislation or local ambition
- Introduced contract management arrangements with Nottinghamshire Health Informatics Service (NHIS) in order to demonstrate delivery of the required services to the necessary standards. This included the revision of and introduction of new key performance indicator

Cumulative Record of IGM&T Committee Members Attendance 2014/15

Member	IGMT Committee Role	Possible	Actual
Andy Hall	Director of Outcomes and Information (Chair) and SIRO for NHS Rushcliffe CCG	6	6
Dr Sean Ottey	Clinical Representative	6	1
Debbie Pallant	Information Governance Lead GEM CSU	6	5 +1 deputy
Petra O'Mahony	Freedom Of Information Lead GEM CSU	6	3
Dr Cheryl Crocker 1st April 2014 to 21st July 2014	Director of Quality and Patient Safety Caldicott Guardian NHS Rushcliffe, Nottingham North & East and Nottingham West CCGs	2	1 + 1 deputy
Rebecca Stone 22nd October 2014 to 13th October 2014	Acting Director of Quality and Patient Safety Caldicott Guardian NHS Rushcliffe, Nottingham North & East and Nottingham West CCGs	1	0
Nichola Bramhall 14th October to present	Director of Nursing and Quality, Caldicott Guardian NHS Rushcliffe, Nottingham North & East and Nottingham West CCGs	3	3
Dr Dean Temple 1st April 2014 to 3rd March 2015	Caldicott Guardian, NHS Mansfield and Ashfield CCG	5	3 + 1 deputy
Dr Ei Cheng Chui	General Practitioner (Caldicott Guardian), NHS Newark and Sherwood CCG	6	6
Dr Mike O'Neil	Clinical Representative & SIRO for NHS Nottingham West	6	5
Hazel Buchanan	Director of Operations (SIRO), NHS Nottingham North and East CCG	6	4 + 2 deputy
Elaine Moss	SIRO for NHS Newark and Sherwood CCG 1st April 2014 to present SIRO for NHS Mansfield and Ashfield CCG 1st April 2014 to 3rd March 2015 Caldicott Guardian for NHS Mansfield and Ashfield CCG 4th March 2015 to present	6	2 + 2 deputy
Simon Crowther 4th March 2015 to 25th March 2015 Marcus Pratt 26th March 2015 to present	SIRO for NHS Mansfield and Ashfield CCG	1	1 deputy
Ian Blair 1st April 2014 to 30th May 2014	Lay Member for NHS Rushcliffe CCG	1	0
Paul Morris	Lay Member for NHS Newark & Sherwood CCG	6	2

Eddie Olla	Director of Health Informatics, NHIS	6	3 + 3 deputy
Jacqueline Taylor	Head of Transformational ICT Services, NHIS	6	4 + 2 deputy
Dr George Ewbank	Clinical Safety Officer	6	6
David Harper* 1st April 2014 to 25th July 2014	Corporate Governance Manager, NHS Mansfield and Ashfield CCG	1	1 deputy
Nicola Treece* 1st April 2014 to 25th July 2014	Corporate Governance Manager, NHS Newark and Sherwood CCG	1	1 deputy
Susan Clarke* 1st April 2014 to 25th July 2014	Governance Officer, NHS Nottingham West CCG	1	0
Diane Butcher* 1st April 2014 to 25th July 2014	Head of Information & Performance, NHS Mansfield& Ashfield and Newark & Sherwood CCGs	1	1 deputy
Caroline Stevens* 1st April 2014 to 25th July 2014	Primary Care Governance Officer, NHS Rushcliffe CCG	1	1
Sergio Pappalettera* 1st April 2014 to 25th July 2014	Contract and Information Manager, NHS Nottingham North and East CCG	1	1

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* The IGMT Committee agreed in July 2014 that CCG IG Leads would no longer be members of the Committee and be recorded in attendance to meetings or as deputies to the SIRO and Caldicott Guardians only

Individual Funding Request Panel (IFR)

The joint Individual Funding Request panel is hosted under a memorandum of understanding by NHS Nottingham West CCG in conjunction with NHS Nottingham North and 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.

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

- 16 Individual Funding Request applications were processed in accordance with the IFR Policy eligibility criteria.
    - The IFR Panel considered 2 requests
    - One was approved by the panel and one was not approved.
    - Nine cases were screened in line with the policy, but all declined for consideration by the IFR panel as they did not demonstrate clinical exceptionality.
    - Three cases were redirected/returned
    - One case was withdrawn.
    - One case is still pending, awaiting further clinical information from requesting trust.
- 8 previously approved cases were reviewed for clinical benefit.
- One patient complaint received in response to previous IFR application where media statement and support provided to CCG Clinical Lead.
- Terms of reference updated and ratified by NHS Nottingham West CCG Governing Body October 2014
- Health Economist stood down from supporting the IFR panel. A new economist was sought and will support the IFR panel process from January 2015
- Annual reports for 2013/2014 were provided to the CCGs indicating the levels of activity and type of requests for IFR applications.
- Provision of a quarterly IFR report for each CCG detailing all requests for funding including commissioned and non-commissioned procedures e.g. IVF, Assessment for Asperger's, Treatment Abroad.
- Provision of two training sessions for IFR panel members including – Critical Appraisal and Defining Exceptionality as per the training needs analysis.
- Midlands & East NHS England CDF/IFR Lead attended a IFR panel meeting to give panel members a brief overview of the current landscape and changes ahead within specialised commissioning in NHS England IFR process specific to the NHS E IFR/CDF.

Cumulative Record of Panel Committee Members Attendance 2014/15

Name	Individual Funding Request Committee Role	Possible	Actual	Name	Individual Funding Request Committee Role	Possible	Actual
Peter Robinson	Chair (Lay Representative)	4	4	Dr Hilary Lovelock	GP –Huthwaite Health Centre – NHS Mansfield and Ashfield CCG	4	0
Usha Gadhia	Nominated Deputy Chair (Lay Representative)	4	3	Dr James Read	GP – The Manor Surgery – NHS Nottingham West CCG	4	4
Dr Mary Corcoran	Consultant in Public Health Medicine	3	3	Darrin Baines	Health Economist – The University of Nottingham	4	0
Oliver Newbould	Chief Officer – NHS Nottingham	4	4	Jane Urquhart	IFR Manager – NHS Mansfield and Ashfield	4	4

	West CCG				CCG		
Sharon Pickett	(Deputy Chief Officer) NHS Nottingham North and East CCG	4	4	Nicky Bird	Senior Prescribing Advisor (South) — NHS Mansfield and Ashfield CCG	4	4
Dr Simon Brenchley	GP – Lombard Medical Practice – NHS Newark and Sherwood CCG	4	3	Dr Jo Copping	Consultant in Public Health	1	1
Dr Sean Ottey	GP – West Bridgford Medical Practice – NHS Rushcliffe CCG	4	4				

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Safeguarding Committees

A joint Safeguarding Committee is established under a memorandum of understanding with NHS Nottingham North & East CCG, NHS Nottingham West CCG, NHS Rushcliffe, NHS Mansfield and Ashfield CCG, NHS Newark and Sherwood CCG and NHS Bassetlaw.

Chaired by the Newark & Sherwood CCG Chief Nurse, it aims are to ensure that systems and process are in place to safeguard vulnerable adults and children. The sub-committee responds to matters referred to it by the Nottinghamshire CCG Governing Bodies, Nottinghamshire Safeguarding Children and Adult Boards, the Nottinghamshire Multi Agency Public Protection Strategic Management Board, the Domestic and the Sexual Abuse Executive Group Wider clinical consultation takes place across the Nottinghamshire and Nottingham City Health Community, the Care Quality Commission and other multi agency partnership groups and forums.

The committee has overseen the health component of the Nottinghamshire Multi Agency Safeguarding Hub which brings partners agencies together to ensure prompt information sharing across the health community to safeguard children and vulnerable adults.

The sub-committee highlights:

- Under the Skin Safeguarding Assessment tool now being used for dedicated safeguarding quality assurance visits
- Bassetlaw Pressure Ulcer Good Practice Protocol adopted by all CCG areas as a systematic approach to dealing with pressure ulcers
- Monitoring organisational progress against Adult and Children's Safeguarding Board self-assessment performance tools
- Monitoring action plans and outcomes of serious case and serious incident reviews
- Monitoring local progress against national standards relating to child sexual exploitation
- Raising the profile of the PREVENT anti-terrorist strategy across commissioned and contracted services
- Monitoring risks relating to Child and Adolescent Mental Health Service Provision and influencing commissioning arrangements

- Monitoring quality of health services relating to children in care of the Local Authority
- A safeguarding risk register has been established for the subcommittee which is used to inform individual CCG Governing Bodies of key issues relating to safeguarding.

Cumulative Record of the Children Safeguarding Committee Members Attendance 2014/2015

	Possible	Actual
Chief Nurse and Director of Quality for Newark and Sherwood and Mansfield and Ashfield CCGs (Chair)	5	5
Director of Quality and Patient Safety and Executive Nurse for Nottingham North & East, Nottingham West and Rushcliffe CCGs (Vice Chair)	5	5 2 deputy
Chief Nurse and Executive Lead for Quality and Safety for Bassetlaw CCG	5	5 3 deputy
Designated Professionals Safeguarding Children CCGs	5	5
Designated Professionals Children in Care	5	5
Continuing Care Commissioning Manager (children lead) Greater East Midlands Commissioning Support Unit (GEM)	5	1
Public Health Manager (children lead) nominated by the Director of Public Health, Nottinghamshire County Council	5	3

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Cumulative Record of the Adults Safeguarding Committee Members Attendance 2014/2015

	Possible	Actual
Chief Nurse and Director of Quality for Newark and Sherwood and Mansfield and Ashfield CCGs (Chair)	5	5
Director of Quality and Patient Safety and Executive Nurse for Nottingham North & East, Nottingham West and Rushcliffe CCGs (Vice Chair)	5	5 2 deputy
Nurse Consultant Safeguarding for Bassetlaw CCG	5	5
Consultant in Public Health nominated by the Director of Public Health, Nottinghamshire County Council	5	4
General Practitioner	-	-
Practice Nurse	-	-
Adult Safeguarding Leads from the member CCGs	5	5
Assistant Director of Quality and Patient Safety for Nottingham North & East, Nottingham West and Rushcliffe CCGs	5	3
Head of Quality and Patient Safety for Newark and Sherwood and Mansfield and Ashfield CCGs	5	4

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Membership and Governing Body Performance and Effectiveness

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.

During 2014 the Governing Body undertook an inclusive leadership development programme which has helped to inform how they work collectively as well as how they can ensure they are leading the CCG as an inclusive organisation. Areas of development include technical knowledge in relation to new responsibilities for example the transformation agenda and delegated functions for primary care co-commissioning, horizon scanning and developing the forward view and maintaining the local focus with member practices whilst progressing the wider agendas.

During 2014/15 the Membership has been regularly attending the Clinical Cabinet as a means of integrating themselves with CCG business. As part of a review of the Clinical Cabinet the Membership self-assessed their increased engagement and contribution to the business of the CCG. Through discussions on co-commissioning, consideration was also taken on the Membership.

The Clinical Commissioning Group Risk Management Framework

NNE CCG recognises that risk management is integral to all its activity and business, and assists in achieving its strategic objectives and priorities.

The Integrated Risk Management Framework describes how NNE CCG identifies risks; how those risks are managed throughout the organisation; the likelihood of occurrence; and their potential impact on the successful achievement of NNE CCG's strategic objectives.

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 appropriately identified, considered as part of everyday business and then appropriately mitigated.

Risk Management Process

Prevention and Management of Risks

Risk management is embedded in the activity of the CCG through the direct identification of risks as well as through effective commissioning procedures and communication with CCG employees. Equality Impact Assessments, Quality Impact Assessments and Privacy Impact Assessments are integrated into the project management office processes and are therefore carried out effectively and efficiently. Where substantial risk is identified through an impact assessment, this is reported back to the relevant committee or group including the Equality and Diversity Forum, the Quality and Risk Committee and the Information Governance, Management and Technology Committee. CCG staff are trained on risk management and are informed of incidents. The CCG have a Communications Cell which is held every two weeks with staff and is used to raise any issues, including incidents and updates on procedures.

All risks relating to the business planning, and commissioning and delivery of services for which we are responsible, be they clinical, non-clinical, financial or corporate, and all risks that could threaten the achievement of NNE CCG strategic objectives must be identified and reported.

There are a number of ways in which risks are identified:

- It is the responsibility of all CCG staff to identify and report risks.
- Risks should be identified at meetings of the Governing Body and through all of its committees.
- The Governing Body Assurance Framework identifies the strategic objectives of the CGG and the risks that could threaten their achievement. The Governing Body Assurance Framework is reviewed and updated every six months, to include any identified new risks and to amend risk ratings as appropriate.

Once the risk has been identified, the reporting person along with the Director of Operations will establish the likelihood of it occurring and the potential impact if it did occur. This will be measured by using the risk assessment matrix, and will take into account the following:

- Risk type (Health, financial, safety, etc.)
- Risk source/context (internal or external)
- What is at risk (impact/exposure to people, reputation, results, assets etc)

NNE CCG populates and maintains two risk registers – the Finance Risk Register and the Corporate/Clinical Risk Register (including Information Governance and Safeguarding risk registers). The Director of Operations will enter all identified risks once reported and quantified onto the Corporate/Clinical risk register. The Deputy Director of Finance will enter all identified financial risks once reported and quantified, onto the Finance Risk Register.

The actions required, and any existing controls to minimise or eliminate a potential risk are then identified and recorded on the risk registers to include a time scale for expected completion of that action and the person responsible for implementation.

After identifying action/s and controls to minimise a risk, the risk should be reassessed taking into account the effect of planned actions. This is referred to as the residual risk score and should be quantified using the risk assessment matrix. The residual risk score confirms the level of risk outstanding after actions have been completed. The residual risk score is recorded on NNE CCG Risk Register.

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

Deterrent of Risks

Counter Fraud

In accordance with its constitutional framework, the clinical commissioning group is required to have adequate arrangements in place for countering fraud, corruption and bribery. The CCG has produced a fraud, bribery and corruption risk assessment and developed a work plan across 4 areas of work:

- Strategic Governance
- Inform and Involve
- Prevent and Deter
- Hold to Account

Counter Fraud reports are received at Audit Committees. These reports inform the Committee of the work carried out by the Counter Fraud Specialist (CFS) and provide an update of progress against the work plan.

Employees have received Counter Fraud training via presentations and eLearning and Counter Fraud surveys are regularly conducted, the results of which form an action plan which is considered when developing the Clinical Commissioning Group's Counter Fraud Risk Assessment and work plan. Regular bulletins are issued to staff which raise awareness, vigilance and reporting and the CFS reviews policy and process to ensure adequate preventative measures are in place.

The Clinical Commissioning Group Internal Control Framework

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

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

The Clinical Commissioning Group has established a wide range of monitoring procedures in order to ensure that the organisation system of internal control continues to operate effectively and that controls do not deteriorate over time.

Information Governance

The NHS Information Governance Assurance Framework sets out the processes and procedures by which the NHS handles information about patients and employees, in particular personal confidential 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 partner organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The clinical commissioning group places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. An information governance management framework has been established and information governance processes and procedures have been developed in line with the information governance toolkit. The Senior Information Risk Owner (SIRO) is a member of the Governing Body, as is the Caldicott Guardian.

All staff undertake annual information governance training and a staff information governance handbook has been implemented to ensure staff are aware of their information governance roles and responsibilities.

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

The CCG, through the joint IGMT Committee has documented relevant risks in the information governance risk register. The register is reviewed at every IGMT meeting along with any mitigating actions. Policies supporting the security of data and access to systems have been put in place and are regularly reviewed within the proposed timescales.

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.

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.

During 2014/15 the CCG has enhanced on its decision making and business practices which directly support due regard to the Public Sector Equality Duty and the Equality Act. The following are steps that have been taken to eliminate discrimination, advance equality of opportunity and foster good relations.

The CCG have the following equality objectives which will be carried forward into 2015/16:

- Equality of opportunity - Improve staff equality monitoring data and use it to inform future succession planning processes
- Eliminate discrimination – Have due regard to the Workforce Race Equality Standard as a CCG and as part of the local health economy
- Foster good relations – Improve patient and public communication by taking into consideration the needs of protected characteristics and by improving information on how and when to use health care services
- Advance equality of opportunity – Improving an understanding of how individuals fare within primary care by expanding on our project to collect equality data through GP member practices
- Eliminate discrimination – Improve on the decision making process through effective use of Equality Impact Assessments
- Foster good relations – Enhance on engagement processes as a local health community by working closely with neighbouring CCGs and the Acute Trust to ensure a wider understanding of how protected characteristics fare against outcomes

NNE 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, leaders of the CCG and in working with our partners. As such, NNE also recognises the benefits of working within local communities themselves and supporting them to change. NNE CCG actively support the PANEL principles[2] in ensuring a human rights approach - **P**articipation in one's own Development; **A**ccountability of duty bearers to rights-holders; **N**on-discrimination and prioritisation of vulnerable groups; **E**mpowerment of rights holders; **L**egality: the express application of a human rights framework.

Sustainable Development Obligations

We are committed to using sustainable approach in commissioning healthcare services and working within the available environmental and social resources, protecting and improving health now and for future generations. To this effect, we will be working to reduce carbon emissions, minimising waste & pollution, making the best use of scarce resources, building resilience to a changing climate and nurturing community strengths and assets.

We have established 2013/14 as a baseline for our emissions. We have calculated our corporate emissions baseline to be 40.88 tCO_2e which is equivalent to 0.99 tCO_2e per full time employee and carbon influence through contracts for commissioned healthcare services and procurement of non healthcare products and services to be 48,965 tCO_2e. Our corporate emissions encompass energy, waste, water and travel. Having established this baseline, we have set an ambitious target of 28% carbon reduction by 2020.

We have adopted an environmental policy and have a board approved Sustainable Development Management Plan (SDMP) with accompanying action plans on how to achieve our ambitious target of 28% reduction by 2020. We have appointed NetPositive to work with us and support us to implement this plan.

[2] A guide to evaluating human rights-based interventions in health and social care, Alice Donald, London Metropolitan University, Human Rights & Social Justice Research Institute

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.

Major risks that were deemed to threaten the achievement of the CCG strategic aims are presented in the table below.

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

Risk	Specific risks we face
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

Risk	Specific risks we face
	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

Table: 25

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.

The structure diagram presented below details the reporting lines and accountabilities between the Governing Body and its Committees. The Executive Team also meets on a weekly basis to discuss the financial position, the risk register and any other current work programs that are of importance.

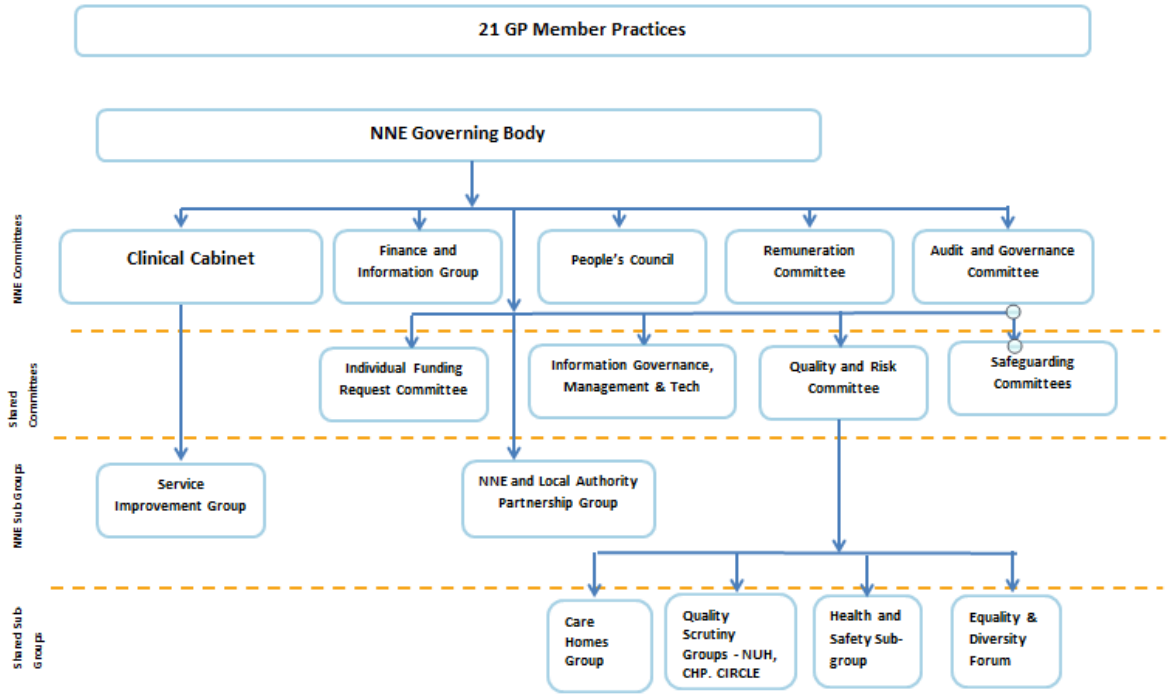

Image: 4

The CCG is required to provide assurances to NHS England in the form of quarterly meetings, in line with the CCG Risk Management Framework. All significant risks that may impact on the CCGs compliance with the licence have been considered and where appropriate documented in the Risk Register.

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

The CCGs Governing Body has oversight of the appropriateness of the organisations arrangements to exercise its functions effectively, efficiently and economically, and as Accountable Officer, I have overall executive responsibility for the use of resources.

The CCG has robust financial governance arrangements in place, the Chief Finance Officer provides a monthly Finance Report to the Governing Body on financial performance, including performance against the organisations statutory financial duties. The finance reports are also presented at the weekly Executive Team meetings.

The CCGs Audit and Governance 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. This is evidenced through the committee's use of a business assurance framework established by the Governing Body.

Risk Pooling

A financial risk pooling agreement for 2014/15 was agreed by the Nottinghamshire County and Nottinghamshire City CCGs with the recommendations of the Risk Pool Steering Committee approved by the Governing Body in March 2014.

The operation of the 2014/15 Risk Pool Agreement is summarised below:-

1) High Cost Patients (i.e. A patient whose costs in the calendar year for acute secondary and critical care services within the scope of the CCG exceed £80,000); and
2) One-off "major incidents" (i.e. events that (i) are expected to occur less frequently than once in every two years; and,(ii) have been recognised by Public Health England and/or an appropriate local health authority as an outbreak or emergency) would be risk shared at a City/County basis.

High cost patients covered as part of this 2014/15 Risk Pool, includes acute secondary and critical care services but does not include Continuing Care and Non NHS Low Secure Services/Locked Rehabilitation which were previously risk shared across the Nottinghamshire County CCGs as part of its Risk Pooling Agreement for 2013/14. Both Chief Finance Officers for the North and South County CCGs agreed that these areas would continue to be risk shared between the County CCGs in 2014/15 on the same basis as 2013/14.

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.

Counter Fraud

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

Employees have received Counter Fraud face to face training and have completed a Counter Fraud survey.

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.

Transformation

NNE CCG is committed to the south Nottinghamshire transformation partnership and has ensured that this is supported through the CCG governance arrangements. Transformation contributes to efficiency and effectiveness use of resources.

Commissioners and providers from health and social care have come together as the South Nottinghamshire Transformation Partnership to collectively improve the health and wellbeing of the local population. Whilst overall citizens receive safe health and social care, services are not consistently coming together in joined up, sustainable models of provision. It is increasingly unlikely that single organisations can find solutions whilst working within their own boundaries with whole system, collaborative working needed and a shift from a reactive bed based model of care to a more preventative and proactive model of care in which citizens are empowered to remain well and independent, taking greater social responsibility for using public services wisely thereby protecting them for future generations.

The organisations have formed a South Nottinghamshire Transformation Board (SNTB), which will be the overarching strategic governing group for the Partnership. Each partner organisation has nominated a representative (named leads and deputies) for the Board and also to underpin the governance structure. Partner representatives will be of sufficient seniority to fully engage in developing robust recommendations and ensuring that they align with decision making at statutory body level including Local Authority political approval processes.

Furthermore, during 2014/15 health and social care commissioners confirmed their intention to move to a system that is commissioned and contracted based on outcomes. During 2015/16, commissioners will join up commissioning for transformational change, engaging citizens in determining the outcomes that matter to them for inclusion in future contracts as well as undertaking detailed design for outcomes-based commissioning and contracting. The Commissioner Group will oversee this work, making recommendations, especially regarding the approach to procurement, to the statutory partner bodies and engaging with LA political processes.

Better Care Fund

The Nottinghamshire Better Care Fund (BCF) plan was signed off by NHS England as "Approved" in December following further work to provide assurance around programme governance in relation to monitoring and delivery of the plan. Section 75 pooled budget will be in place for 1st April 2015 with the appropriate governance structures at County level to allow for transparency of reporting.

A county wide structure has been implemented, including terms of reference for a county-wide BCF governance structure. A Finance, Planning and Performance provides oversight of progress with schemes and risks to delivery with escalation to the Programme Board. The Programme Board reports on progress of the plan on a quarterly basis by exception.

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 the system of internal control within the Clinical Commissioning Group.

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.

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.

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.

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 2014/15 and have managed the risks assigned to them.

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.

Quality and Risk Committee

Responsible for monitoring, reviewing and providing assurance to the GB that services commissioned by the CCG are being delivered in a high quality and safe manner promoting a culture of continuous improvement and innovation.

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 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.

Internal and External Audit

Both Internal and External Audit carry out independent reviews of systems and processes within the organization. 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.

Other Assurance Mechanisms

NHS England have supported the CCG through the assurance framework. This has included informal monthly meetings alongside quarterly checkpoints.

The process is structured around six assurance domains that reflect the key elements of an effective clinical commissioner and which were integral to the licensing process. For the first two quarters of 2014/15, the outcome of the quarterly checkpoint process has been that the Clinical Commissioning Group has been 'assured with support', specifically in relation to one assurance domain (*Are patients receiving clinically commissioned, high quality service?*). This has related to the consistent failure to deliver a key target – the Accident and Emergency Department 4-hour waiting time standard – and management of the urgent care system as a health community."

Head of Internal Audit Opinion

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

"Significant Assurance as there is a generally sound system of internal control, designed to meet objectives, and that controls are generally being applied consistently. This opinion is determined through our review of your Governing Board Assurance Framework (BAF) and associated processes and the work that we have undertaken throughout the year."

Internal Audits with Limited Assurance

During the year, Internal Audit did not issue any new reports with limited assurance.

Internal Audits with No Assurance

During the year, Internal Audit did not issue any new reports with no assurance.

Significant Issues

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

The overall objective of the service audit work undertaken (by Deloittes) is to evaluate the effectiveness of the control environment for the CSU and provide assurance to the CSU and therefore NHS England and the CCG, on the adequacy and effectiveness of the key controls in operation.

During the financial year 2013/14 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 that financial year.

For the financial year 2014/15 Deloittes have undertaken two separate reviews for the periods 1 June 2014 to 30 September 2014 and 1 October 2014 to 31 March 2015. Their key conclusion for both of these periods is that the controls tested were operating with sufficient effectiveness to provide reasonable assurance that the related control objectives were achieved throughout the period 1 June 2014 through to 31 March 2015, although a number of control deficiencies were identified for both periods reviewed. These control deficiencies have been reviewed by the CCG and it has been confirmed that these have limited impact upon the CCG due to sufficient compensating controls being in place locally.

For the period after 1 November 2014 it should be noted that the technical finance function, undertaken by GEM on behalf of the CCG, was brought back in-house and so a service audit report on controls in relation to Technical Finance for this period are no longer relevant.

The audit report does not cover the period 1 April 2014 to 31 May 2014. For this period the CCG recognises the limited risk that is associated with not having a reasonable assurance opinion from a service audit but assesses this risk as minimal due to a number of reasons:

1) The CCG commissioned a limited range of financial services (primarily payroll data processing, Balance Sheet maintenance, control account reconciliations and suspense clearance) from the CSU compared to other CCGs around the country, with the management accounting function provided by the CCG's in-house Finance Team. This management accounting function includes the key spend areas of Healthcare Service Level Agreements, Prescribing & Continuing Care.

2) As previously noted, all finance services were brought back in-house with effect from 1 November 2014. At this time of "take-on" the CCG team worked closely with both Internal and External Audit to ensure issues were identified and resolved.

3) Financial services continue to be the subject of scrutiny through the combined Internal Audit Budgetary Control, Financial Reporting and Key Financial Systems (including payroll). This Budgetary Control, Financial Reporting and Key Financial Systems report, undertaken during quarter 4 and issued on 27 March 2015, confirms an audit opinion of Significant Assurance.

4) In mitigating against any further risk to the CCG, the CCG had a number of compensating controls in place:

    a) Control Account Reconciliations were reviewed 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 was, and continues to be, the responsibility of the CCG therefore variance analysis and reporting would highlight any areas to be investigated

c) Regular review of nominal rolls and regular monthly variance analysis of pay-related management accounts
d) The CCG held monthly performance meetings with the CSU where it discussed performance against the SLA which covers the financial services provided by the CSU
e) Regular reporting of all aspects of finance information to NHS E Area and Regional team is submitted monthly. This information is subject to challenge and scrutiny by NHS E colleagues. No issues have been highlighted to CCGs relating to the service previously carried out by GEM.

NHS 111 Service

The NHS 111 Service's call handling targets have not been achieved consistently throughout the year, particularly during the winter months when demand grew more rapidly than expected. The CCG is continuing to work with the co-ordinating commissioner for this service to develop a recovery plan, which is focussed on the recruitment and retention of staff.

Data Quality

The clinical commissioning group has robust controls in place to ensure the required standards for data quality from all providers where it commissions services. Locally defined schedules of the NHS Standard Contract include elements requiring standards for data quality. In addition, the clinical commissioning group has signed off the provider Trusts' Data Quality Strategies.

The IGMT Committee includes a standing agenda item to receive quarterly Data Quality Reports which summarises the data quality issues associated with key provider organisations, the relative benchmarking of data quality for these providers and any national expected standards. The report also outlines the actions being taken within and out-with the CCG to improve the quality of data to an acceptable level.

A joint Data Management Team across Nottinghamshire CCGs is hosted by NHS Rushcliffe CCG. The Data Management Team is responsible for processing and validating data as well as developing business intelligence solutions, managing all data flows into and out of the clinical commissioning group including testing the accuracy of data being submitted nationally and locally by providers. Ultimately allows the CCG to reinstate some of the data quality checks which were suspended following the national Information Governance restrictions mandated under the Health & Social Care Act 2012.

Business Critical Models

The clinical commissioning group is undertaking work to document business critical models across its operation. Quality Assurance is in place and the methods used are dependent upon the nature and purpose of the business critical model.

For financial modelling the following quality assurance processes are in place:

- Adherence to published Department of Health guidance
- Use of version control
- Internal peer review within the Finance Department
- On-going process to inform contract team of initial envelopes and updates to Financial Plan and envelopes in line with contract negotiations until contacts formally signed off.
- Submission to the NHS England Area team via spreadsheet with inbuilt validation rules
- Critical evaluation via external peer review from the Area Team

In addition to the above, for the development of acute contract activity plans the following processes are in place:

- External confirm and challenge process with acute provider directorates.
- Final formalised sign off following acceptance checking by providers.

Data Security

The clinical commissioning group submitted a satisfactory level of compliance standards with the Information Governance Toolkit at level 2. As per the requirements for level 2 compliance, all staff completed their mandatory Information Governance training during 2014/15 ensuring that all staff members were aware of their responsibilities relating to information governance.

All information governance incidents are taken extremely seriously. The clinical commissioning group is committed to reporting, managing and investigating all information governance incidents and near misses. Staff are encouraged to report all incidents and near misses to ensure learning can be collated and disseminated within the organisation.

The clinical commissioning group did not report any Serious Untoward Incidents involving information, confidentiality or security between April 2014 and March 2015.

Personal Confidential Data

At the formation of the CCGs in April 2013, the ability to validate invoices that was available to PCTs was discontinued, leaving CCGs at financial risk due to potential misattributed charges. To address this, NHS England introduced the Controlled Environment for Finance (CEfF) framework under s251 legislation. Under the CEfF arrangements, accredited organisations may process personal confidential data for the singular purpose of determining whether or not payment for a patient's care is the responsibility of the invoiced CCG. The Nottinghamshire CCGs were successful in becoming accredited on 19 March 2014. Risk mitigating measures were put in place in the interim, including written communication to provider organisations setting out the intention to recover incorrect charges once the ability to validate was restored. As accreditation was confirmed very late in the financial year, decisions on how to prioritise resources for making retrospective claims for 2013/14 were taken by respective finance teams. With the CEfFs now in place and fully operational, there is no equivalent risk relating to the 2014/15 financial year.

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 legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, the 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 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.

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

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 unit of planning, Transformation and the Better Care Fund have been priorities for 2014/15 in order to ensure that the governance arrangements align with our statutory responsibilities. These have been identified within the governance statement and further aid to support robust governance arrangements.

Signed on behalf of Sam Walters, Chief Officer

Sharon Pickett, Deputy Chief Officer

Signature: S Pickett

Date: 27 May 2015

Annual Accounts

Chief Financial Officer Statement

The Financial Statements provide an overview of our performance for 2014/15. The full Statutory Accounts, including the Independent Auditor's Report are attached at Appendix 1.

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, not exceeding our running costs allocation and delivering against the Better Payment Practice Code target.

The CCG commenced the year in a financial position that required delivery of a £4.2 million savings target (QIPP – Quality, Innovation, Productivity and Prevention – target). This target has been delivered, albeit with an element delivered on a one-off, non-recurrent basis. The CCG has also experienced cost pressures, mainly across acute and continuing healthcare programme areas. The CCG has contained these pressures by utilising contingency reserves and has successfully delivered the surplus target of £2.083 million as set by NHS England.

The CCG exits 2014/15 with an underlying recurrent surplus position that reflects the going concern declaration. However, the CCG continues to face financial challenges and a QIPP target of circa £7.1 million is required to be delivered in 2015/16 in order to achieve our surplus target of 1%.

The Better Care Fund (BCF) commences at the start of the new financial year, and this sees a £9.1 million investment by the CCG. The operation of the BCF is described in more detail in the Strategic Report section of the Annual Report. It is key that the financial and operational objectives of the BCF schemes are delivered and 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 continue to be used and invested to improve the health and well-being of the residents of Nottingham North and East CCG.

Finally, thanks go to all staff, managers and members for the notable success in delivering the 2014/15 financial targets.

Financial Performance

Our annual report and accounts cover the 12 month period from 1 April 2014 to 31 March 2015. 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	1,686	2,087
Remained within cash limit	195	45
Identification of 2% funding committed non recurrently	4,096	4,096
Identification of 0.5% contingency to meet in year cost pressures	843	843
Running cost to be within notified allowances	3,654	2,720

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Note 1

The CCG Planned Surplus was £1,686k. During the year, NHS England returned £397k to the CCG in respect of a refund to the Continuing Healthcare Risk Pool Contribution, which resulted in an increase to the surplus.

Note 2

The Notified Running Cost Allowance for Nottingham North & East CCG for 2014/15 includes a non-recurrent allocation for the Quality Premium of £89k.

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.

Audited Financial Statements and Independent Auditor's Report

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

Working Capital and Liquidity

We ended 2014/15 with a cash balance of £45k (0.3%), as directed by NHS England.

Events after reporting period

In 2015/16, the CCG will take over responsibility for Co-commissioning budgets which are transferring from the Area Team.

1. Responsibility for GP Primary Care Commissioning will transfer from NHS England to the CCG under delegated authority. The anticipated level of resource transfer for NNE is £18,186
2. The CCG will enter into a Joint Agreement for a Pooled Budget for the Better Care Fund. The CCG will contribute £9,115

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 £2,888k during 2014/15. A summary of our main savings delivered during the year is shown below:

Programme Areas	**2014/15 QIPP £'000**
Contracting	938
Mental Health	170
Planned Care	22
Prescribing	429
Unplanned Care	1,263
Other	66
Total	**2,888**

Table: 27

Statement of the Accountable Officer

I certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the NHS Act 2006 (as amended). Signed on behalf of Sam Walters, Chief Officer.

Sharon Pickett, Deputy Chief Officer

Signature: S Pickett

Date: 27 May 2015

Appendix 1 – 2014/2015 Annual Accounts and Independent Auditor's Report

NHS
Nottingham North and East
Clinical Commissioning Group

NHS Nottingham North and East Clinical Commissioning Group

2014/15

Annual Accounts and Independent Auditor's Report

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KPMG

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 2015 on pages 6 to 32 of Appendix 1. These financial statements have been prepared under applicable law and the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Members of 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 pages 63 to 64, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2015 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

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

In our opinion:

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

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

Matters on which we are required to report by exception

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

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

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

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

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

Respective responsibilities of the CCG and auditor

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

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

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

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

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

- securing financial resilience; and

- challenging how it secures economy, efficiency and effectiveness.

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

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

Conclusion

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

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.

T Crawley

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

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

28 May 2015

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

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	2,369	2,257
Operating Expenses	5	167,767	163,807
Other operating revenue	2	(2,207)	(2,221)
Net operating expenditure before interest		**167,929**	**163,843**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	1
Net operating expenditure for the financial year		**167,929**	**163,844**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**167,929**	**163,844**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	1,953	1,984
Operating Expenses	5	785	1,683
Other operating revenue	2	(19)	(328)
Net administration costs before interest		**2,719**	**3,339**
Programme Income and Expenditure			
Employee benefits	4.1.1	416	273
Operating Expenses	5	166,982	162,124
Other operating revenue	2	(2,188)	(1,893)
Net programme expenditure before interest		**165,210**	**160,504**

Other Comprehensive Net Expenditure		2014-15 £000	2013-14 £000
Impairments and reversals	22	0	0
Net gain/(loss) on revaluation of property, plant & equipment		0	0
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Movements in other reserves		0	0
Net gain/(loss) on available for sale financial assets		0	0
Net gain/(loss) on assets held for sale		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Share of (profit)/loss of associates and joint ventures		0	0
Reclassification Adjustments		0	0
On disposal of available for sale financial assets		0	0
Total comprehensive net expenditure for the year		**167,929**	**163,844**

The notes on pages 10 to 32 form part of this statement.

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	13	0	0
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		**0**	0
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	1,449	1,915
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	43	14
Total current assets		**1,492**	1,929
Non-current assets held for sale	21	0	0
Total current assets		**1,492**	1,929
Total assets		**1,492**	1,929
Current liabilities			
Trade and other payables	23	(6,794)	(7,916)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(117)	(57)
Total current liabilities		**(6,911)**	(7,973)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(5,419)**	(6,044)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(5,419)**	(6,044)
Financed by Taxpayers' Equity			
General fund		(5,419)	(6,044)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(5,419)**	(6,044)

The notes on pages 10 to 32 form part of this statement.

The financial statements on pages 1 to 32 were approved by the Audit Committee on 27 May 2015 and signed on its behalf by:

Sharon Pickett

Chief Accountable Officer

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(6,044)	0	0	**(6,044)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(6,044)**	**0**	**0**	**(6,044)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	(167,929)			(167,929)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(167,929)**	**0**	**0**	**(167,929)**
Net funding	168,554	0	0	168,554
Balance at 31 March 2015	**(5,419)**	**0**	**0**	**(5,419)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	**0**	**0**	**0**	**0**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Commissioning Board balance at 1 April 2013	**0**	**0**	**0**	**0**
Changes in NHS Commissioning Board taxpayers' equity for 2013-14				
Net operating costs for the financial year	(163,844)			(163,844)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Commissioning Board Expenditure for the Financial Year	**(163,844)**	**0**	**0**	**(163,844)**
Net funding	157,800	0	0	157,800
Balance at 31 March 2014	**(6,044)**	**0**	**0**	**(6,044)**

The notes on pages 10 to 32 form part of this statement.

Statement of Cash Flows for the year ended
31 March 2015

	Note	**2014-15 £000**	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(167,929)	(163,844)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	466	(1,915)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(1,122)	7,916
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	60	57
Net Cash Inflow (Outflow) from Operating Activities		**(168,525)**	(157,786)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(168,525)**	(157,786)
Cash Flows from Financing Activities			
Net Funding Received		168,554	157,800
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**168,554**	157,800
Net Increase (Decrease) in Cash & Cash Equivalents	20	**29**	14
Cash & Cash Equivalents at the Beginning of the Financial Year		**14**	0
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**43**	14

The notes on pages 10 to 32 form part of this statement.

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 Charitable Funds

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

1.6 Pooled Budgets

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

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

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

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

- The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group's share of any liabilities incurred jointly; and,
- The clinical commissioning group's share of the expenses jointly incurred.

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

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

- Gross Accounting

The Clinical Commissioning Group has entered into an arrangement with the other Nottinghamshire Clinical Commissioning Groups in adopting Gross Accounting in relation to transactions between DH Group Bodies, except transactions deemed to be in the nature of a "recharge". This is consistent with the requirements contained within IAS 8.

- Maternity Pathway Costs

The Clinical Commissioning Group prepays 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 tha have the most significant effect on the amounts recognised in the financial statements:

- Partially Completed 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.

Notes to the financial statements

1.8 Revenue

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

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

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

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

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

1.9.2 Retirement Benefit Costs

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

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

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.

Notes to the financial statements

1.12 Intangible Assets

1.12.1 Recognition

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

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

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

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

1.12.2 Measurement

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

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

1.13 Depreciation, Amortisation & Impairments

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

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

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

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

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.

Notes to the financial statements

1.17 Leases

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

1.17.1 The Clinical Commissioning Group as Lessee

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

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

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

1.17.2 The Clinical Commissioning Group as Lessor

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

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

1.18 Private Finance Initiative Transactions

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

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

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

1.18.1 Services Received

The fair value of services received 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.

Notes to the financial statements

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

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

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.

Notes to the financial statements

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.

Notes to the financial statements

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

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

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 Standards That Have Been Issued But Have Not Yet Been Adopted

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

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

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

2 Other Operating Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	754	12	742	1,768
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	1,453	7	1,446	453
Total other operating revenue	**2,207**	**19**	**2,188**	**2,221**

3 Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
From rendering of services	2,207	19	2,188	2,221
From sale of goods	0	0	0	0
Total	**2,207**	**19**	**2,188**	**2,221**

4 Employee benefits and staff numbers

4.1.1 Employee benefits

2014-15	Total			Admin			Programme			2013-14
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits										
Salaries and wages	1,897	1,897	0	1,556	1,556	0	341	341	0	1,811
Social security costs	192	192	0	161	161	0	31	31	0	162
Employer Contributions to NHS Pension scheme	280	280	0	236	236	0	44	44	0	239
Other pension costs	0	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0	45
Gross employee benefits expenditure	**2,369**	**2,369**	**0**	**1,953**	**1,953**	**0**	**416**	**416**	**0**	**2,257**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,369**	**2,369**	**0**	**1,953**	**1,953**	**0**	**416**	**416**	**0**	**2,257**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,369**	**2,369**	**0**	**1,953**	**1,953**	**0**	**416**	**416**	**0**	**2,257**

4.1.2 Recoveries in respect of employee benefits

There were no recoveries in respect of employee benefits (2013/14: £nil).

4.2 Average number of people employed

	2014-15 Total Number	2014-15 Permanently employed Number	2014-15 Other Number	2013-14 Total Number
Total	**46**	**46**	**0**	42
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total days lost	702	974
Total staff years	156	292
Average working days lost	**4.50**	**3.34**

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.

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

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total		2013-14 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**	Number	£
Less than £10,000	0	0	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0	1	10,255
£25,001 to £50,000	0	0	0	0	0	0	1	34,984
£50,001 to £100,000	0	0	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**2**	**45,239**

	Departures where special payments have been made		2013-14	
	Number	**£**	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	Other agreed departures		2013-14	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	1	34,984
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**0**	**0**	**1**	**34,984**

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

Where entities have agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

4.5.1 Accounting Valuation

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

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

4.5.2 Full actuarial (funding) valuation

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

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

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

4.5.3 Scheme Provisions

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

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

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

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

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

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

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

5 Operating expenses

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	1,963	1,547	416	1,628
Executive governing body members	406	406	0	629
Total gross employee benefits	**2,369**	**1,953**	**416**	**2,257**
Other costs				
Services from other CCGs and NHS England	15,898	269	15,629	19,515
Services from foundation trusts	8,458	0	8,458	6,649
Services from other NHS trusts	100,470	26	100,444	97,473
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	16,993	0	16,993	11,886
Chair and Non Executive Members	0	0	0	0
Supplies and services – clinical	0	0	0	0
Supplies and services – general	1,322	33	1,289	250
Consultancy services	44	38	6	100
Establishment	784	210	574	561
Transport	32	5	27	50
Premises	1,178	106	1,072	1,262
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets	0	0	0	0
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	72	72	0	79
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	21,846	0	21,846	21,110
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	243	0	243	425
Other professional fees excl. audit	(23)	(23)	0	416
Grants to other public bodies	0	0	0	0
Clinical negligence	1	1	0	1
Research and development (excluding staff costs)	0	0	0	0
Education and training	55	44	11	27
Change in discount rate	0	0	0	0
Provisions	60	0	60	0
CHC Risk Pool contributions	240	0	240	0
Other expenditure	94	4	90	4,003
Total other costs	**167,767**	**785**	**166,982**	**163,807**
Total operating expenses	**170,136**	**2,738**	**167,398**	**166,064**

6.1 Better Payment Practice Code

Measure of compliance	**2014-15 Number**	**2014-15 £000**	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	1,675	19,757	1,326	18,861
Total Non-NHS Trade Invoices paid within target	1,654	19,676	1,290	18,216
Percentage of Non-NHS Trade invoices paid within target	**98.75%**	**99.59%**	**97.29%**	**96.58%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,874	129,071	1,381	123,649
Total NHS Trade Invoices Paid within target	1,847	128,441	1,347	122,069
Percentage of NHS Trade Invoices paid within target	**98.56%**	**99.51%**	**97.54%**	**98.72%**

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

There were no late payments of commercial debt during the year (2013/14: £1).

7 Income Generation Activities

There were no income generation activities during the year (2013/14: £nil).

8 Investment revenue

There was no investment revenue during the year (2013/14: £nil).

9 Other gains and losses

There were no other gains and losses during the year (2013/14: £nil).

10 Finance costs

There were no finance costs during the year (2013/14: £1).

11 Net gain/(loss) on transfer by absorption

Transfers as part of a 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.

There was no gians/(loss) on transfer by absorption during the year (2013/14: £nil).

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payments recognised as an expense					
Minimum lease payments	0	1,163	0	**1,163**	1,259
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**1,163**	**0**	**1,163**	**1,259**

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

12.1.2 Future minimum lease payments

	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payable:					
No later than one year	0	0	0	**0**	0
Between one and five years	0	0	0	**0**	0
After five years	0	0	0	**0**	0
Total	**0**	**0**	**0**	**0**	**0**

12.2 As lessor

12.2.1 Rental revenue

	2014-15 £000	2013-14 £000
Recognised as income		
Rent	0	0
Contingent rents	0	0
Total	**0**	**0**

12.2.2 Future minimum rental value

	2014-15 £000	2013-14 £000
Receivable:		
No later than one year	0	0
Between one and five years	0	0
After five years	0	0
Total	**0**	**0**

13 Property, plant and equipment

There CCG has no property, plant and equipment at the year end (2013/14: £nil).

14 Intangible non-current assets

There CCG has no intangible non-current assest at the year end (2013/14: £nil).

15 Investment property

The CCG has no investment property at the year end (2013/14: £nil).

16 Inventories

The CCG has no inventories at the year end (2013/14: £nil).

17 Trade and other receivables

	Current 2014-15 £000	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	233	0	1,256	0
NHS receivables: Capital	0	0	0	0
NHS prepayments and accrued income	926	0	168	0
Non-NHS receivables: Revenue	118	0	62	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments and accrued income	106	0	342	0
Provision for the impairment of receivables	0	0	0	0
VAT	66	0	88	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	(1)	0
Total trade & other receivables	**1,449**	**0**	**1,915**	**0**
Total current and non current	**1,449**		**1,915**	
Included above:				
Prepaid pensions contributions	0		0	

17.1 Receivables past their due date but not impaired

	2014-15 £000	2013-14 £000
By up to three months	46	73
By three to six months	32	0
By more than six months	0	0
Total	**78**	**73**

£45,197 of the amount above has subsequently been recovered post the statement of financial position date (2013/14: £73,000).

17.2 Provision for impairment of receivables

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	0	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2015	**0**	**0**

	2014-15 £000	2013-14 £000
Receivables are provided against at the following rates:		
NHS debt	0	0

18 Other financial assets

The CCG has no other financial assets at the year end (2013/14: £nil).

19 Other current assets

The CCG has no other current assets at the year end (2013/14: £nil).

20 Cash and cash equivalents

	2014-15	2013-14
	£000	£000
Balance at 1 April 2014	14	0
Net change in year	29	14
Balance at 31 March 2015	**43**	**14**
Made up of:		
Cash with the Government Banking Service	43	14
Cash with commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**43**	**14**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2015	**43**	**14**
Patients' money held by the clinical commissioning group, not included above	0	0

21 Non-current assets held for sale

The CCG has no non-current assets held for sale at the year end (2013/14: £nil).

22 Analysis of impairments and reversals

The CCG has no impairments and reversals in during the year (2013/14: £nil).

23 Trade and other payables

	Current 2014-15 £000	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	0	0	0	0
NHS payables: revenue	856	0	3,383	0
NHS payables: capital	0	0	0	0
NHS accruals and deferred income	632	0	271	0
Non-NHS payables: revenue	3,990	0	3,624	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals and deferred income	942	0	434	0
Social security costs	26	0	21	0
VAT	0	0	0	0
Tax	29	0	26	0
Payments received on account	0	0	81	0
Other payables	319	0	76	0
Total trade & other payables	**6,794**	**0**	**7,916**	**0**
Total current and non-current	**6,794**		**7,916**	

Other payables include £38,000 outstanding pension contributions at 31 March 2015 (2013/14: £nil).

24 Other financial liabilities

The CCG has no other financial liabilities at the year end (2013/14: £nil).

25 Other liabilities

The CCG has no other liabilities at the year end (2013/14: £nil).

26 Borrowings

The CCG has no borrowings at the year end (2013/14: £nil).

27 Private finance initiative, LIFT and other service concession arrangements

The CCG has no private finance initiative, LIFT or other service concession arrangements at the year end (2013/14: £nil).

28 Finance lease obligations

The CCG has no finance lease obligations at the year end (2013/14: £nil).

29 Finance lease receivables

The CCG has no finance lease receivables at the year end (2013/14: £nil).

30 Provisions

	Current 2014-15 £000	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Continuing care	117	0	57	0
Other	0	0	0	0
Total	**117**	**0**	**57**	**0**
Total current and non-current	**117**		**57**	

	Continuing Care £000s	**Other £000s**	**Total £000s**	2013-14 Total £000s
Balance at 1 April 2014	**57**	**0**	**57**	0
Arising during the year	60	0	60	57
Utilised during the year	0	0	0	0
Reversed unused	0	0	0	0
Unwinding of discount	0	0	0	0
Change in discount rate	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0
Balance at 31 March 2015	**117**	**0**	**117**	**57**
Expected timing of cash flows:				
Within one year	117	0	117	57
Between one and five years	0	0	0	0
After five years	0	0	0	0
Balance at 31 March 2015	**117**	**0**	**117**	**57**

31 Contingencies

	2014-15 £000	2013-14 £000
Contingent liabilities		
Continuing Care	0	57
NHS Property Services	779	0
Net value of contingent liabilities	**779**	**57**

During 14/15, the CCG received various versions of the pricing model from NHS Property Services. The CCG was unable to confrim the figures, and as a result the CCG wrote to NHSPS proposing payment in line with 13/14 charges. At the date of the Accounts, NHSPS has not responded to this request. A Contingent Liability has been recognised in the accounts in the event that NHSPS do not agree to the CCG proposal.

	2014-15 £000	2013-14 £000
Contingent assets		
Amounts payable against contingent assets	0	0
Net value of contingent assets	**0**	**0**

32 Commitments

32.1 Capital commitments

	2014-15	2013-14
	£000	£000
Property, plant and equipment	0	0
Intangible assets	0	0
Total	**0**	**0**

32.2 Other financial commitments

The NHS Clinical Commissioning Group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2014-15	2013-14
	£000	£000
In not more than one year	0	0
In more than one year but not more than five years	0	0
In more than five years	0	0
Total	**0**	**0**

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

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

33.1.3 Credit risk

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

33.1.4 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2014-15 £000	**Loans and Receivables 2014-15 £000**	**Available for Sale 2014-15 £000**	**Total 2014-15 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	233	0	233
· Non-NHS	0	118	0	118
Cash at bank and in hand	0	42	0	42
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**393**	**0**	**393**

	At 'fair value through profit and loss' 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,256	0	1,256
· Non-NHS	0	62	0	62
Cash at bank and in hand	0	14	0	14
Other financial assets	0	(1)	0	(1)
Total at 31 March 2014	**0**	**1,331**	**0**	**1,331**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £000	**Other 2014-15 £000**	**Total 2014-15 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	1,488	1,488
· Non-NHS	0	5,250	5,250
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**6,738**	**6,738**

	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,654	3,654
· Non-NHS	0	4,098	4,098
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2014	**0**	**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 2014 ending 31 March 2015 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

	2014-15 £000	2013-14 £000
Balance Brought Forward	**544**	0
Income		
Nottingham City Council	1,349	1,286
Nottinghamshire County Council	2,328	2,313
Bassetlaw CCG	437	466
Nottinghamshire County CCGs	2,400	2,210
Nottingham City CCG	1,229	1,314
Other	222	968
Total income	**7,965**	**8,557**
Expenditure		
Partnership Management & Administration Costs	360	287
Contract Management Fee	1,191	1,091
ICES Equipment	5,445	5,545
Continuing Healthcare Specialist Equipment	235	286
Minor Adaptations	849	804
Project Provision Expenditure	76	0
Total expenditure	**8,156**	**8,013**
Remaining Balance under/(overspend)	**353**	**544**

The Nottingham North and East CCG contribution to the pool is £774,000 (2013/14: £477,000).

36 NHS LIFT investments

The CCG has no NHS LIFT investments at the year end (2013/14: £nil).

37 Intra-government and other balances

	Current Receivables 2014-15 £000	Non-current Receivables 2014-15 £000	Current Payables 2014-15 £000	Non-current Payables 2014-15 £000
Balances with:				
· Other Central Government bodies	0	0	0	0
· Local Authorities	49	0	0	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	245	0	535	0
· NHS Trusts and Foundation Trusts	914	0	953	0
Total of balances with NHS bodies:	**1,159**	**0**	**1,488**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	241	0	5,306	0
Total balances at 31 March 2015	**1,449**	**0**	**6,794**	**0**

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	87	0	82	0
· Local Authorities	0	0	0	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	629	0	2,794	0
· NHS Trusts and Foundation Trusts	795	0	860	0
Total of balances with NHS bodies:	**1,424**	**0**	**3,654**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	404	0	4,180	0
Total balances at 31 March 2014	**1,915**	**0**	**7,916**	**0**

38 Related party transactions

IAS 24 applies to material transactions between NHS bodies and related parties.

Details of related party transactions with individuals are as follows:

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	17	0	1	0
The Calverton Practice	109	0	9	0
The Peacock Practice	13	0	1	0

Details of related party transactions with other bodies are as follows:

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 as follows:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
NHS England;	16,756	1,195	536	246
NHS Foundation Trusts;	8,724	0	489	329
NHS Trusts;	100,757	54	466	586
Health Education England	0	63	0	0
NHS Special Health Authorities	5	0	0	0
NHS Property Services/Community Health Partnerships	398	0	0	0

39 Events after the end of the reporting period

Co-Commisioning

Early in 2015 the CCG received confirmation that it had been approved for full delegated primary care co-commissioning status for 2015/16. This will cover the commissioning of some GP services previously commissioned by NHS England and will allow the CCG whole system integration to support the delivery of a single out of hospital health and well-being network and strengthen the CCGs ability to create a whole systems integrated care solution. The CCG will receive an allocation of £18.186m in 2015/16.

Better Care Fund

The Better Care Fund was announced by the Government in June 2013 spending round, to ensure a transformation in integrated health and social care. In 2015/16 an additional £1bn has been transferred from NHS England Area Teams for former Section 256 schemes to CCGs to create the total fund at £3.8bn. The CCG has received an additional £3.124m, which has been put towards creation of a Better Care Fund pooled budget in NNE of £9.115m in 2015/16 and a contingency has been agreed of £495k which is being withheld from the amount paid into the pool.

The impact of these two events on future accounts is represented as follows:

Description of Event	Note 5 Operating Expenses £'000	Note 35 Pooled Budget - CCG Share £'000
Creation of Better Care Fund 2015/16	9,115	9,115
Implementation of primary care co-commissioning 2015/16	18,186	
Total	**27,301**	**9,115**

40 Losses and special payments

40.1 Losses

There were no losses or special payments during the year (2013/14: £nil).

41 Third party assets

	2014-15 £'000	2013-14 £'000
Third party assets held by NHS Nottingham North & East CCG	0	0

42 Financial performance targets

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

	2014-15 Target	**2014-15 Performance**	2013-14 Target	2013-14 Performance
Expenditure not to exceed income	172,223	170,136	167,083	166,065
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	170,017	167,930	164,862	163,844
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Direction	3,654	2,720	3,414	3,339

43 Impact of IFRS

There has been no impact of IFRS on the CCG during the year (2013/14: £nil).

44 Analysis of charitable reserves

The CCG has no charitable reserves at the year end (2013/14: £nil).