NHS
Nottingham North and East
Clinical Commissioning Group

Putting good health *into practice*

Our Annual Report and Accounts 2015/16

This is the Annual Report and Accounts for NHS Nottingham North and East Clinical Commissioning Group 2015/16. It includes information about the organisation and its activities during 2015/16.

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

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Performance Report

NHS Nottingham North and East Clinical Commissioning Group assumed statutory responsibility from NHS Nottinghamshire County Primary Care Trust for commissioning a range of health care services for the registered population of Nottingham North and East from 1 April 2013. This document fulfils our duty to produce an annual report on how we have discharged our functions in 2015/16. It also highlights our achievements, as well as the challenges faced during 2015/16.

The Annual Report will be presented alongside our annual financial accounts, which have been prepared under a Direction issued by NHS England under the Health and Social Care Act 2012 c.7 Schedule 2 s.17.

Overview

Chief Officer's Statement

I am delighted to present Nottingham North East Clinical Commissioning Group's (NNE CCG) Annual Accounts and Report which describes our third full year in operation. During our third year we have continued to mature as an organisation and develop close working relationships with partners and organisations across the health and social care economy. In particular, during 2015/16 we have developed a greater understanding of how we can work effectively across health and social care and taken the opportunity in 2015/16 to understand more about our patients and carers and build relationships with our local communities.

I feel that 2015/16 has been a successful year due to our commitment and achievement in delivering against the aims of The Five Year Forward View. The report outlines some of our most significant achievements in tackling health inequalities, improving the quality of care and ensuring robust financial management working towards reducing the financial gap.

2015/16 was our first year with delegated authority for GP contracts and this has provided us with opportunities to support and develop our local services. The practices in NNE CCG have been committed in working with the CCG to reduce unwarranted clinical variation and make efficiency savings. We have embraced the advantages in using technology and have supported our practices in implementing telephone triage systems, implemented a system to help GPs and patients navigate through care journeys, joint up systems so that relevant patient information can be shared between clinicians.

The year has not been without its challenges as the demand for services has continued to increase and we have seen intense pressure on our urgent care system, in particular the Emergency Department at both our local Trusts. Reducing demands on hospital services in particular the urgent care services has been a priority for the CCG and will continue to be a focus for 2016/17.

2015/16 has been a rewarding and challenging year, a year of consolidation and development both as a CCG and as part of the wider system. 2015/16 has strengthened the foundations for improved health and social care in 2016/17.

Purpose and Activities of the Organisation

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

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 150,000, organised collectively to commission health services for the patient population living in and around Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield, and Newthorpe.

NNE CCG's vision is:

"Putting Good Health into Practice"

This vision will be delivered through:

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

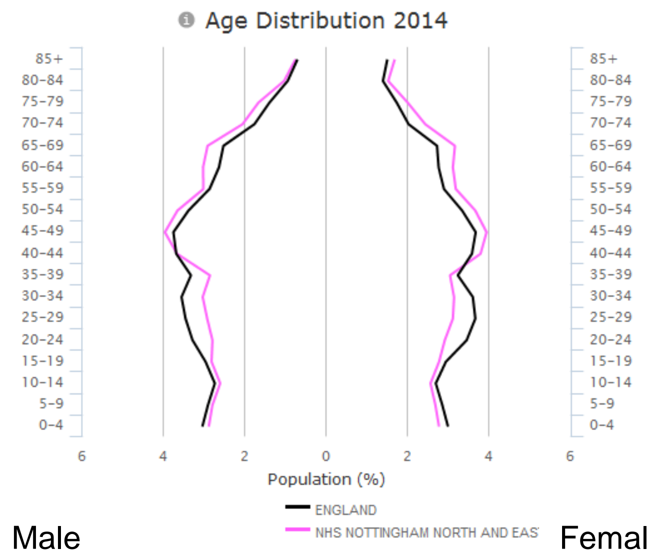
Our Population

The population of NNE CCG is spread across a mix of urban areas and rural villages and has a registered population of approximately 150,000. 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

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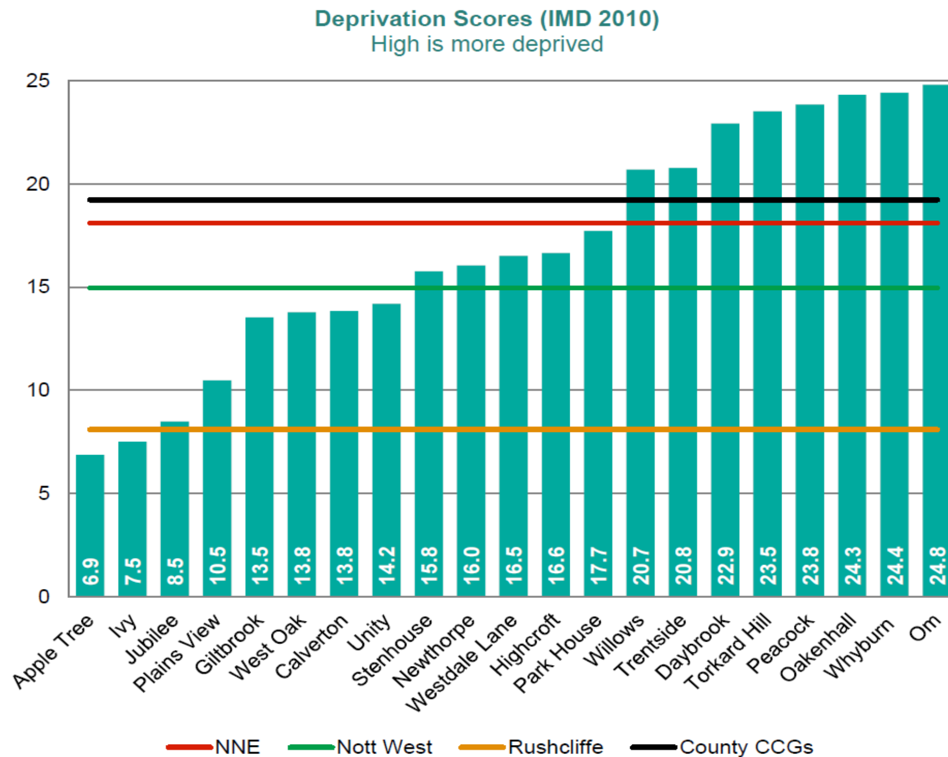
Health, Health Inequalities and Deprivation

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.



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Our Providers

We commission services from NHS, local authority, voluntary sector and private organisations. In order to support integration across the public sector we may also commission from other agencies, particularly in relation to services for prevention.. The organisations from which we commission the majority of our services are:

- Nottingham University Hospitals NHS Trust
- Sherwood Forest Hospitals
- Nottinghamshire Healthcare NHS Trust – including mental health and community services
- Circle Nottingham Ltd (based at the Nottingham Treatment Centre)
- East Midlands Ambulance Service (EMAS)

Our Commissioning Partners

In order to allow us to work efficiently and effectively as part of the wider system, we work collaboratively with our neighbouring CCGs and the Local Authority.

With neighbouring CCGs, working collaboratively allows us to share resources and commission jointly alongside reducing complexities within the system. More specifically, collaborating in this way enables the CCGs included to:

- maximise management and clinical capacity and capability, whilst remaining within the prescribed running costs allowance
- integrate commissioning and provision across primary care, community services and acute care
- share, spread and sustain good practice and influence clinical behaviours using sound evidence
- Scale commissioning control appropriately, e.g. at local level for specific local needs and at broader scale when commissioning as a group of CCGs.

We collaborate with Nottinghamshire County Council to commission services for children and young people through the Children's Integrated Commissioning Hub (ICH). The ICH aims to act as a system leader for children and young people's health and wellbeing services across the Nottinghamshire county CCGs, public health, and wider children's services within NCC. The ICH is uniquely placed to integrate and coordinate the commissioning of services across the system through expertise and knowledge around the children and young people's agenda and strong working relationships and partnerships. We have had a successful first year of the Better Care Fund and as a result work jointly with Nottinghamshire County Council on services for Carers.

The CCG is a member of the Health and Wellbeing Board and during 2015/16 has worked closely with the County Council and other partners to deliver the Health and Wellbeing Strategy. This has allowed the CCG to be actively involved in multi-agency planning on air quality, housing, health inequalities and the challenges of obesity.

Our Activities

As mentioned above, the CCG continues to work collaboratively as part of a wider health and social care system and 2015/16 has been a successful year in delivering against CCG objectives, the Nottinghamshire health and wellbeing strategy and overall transformation.

The CCG priorities for 2015 – 2016, were to:

- reduce health inequalities in the local population by targeting those people with the greatest health needs
- drive up the quality of care in order to improve health outcomes and reduce unwarranted clinical variation
- direct available resources to where they will deliver the greatest benefit to the local population
- commission appropriate models of care for older and vulnerable people with complex needs, ensuring all patients are treated with dignity and respect
- ensure that patients are able to make choices about the care they receive and are seen in the right place at the right time by the right person.

The priorities have been delivered through our Operational Plan for 2015/16. Some of our key achievements are as follows:

Quality of Care

During 2015/16 we have worked with providers to ensure that quality schedules and Quality Contract/Commissioning for Quality and Innovation (CQUIN) schemes promote the development of comprehensive patient safety indicators including the measurement of the nature and level of harm that can occur in healthcare services and the safety culture of the organisation.

We have developed quality dashboards that facilitate the triangulation of both process and outcome measures across the range of quality indicators and have used a range of safety data including safety thermometer, incident reporting, claims and complaints to facilitate benchmarking and peer review to support the identification and sharing of best practice

Supporting Improvements in Primary Care

2015/16 was our first year of delegated authority for GP contracts and more detail can be found in our primary care strategy. Successes that we achieved in 2015/16 include:

- The development and implementation of a Quality Framework
- Improved GP access by using the Prime Minister's Challenge Fund to implement Telephone Triage Services in our GP practices
- Tackling unwarranted variation with the implementation of Map of Medicine which helps GPs with patient consultations and care journeys
- Training and workshops for clinical and non-clinical staff in GP practices

A new relationship with patients and communities

As mentioned NNE have pockets of greater deprivation and in order to understand more about health inequalities we've been working directly with our local communities as well as having joint plans with District and Borough Councils on different areas including loneliness and exercise. We have been looking at how to improve our local communities directly with residents through the Connected Communities C2 framework. Following successful listening events we have had community meetings and events focused on issues identified by local residents. Within Hucknall this has led to a joint initiative with Ashfield District Council to provide a team of support workers directly within our C2 community. In Daybrook a group of providers and residents have formed a partnership group called We Love Daybrook (WeLD). WeLD have been meeting monthly and taking forward community events and activities, including looking at how to support the most vulnerable.

Initiatives to empower patients include shared decision making. During 2015/16 we produced shared decision making tools for knee surgery and cataracts which have been successfully implemented by GPs and welcomed by patients. We developed a communications plan to promote Shared Decision to our GPs and patient population. Patients were involved in designing, and helping to write the copy for, the campaign collateral.

We have increased our support to carers through Carers Champions in each of our practices. During 2015/16 through the Carers Champions peer groups have been established, carers are being identified and their health needs are being addressed, GPs and clinicians can now signpost carers to services and support. During 2015/16 the CCG has also been working closely with schools on identifying young carers and having the knowledge and information to ensure that these young people have the support they need.

Improving the primary care management of Atrial Fibrillation (AF)

The CCG implemented a cardiovascular disease (CVD) strategy. The first stage of this strategy was to improve the primary care management of patients with AF. Through Right Care and Commissioning for Value AF was identified as an area to focus on in order to deliver against our priorities. The completed audit and review of patients achieved the following improvements in the primary care management of patients with AF:

- AF prevalence increased from 1.74% to 2.06% for NNE (national average of all GRASP data = 1.88%)

- The percentage of patients with a GRASP AF CHAD2VAS score increased from 54.13% to 83.48% (national average of all GRASP data = 84.3%, the score identifies the risk of stroke)
- The percentage of patients with AF not on anticoagulation reduced from 35.2% to 30.19% (the provision of anti-coagulation for suitable patients reduces the risk of stroke)

Diabetes and Education in Diabetes

During 2015/16, the CCG implemented the Year of Care training programme. The programme aims to improve care for diabetic patients by focusing on patient centred care planning and self-management. The training has demonstrated that where care planning and support for self-management are implemented there can be improvements in patient experience, care processes and clinical outcomes. NNE CCG was also involved in the development of the Diabetes Hypo Pathway with the ambulance service and which now covers Nottinghamshire. The pathway enables patients who have had a hypoglycaemia episode to be referred to their GP practice in order for their diabetes management to be reviewed and to reduce the risk of a second episode.

Respiratory

During 2015/16 NNE has undertaken a respiratory review, which has seen significant improvements within primary care and our community services. The review has led to the development of a patient support group (Breathe Easy Hucknall), the roll out of self-management plans for both COPD and Asthma to support patients, including the relaunch of the ‘Emergency Respiratory Pink Card’ which has enabled direct access for all patients with a respiratory condition to the respiratory assessment unit. In addition, funding for ‘COPD 6’ machines has been obtained to support both primary care and the community respiratory team with the review and management of housebound and care home patients who are unable to complete the normal diagnostic test for COPD. Every practice has identified a lead GPs and nurse for respiratory disease.

Implementation of Care Delivery Groups

A Care Delivery Group has been implemented in the Arnold area within Locality 2 since November 2015. It is intended to improve the management of older people’s care in a multidisciplinary way across health, social care and voluntary sectors. The approach aims to provide an integrated care pathway designed to help improve the navigation of services between agencies and reduce duplication within the system. Funding through the Better Care Fund was secured to enhance the existing multidisciplinary team (MDT) consisting of primary care and community health service including both nursing and therapy with a social worker, a community care

officer, and a Living Well Coordinator from Age UK Notts. The new staff have been attending the MDT meetings to discuss patients at risk of unplanned hospital admissions, picking up referrals related to social care and those that could benefit from support around self-help.

Medicines Safety

In the last year, the team has continued to focus on safety and is building on previous work around implementation of the Royal college of GPs indicators by working with all practices across the CCG to implement PINCER. PINCER is a pharmacist information technology intervention for reducing clinically important errors in medication management. A member of the team also acts as designated Medicines Safety Officer (MSO) representing the CCG as part of the Nottinghamshire and Derbyshire Medicines Safety Officers Network. This enables CCG MSO leads to work together to support and improve medicines safety across the interfaces during transfer of care between health and social care services including primary care, secondary care and community care.

Care Homes and Vulnerable Patients

Due to a new role, in 2015, we have had resource directly focused on medicines management in care homes. The CCG have ensured that systems and processes for medicines management are safe as well as focusing on particular areas of prescribing and carrying out individual patient medication reviews. The CCG have been running information sessions and medication reviews with staff and individuals in sheltered accommodation. The CCG has also been developing new tools to support medicines management for individuals with learning disabilities.

Driving forward Technology to Improve Patient Care

The CCG is improving patient care through using technology to share patient records. During 2015/16 the CCG worked with the Connect Nottinghamshire team to implement the medical interoperability gateway (MIG) across a number of care organisations in the county. MIG enables a subset of coded data from a patient's GP clinical record to be shared with clinicians in other, mainly urgent care settings to facilitate the best possible care for the patient. Currently 85% of NNE patient records are able to be shared via MIG with clinicians at NEMS, 111, EMAS and local ED departments. Patients are always asked permission to view their record by clinical staff and if permission is denied they are not allowed to look. They can't see everything just the bits of information that make it easier for them to treat and care for patients in the most appropriate way. The CCG will continue to work with the Connect Nottinghamshire team during 2016/17 to develop and implement more

advanced information sharing for specific datasets of information such as for people approaching the End of Life.

Transformation - Greater Nottingham Health and Care Partners

Commissioners and providers from health and social care organisations across Greater Nottingham have come together to co-ordinate a response to current challenges, recognising that no single organisation can achieve quality and sustainable provision alone. Formally known as the South Nottinghamshire Transformation Board, Greater Nottingham Health and Care Partners have agreed to create a profoundly different system with the attributes of an accountable care system.

Population Segments

In 2015/16 we started to develop a long term service strategy based on the perspectives of five different 'population groups' - older people; people with long term conditions; mothers, children and young people; people with mental health problems and the mostly healthy. Models of care for each population group were developed by working groups and agreed by our newly formed Clinical Leadership Forum which includes lay leaders (members of the public). These models of care describe what services will look and feel like through the eyes of someone who relates to one or more of these population groups.

Identifying and delivering improvements

During 2015/16 three 'service' work streams were established on primary and integrated care, urgent care and elective care which incorporate the work of the three Vanguards in Greater Nottingham - the Urgent care Vanguard, The City CCG Support to Care Homes Vanguard and the Principia MCP Vanguard

The Elective Care Work stream for Greater Nottingham has actively adopted the RightC

are approach to identifying value opportunities in care pathways ahead of the national roll-out. The RightCare value based commissioning packs have highlighted opportunity for the 4 CCGs to improve both clinical outcomes and the cost of care in cancer services, MSK, neurological conditions, and gastro-intestinal.

Analysis has been undertaken of the current state, including transparency around financial impacts, to identify opportunities for service transformation in the key areas identified by applying the RightCare methodology:

- Cancer
- MSK

- Standardised pathways including needs-led follow-up care – focusing initially on ENT, community plastics, access to diagnostics, gastro-intestinal and system wide needs-led follow up care.

Our Strategic Objectives and Risks

Strategic Objective 1: The CCG has effective and appropriate financial management including stretching itself financially, efficient financial controls and processes and good governance. The **identified risk** is that the CCG is unable to deliver against plan due to continually increasing activity, unexpected costs and an inability to maintain QIPP savings

Strategic Objective 2: The CCG has effective and appropriate financial management including stretching itself financially, efficient financial controls and processes and good governance. The **identified risk** is that the fragility of the system impacts on the capability of the CCG to deliver against its financial duties.

Strategic Objective 3: The CCG has comprehensive and achievable plans as both a CCG and as part of a wider system. The **identified risk** is that the Capacity and demands impacting on short term performance hinder the capability to support transformation, the footprint and plans for the long term.

Strategic Objective 4: The CCG demonstrates that it is planning effectively providing a basis for transforming services, improving outcomes while ensuring that patients receive the high quality, timely care that they have a right to expect today. The **identified risk** is that the CCG is unable to provide confidence to its local population that it is commissioning clinically safe, high quality, compassionate services. Lack of adequate focus and challenge may lead to compromised quality, outcomes or inappropriate prioritisation

Strategic Objective 5: The CCG demonstrates that it is planning effectively providing a basis for transforming services, improving outcomes while ensuring that patients receive the high quality, timely care that they have a right to expect today. The **identified risks** are;

1. Due to a lack of understanding and/or effort to recognise the different population segments, the CCG is unable to plan effectively and reduce health inequalities and/or demonstrate continuous improvements for the protected characteristics.
2. There is a risk that pressures and fragility within the system, ie ED, Cancer, EMAS, impact on the CCG's capability to deliver against targets.

Strategic Objective 6: To ensure effective and efficient management of delegated functions and high quality primary care. The **identified risk** is that there is Limited

engagement between member practices and with the CCG impacts on the capability to work together on delivery of transformational change, including gaining benefits through commissioning, federation and to improve the quality of primary medical services.

Strategic Objective 7: To ensure a well-led organisation including strong leadership and good governance resulting in delivery of all statutory functions and duties, partnership working and a strong workforce. The **identified risks** are;

1. Due to the resource and focus required as lead commissioner for NUH, leaders are not visible and are not able to focus on the short and longer term priorities of the CCG
2. Lack of succession planning in the leadership team and the Governing Body impacts on the capability to evidence robust leadership.

Performance Summary

The CCG has had a successful year of consolidation and development which is evident in our performance. In order to support improvements in care and outcomes, the CCG monitors it's performance against the CCG Assurance Framework. The assurance framework covers five components: well-led; delegated functions; finance; performance and planning. The 'performance' element of the framework includes indicators relating to quality and outcomes in the CCG delivery dashboard. The dashboard also includes the national Commissioning Outcomes Indicator Set that is used to measure how we are contributing to progress in the domains of the NHS Outcomes Framework, as well as other indicators from the NHS Constitution, the Better Care Fund, and a range of other sources.

A summary of indicators and performance is as follows:

92.48%	**97.65%**	**90.48%**
Admitted patients who were treated within 18 weeks. (standard 90%)	Non admitted patients who were treated within 18 weeks. (standard 95%)	Patients treated within 4 hrs of attending Accident and Emergency. (standard 95%)
97.09%	**82.67%**	**91.33%**
Patients received their first treatment within 31 days following a diagnosis of cancer. (standard 96%)	Patients diagnosed with cancer treated within 62 days of a referral from their GP. (standard 85%)	Patients with suspected cancer were seen by a consultant within 14 days of referral by their GP. (standard 93%)
69.12%	**60.83%**	**69.7%**
Ambulance services responded within 8 minutes to immediately life threatening cases where defibrillator required. (standard 75%	Ambulance responded within 8 minutes to immediately life threatening cases. (standard 75%)	Patients estimated to have dementia have been identified.
3.94%	**53.28%**	**£198,368k**
Patients estimated to have depression and/or anxiety have received psychological therapies. (standard 3.75%)	Patients who had completed treatment were moving to recovery. (standard 50%)	Remained within resource limit.
£3,201k	**£7.1m**	**92%**
Remained within running cost allowance.	Quality, Innovation, Productivity and Prevention target achieved.	Proportion of older people (65+) who were still at home 91 days after discharge from hospital to reablement services (target 90.7%)
665	**2,742**	**0**
Permanent admissions of older people (65+) to residential and nursing care homes per 100,000 population. (target 657.35)	Number of delayed days in transfers of care from hospital per 100,000.	Number of cases of meticillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infections (BSI).
39	**45,232**	**7.7%**
Number of complaints received.	Mileage covered through work travel.	Decrease in greenhouse gas admissions from 2014/15.

Well-Led	Finance	Performance	Planning	Delegated Functions
Good	Good	Good	Good	Good

Performance Analysis

Clinical Commissioning Groups (CCGs) are subject to a continuous assurance process – the CCG Assurance Framework 2015/16 - that aims to provide confidence to internal and external stakeholders and the wider public that the CCG is operating effectively to commission safe, high-quality and sustainable services within their resources, delivering on their statutory duties and driving continuous improvement in the quality of services and outcomes achieved for patients.

Financial Performance

The 2015/16 financial year for NHS Nottingham North and East has been a tough year, with a savings target (QIPP) of £7.1million required to maintain financial balance. In addition, the financial year saw the CCG take over delegated budgetary responsibility for GP Primary Care contracts and also the first full year of the Better care Fund. Both these areas presented a degree of uncertainty, and therefore financial risk, to the CCG in an already challenging financial environment.

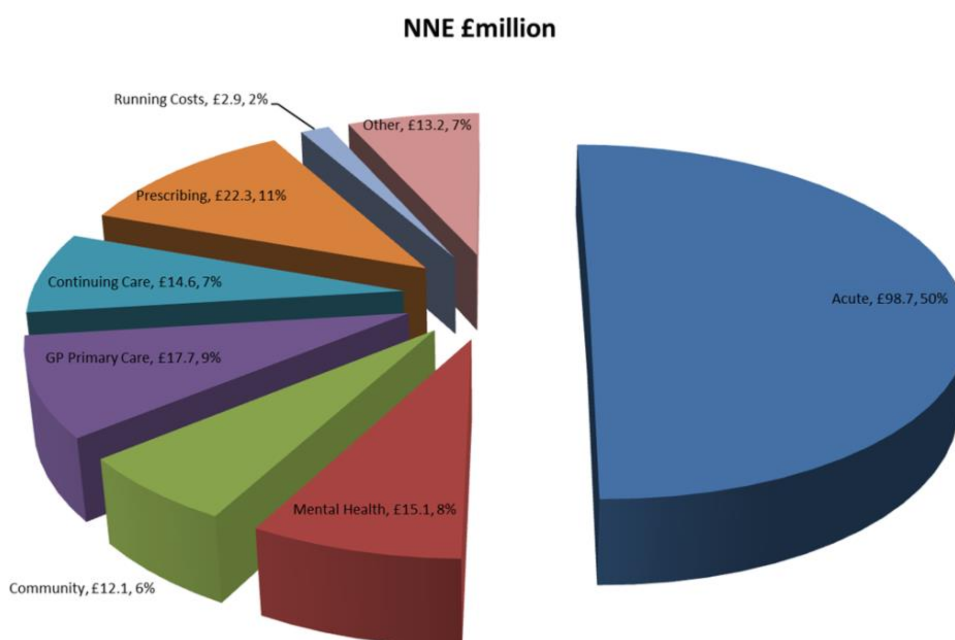
It is pleasing to note, therefore, that the CCG has met all of its financial duties for the year, including delivery of the planned surplus target of £1.798million. The duties are summarised below:

Delivery of 2015/16 Financial Duties

Financial Duty	Target £k	Delivery
Keep within Revenue Resource Limit	£198,368	✓
Achieve planned surplus	£1,798	✓
Cash balances within agreed limit	< £145	✓
Remain within Running Cost Allowance	£3,201	✓
Achieve BPPC targets	>95%	✓

The Better Payment Practice Code (BPPC) requires the CCG to aim to pay all valid NHS and non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

The CCG spends its allocation across a range of programme areas, and has a set limit against which to run the organisation (Running Cost Allowance). After accounting for the planned surplus (this forms part of the £198,368k allocation) the chart below shows where we spend our resource:



Delivery of the QIPP target has been a key area for the Finance Committee to oversee. The overall £7.1million target has been met, with £4.6million recurrently delivered through programme QIPP and the balance met through non-recurrent resources. The final delivery by programme is as follows:

QIPP Delivery by Programme

Programme	£k
Community Services	£129
Continuing Care	£56
Contracting	£915
Mental Health	£124
Planned Care	£752
Prescribing	£786
Unplanned Care	£1,828
Other	£43
Non recurrent	£2,473

Financial Governance

In line with the national picture, the CCG has been subject to an increasing level of financial governance processes. Our own internal financial governance framework includes the finance committee (Finance and Information Group) which meets monthly and oversees the financial and QIPP position of the CCG.

In July the CCG was subject to the national NHS England Financial Control Environment Assessment and of the 18 indicators was assessed as 1 excellent, 14 good and 3 moderate. The 3 moderate indicators all relate to the challenging financial position that the CCG is in, linked to the high QIPP target.

The Internal Audit programme for the CCG Finance covered Budgetary Control and Key Financial systems. Significant assurance was attained from the audits, contributing to the subsequent overall Significant Assurance Head of Internal Audit opinion for the CCG.

The CCG's external auditors have completed their year-end audit preparation with the pre-audit and Value for Money assessment both not raising any significant concerns. Finally, the CCG was selected to form part of a Department of Health Transaction Review towards the end of the financial year and the finance team was pleased to be able to assist the DH's auditors in their review work.

2016/17 Financial Plans

The new financial year continues to see a challenging financial environment, for the CCG and the local health economy overall. The CCG receives a 4.46% increase in its recurrent revenue allocation, however, with a number of national pre-commitments against this uplift coupled with inflationary pressures related to the impact of the national tariff payment mechanism, the CCG continues to have a tough QIPP target of £8.1million in order to deliver the NHS England business rules.

2016/17 Financial Plan Metrics

Metric	£k
Business Rules:	
Surplus - 1% requirement	£1,873
Running Cost Allowance	£3,246
Contingency - 0.5% requirement	£1,031
Non recurrent reserve - 1.0% requirement	£2,011
Resultant Plan	
Recurrent underlying position	£3,728
QIPP	-£8,086

Evidently the CCG faces significant financial risk in the new financial year. Whilst our financial plans allow for both demographic and other growth and cost pressures, the rising demand for services such as continuing healthcare, prescribing as well as acute care continue to place huge pressures on the CCG budget. QIPP plans to deliver the £8.1m are in place and it will be key for the CCG to ensure delivery throughout the year. As part of the QIPP planning, the CCG is utilising the Rightcare Commissioning for Value data to identify opportunities. Rightcare is a collaboration between NHS Right Care, NHS England and Public Health England and seeks to

identify priority programmes which offer the best opportunities to improve healthcare for our population.

The health economy overall similarly faces significant challenge and risk and this is being overseen by the Greater Nottinghamshire Transformation Programme (GNTP). The GNTP brings together key players from all the local health organisations as well as the City and County Councils and is addressing the transformation requirement and the Sustainability and Transformation Plan (STP) for the planning footprint. As part of the GNTP, a finance director's group has been established – this is chaired by the CCG's Chief Finance Officer. The STP additionally encompasses the health and social care organisations in mid Nottinghamshire.

GP Primary Care commissioning and also the Better Care Fund (BCF) enters the second full year in 2016/17. The CCG continues to invest significant resource into integrating services in conjunction with social care and other CCG partners. Financial plans to support the development of integrated primary care, community care beds and services and home care services continue.

Commissioning Outcomes

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 2015/16 we met or exceeded all the national targets for elective waiting times set by the Department of Health.

In the year to 31 March 2016:

- 92.29 per cent of admitted patients were treated within 18 weeks (national standard 90 per cent).
- 97.60 per cent of non-admitted patients were treated within 18 weeks (national standard 95 per cent).
- 208 patients waited more than six weeks for a diagnostics test, which is outside of the one per cent national tolerance.
- 97.33 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 2016:

- 91.70 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).
- 97.06 per cent of patients received their first treatment within 31 days following a diagnosis of cancer (national standard 96 per cent).
- 82.65 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:

- Reduce waiting times for diagnostic tests for patients suspected of having cancer
- Increase the numbers of clinical staff available
- Redesign clinical pathways to provide a better patient experience
- Ensure that appropriate levels of capacity are in place to meet the demand from local and national screening campaigns

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 March 2016:

- 89.55 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. Plans are in place to:

- Increase the number and type of staff within the A&E department
- Review the clinical pathway to improve the patient flow through the department
- Increase the number of medical decision makers working overnight

We are continuing to work with the wider Nottingham health community to improve performance for our population. We recognise this remains a high priority going forward in 2016/17.

Ambulance – East Midlands Ambulance Service

In the year to 31 March 2016:

- 69.12 per cent of calls assigned as Red 1 (immediately life threatening cases where a defibrillator is required) were responded to within eight minutes (national standard 75 per cent).
- 60.83 per cent of calls assigned as Red 2 (immediately life threatening cases) were responded to within eight minutes (national standard 75 per cent).
- 62.21 per cent of all calls assigned as Red were responded to within eight minutes (national standard 75 per cent).

Ambulance Service performance data is at East Midlands level. Performance has been under close scrutiny throughout 2015/16 and we will continue to work with our provider organisation and co-ordinating commissioner, NHS Hardwick CCG, to improve performance in this area through 2016/17. Please see the Governance Statement further on in this report for more detail.

Cancelled Elective Operations – Nottingham University Hospitals

In the year to 31 March 2016:

- Seventeen elective operations were cancelled at the last minute for non-clinical reasons and not rebooked within 28 days (national standard is zero).

We will continue working with our provider organisations to monitor and improve performance in this area during 2016/17.

Dementia Diagnosis Rate

In April 2015, NHS Nottingham North & East CCG was required to submit dementia diagnosis rate targets, against which we were monitored, as part of our formal planning submission to NHS England. The diagnosis rate target for 2015/16 was 67 per cent.

As at 31 March 2016 the achievement figure is:

- 69.7 per cent of patients estimated to have dementia have been identified

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 is that each quarter, at least 3.75 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 year to 31 March 2016:

- 3.67 per cent of patients estimated to have depression and/or anxiety disorders within the CCG had received psychological therapies (national target is 3.75 per cent for each quarter).

- 51.47 per cent of patients who had completed treatment were 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.

Better Care Fund Metrics

Our transformation plans are aligned with our components of the Better Care Fund, which is a critical part of delivering the CCG's Operational Plan and the five year local health and care system's Sustainability and Transformation Plan, and is therefore a key contributor to the delivery of the ambitions set out in the Five Year Forward View (FYFV).

During 2015/16 partners worked together to monitor implementation of schemes and progress against national conditions and key metrics. The key metrics demonstrate the progress made in 2015/16:

- 1,938 fewer non-elective admissions than planned in 2015
- 17 more people than planned being permanently admitted to care homes (April to December 2015)
- 92 per cent of people remaining at home 91 days after local community reablement services (April to December 2015)
- 873 fewer days than planned on delayed hospital discharges (October to December 2015)
- 38 fewer admissions to care homes directly from hospital (April to December 2015)

Quality Performance

Commissioning is a tool for ensuring high quality, cost–effective care which relies on adequate and meaningful data. Quality underpins the work undertaken by clinical commissioning groups. The South Nottingham Clinical Commissioning Groups (CCGs) are working in partnership to improve health and change lives. The mission is to improve the health and wellbeing of people in South Nottingham with a specific aim to improve quality by delivering improved safety, effectiveness of services and improved patient experience.

The three quality domains are:

- Patient Safety (the safety of treatment and care provided to patients)
- Patient experience (the experience patients have of the treatment and the care they receive)

- Clinical Effectiveness (measured by both clinical outcomes and patient-related outcomes)

Quality is only achieved when all three domains are met; delivering on one or two is not enough. To achieve a good quality service the values and behaviours of those working in the NHS need to remain focussed on patients first. An organisation that is truly putting patients first will be one that embraces and nurtures a culture of open and honest cooperation. The CCG has implemented a Quality Strategy that covers the period 2014-2019 to support continuous quality improvement.

Our ambition is to commission excellent, safe and cost effective healthcare for Nottinghamshire.

The following aims support the achievement of this ambition:

- **Patient safety *aim:*** *To commission safe services for our local community, patient safety will be our highest priority.*
- ***Patient experience aim:*** *We will commission patient-centred services that meet patient expectations*
- ***Clinical effectiveness aim:*** *We will commission safe, effective and evidence-based care that the delivers the best health outcomes across a range of conditions as set out in NHS Outcomes Framework and NICE Quality Standards.*

Our priorities, which are aligned to our commissioning intentions and values are:

- Reduction of health care acquired infections (HCAI)
- Reduction in Serious Incidents and Never Events
- Reduction of avoidable pressure ulcers
- Reduction of falls and harm from falls
- Safeguarding vulnerable adults and children
- Improvement in quality of care home services
- Improvement in quality of primary care medical services
- Improvement in patient experience and complaints management

We have worked with providers to ensure that quality schedules and CQUIN schemes promote the development of comprehensive patient safety indicators including the measurement of the nature and level of harm that can occur in healthcare services and the safety culture of the organisation.

We have developed quality dashboards that facilitate the triangulation of both process and outcome measures across the range of quality indicators and have used a range of safety data including safety thermometer, incident reporting, claims

and complaints to facilitate benchmarking and peer review to support the identification and sharing of best practice

We measure performance against targets set either nationally or locally through these quality dashboards which are scrutinised by the Quality and Risk Committee and reported to the Governing Body for information and assurance. Our performance against each priority for 2015-16 is detailed below:

Healthcare Associated Infections (HCAIs)

Targets for CCGs are set nationally and population based. Cases are designated as pre or post 72 hours, using the Public Health England definition, which is:

- Pre 72 hour / Community Acquired = diagnosis confirmed by a stool sample taken within 72 hours of admission to hospital or diagnosis from a GP sample.
- Post 72 hour / Hospital Acquired = diagnosis confirmed by a stool sample taken 72 hours after admission to hospital.

The table below shows year end position against limits.

Organisation	*Clostridium difficile*			MRSA Blood Stream Infection (BSI)	
	Full Year Limit to end 2015/16	Actual to end of 2015/16	Pre/Post 72 hour	Full Year Limit	Actual to end of 2015/16
NNE CCG	47	32	22 pre/10 post 72hr	0	0
NUH	91	95	N/A	0	6

All cases of *Clostridium difficile (C diff)* and meticillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infections (BSI) are subject to a Root Cause Analysis (RCA) or Post Infection Review (PIR). Where lapses in care are identified appropriate action plans are developed to mitigate risk and learning is shared across the health community.

Comparison with other similar organisations is helpful to gain contextual detail on trajectories against performance targets. Categorisation of CCGs by RightCare has been linked to the Office of National Statistics (ONS) clusters. Nottingham North and East are in a peer group named manufacturing towns. The CCG has compared well against their peers for *C diff* and MSRA have achieved their trajectories.

Within Nottingham University Hospitals NHS Trust C diff toxin positive assessments have identified lapses in the quality of care in 14 cases year to date. 10 cases have

been identified as avoidable. (5 cases reported in March 2016 are still under investigation). Lapses in care include:

- Cross-infection
- Inappropriate antimicrobials
- Delayed diagnosis

Of the six MRSA bacteraemia cases reported by NUH in 2015/16, only one to date has been identified as clinically avoidable following post infection review which is subject to CCG scrutiny. This was associated with an intravenous line and the Trust continues to deliver training and audit compliance with line care. Five infection prevention and control related quality visits have taken place at the Queens Medical centre campus between June – February 2016 by the CCG and the Trust Development Authority (TDA).

The Trust has implemented a significant amount of proactive initiatives over the year to address the previous concerns relating to cleanliness and basic infection control measures. Four clinical areas were visited; a mixture of announced and un-announced locations. The visiting group was assured that:

- Strategic leadership of infection control was strong and that the Board were fully engaged.
- Infection prevention and control is owned at all levels.
- The environment was clean.

The focussed work on infection prevention and control has had a significant impact on infection rates in the latter two quarters of the year enabling the Trust to recover from an end of Quarter 2 position of being 30% over *C diff* trajectory to a year end position of only 4% over.

The Trust also compares relatively favourably when rates of *C diff* and MRSA BSI per 1000 admissions is compared with peer Trusts. The challenge going forward is to sustain this improvement and the CCGs will continue to work closely with the Trust to achieve this.

Venous Thromboembolism Risk Assessment (VTE)

At points during the year NUH have failed to achieve the 95% target for completion of risk assessment for Venous Thromboembolism (VTE) within 24 hours by a small margin. The clinical risk associated with this underperformance has been assessed and found to be low due to the fact that all appropriate patients have been given prophylaxis and assessments have been completed within 48 hours. The Trust has implemented an action plan to improve compliance including weekly feedback to clinical teams and the introduction of electronic alerts.

Serious Incidents (SIs) and Never Events (NEs)

The table below identifies the number of SIs reported by providers where the South Nottingham CCGs are Co-ordinating Commissioners. These providers are: Nottingham University Hospitals Trust (NUH), Health Partnerships (HP), Circle Nottingham (CN), Nottingham Woodthorpe Hospital (NWH) and BMI The Park. A section has been added to include Primary Care (PC) SIs due to delegated responsibility from NHS England to the CCGs for oversight and monitoring from 1 April 2015. The main categories of Serious Incidents reported are grade 3 or 4 pressure ulcers, falls, maternity incidents and healthcare associated infections.

The revised SI framework (March 2015) moved away from grading incidents based on severity (0-2) instead focusing on the level of investigation required, which makes the data for 2015/16 incomparable with previous years.

It should be noted that quarter 4 data is provisional and cannot be fully validated until 60 days post year end when all investigations are concluded. The number could reduce if following scrutiny of the investigations it is determined that any incidents do not meet the SI criteria and are downgraded. The rise in SIs reported at NUH in quarter 4 is linked to increased seasonal infection outbreaks (norovirus/ D&V and influenza), an increase in pressure ulcers and a rise in 12 hour ED breaches which are reported as SIs.

Serious Incidents – 2015/16				
Organisation	**Concise[1]**	**Comprehensive[2]**	**Independent Investigation[3]**	**Full Year Total**
NUH	92	24	0	116
HP	89	0	0	89
Circle	0	3	0	3
NWH	0	0	0	0
The Park	0	0	0	0
NNE PC	4	0	0	4
Total	**182**	**27**	**0**	**212**

[1]Concise - less complex incidents managed by individuals or a small group at a local level

[2]Comprehensive - complex issues managed by a multidisciplinary team involving experts and/or specialist investigators where applicable

[3]Independent - required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are in place to

ensure they should never happen. The table below shows the number of Never Events reported by organisation during 2015/16. The Never Event framework was updated in March 2015 with the list of Never Events reducing from 25 to 14; it is therefore not possible to compare with numbers reported in the previous year.

Never Events		
Organisation	***2014/15* Full Year**	**2015/16 Full Year**
NUH	3	5
HP	0	1
Circle	2	0
NWH	n/a	0
BMI The Park	n/a	0

One Never Event was reported in September at NUH which consisted of a medication error (wrong route administration, epidural infusion of post-operative analgesia incorrectly administered via an intravenous route). Three Never Events were reported in quarter 3 at NUH. These consisted of a medication error (wrong route administration, oral morphine given intravenously), wrong implant/prosthesis (wrong size screws used to fix a maxillofacial plate) and a retained foreign object post-procedure (vaginal swab). One Never Event was reported in quarter 4 at NUH (wrong size hip prosthesis). All cases resulted in low harm to the patient and duty of candour was applied with apologies and explanations offered to the patients along with copies of the investigation reports (once completed). The CCGs have scrutinised the root cause analysis investigations and associated action plans developed by the Trust in response to these incidents and have been satisfied that the Trust has taken appropriate action to prevent future recurrence. Given the rise in reported Never Events, the Trust and the CCGs have undertaken a thematic review of the cases which has concluded that there are no common links in terms of clinicians and areas involved. Work continues in the Trust to ensure that lessons learned from incidents are widely shared across the organisation. The CCG has also undertaken quality visits to the orthopaedic department and to the theatre suite to assess safety processes including medication prescribing and administration practices and use of the WHO checklist which has provided some additional assurance.

Pressure Ulcers

The table below shows the number of pressure ulcer serious incidents reported during 2015/16. The data for quarter 4 is yet to be validated and therefore may reduce (if investigation demonstrates that the pressure ulcers were unavoidable).

Organisation	2015/16 Full Year
NUH	36
HP	83
Circle	0
NWH	0
The Park	0
NNE Primary Care	2

Only pressure ulcers which are assessed as grade 3 or 4 are reported as serious incidents. It is not appropriate to benchmark the numbers of serious incidents reported with other organisations as the numbers reported can be influenced by a number of factors including activity levels, patient demographics and acuity and differing reporting cultures. The numbers of pressure ulcers assessed as grade 1 or 2 are also reported internally by organisations and this data has been reviewed during the year at the Quality Scrutiny Panels held with providers. Data is also reported nationally as part of the safety thermometer dataset.

NUH pressure ulcer prevalence remains well below the national average. HP were previously identified as a significant outlier with higher than national average prevalence. This has improved in year but HP continues to have higher than national average prevalence. Analysis of the data has been undertaken in year and a number of factors have been identified which may be contributing to this including positive reporting culture, increased activity and acuity, significant numbers of inherited cases and issues with concordance.

Significant work has been undertaken during 2015/16 in NUH, HP and Circle to improve the recognition and management of risk of pressure ulcer development and as a result of the issues with concordance in the community some training in human factors has been introduced to support staff in dealing with this aspect.

The rise in pressure ulcers reported at NUH in quarter 4 is thought to be linked to increased activity and delays in ED. The Trust has introduced a process to follow-up patients at risk of pressure ulcers who were delayed in ED to identify if the delay has contributed to the development of pressure ulcers which has led to more ulcers being determined as avoidable than was previously the case. Nursing metrics are being introduced to ED to monitor compliance with risk assessment and interventions including pressure ulcers and falls.

Falls

16 falls resulting in moderate harm or above were reported during 2015/16. Total falls including those not resulting in harm are also recorded and data is submitted nationally as part of the safety thermometer dataset. Nottingham University Hospitals NHS Trust have committed to continue their previous Quality Contract/Commissioning for Quality and Innovation (CQUIN) work into falls prevention by expanding the falls prevention team, aligning the falls prevention care bundle with e-observations and expanding the RCA process to learn from repeat fallers, which is their main challenge. Since 2010/11 Nottingham University Hospitals NHS Trust have seen a 15% reduction in falls overall and have reduced the average number of falls per person from 1.62 to 1.25. Nottingham University Hospitals NHS Trust falls prevalence remains below the national average.

We have continued to scrutinise root cause analysis reports following serious incidents and identified recurring themes and trends, using this information to work collaboratively with providers to develop strategies to reduce harms for example a reduction in pressure ulcers, falls and healthcare associated infections. We have continued to develop robust methods of feedback, particularly in primary care, to facilitate learning from incidents and encourage increased reporting by demonstrating the positive impact that this can have on improvement.

Safeguarding

During 2015/16 the CCG Quality Team underwent a restructure resulting in additional resources to support improved quality monitoring in primary care and to provide a dedicated resource for safeguarding adults given its statutory nature. Compliance with the Care Act has been assessed and assured.

We have engaged with both Adults and Children's Safeguarding Boards to ensure that emerging safeguarding priorities and risks are appropriately identified and managed including child sexual exploitation, modern slavery and female genital mutilation. Lessons from Serious Case Reviews, Domestic Homicide Reviews and Safeguarding Adult Reviews have been widely shared to ensure learning and adoption of best practice.

We have also engaged with providers to ensure that their safeguarding systems and processes are robust using safeguarding adult's assurance frameworks, markers of good practice and Section 11 audits to identify areas of good practice and areas for further development. We have received quarterly PREVENT returns from providers to ensure that appropriate staff training has taken place and to monitor referral activity.

In October 2015 the CQC undertook a review of Children Looked After and Safeguarding in Nottinghamshire which involved various commissioners and providers. The final report was received on 21 March 2016 which identified a number of areas of good practice including maternity, health visiting and some elements of emergency care. There were however some areas for improvement including Children and Adolescent Mental Health Services. The CCGs are currently collating a response from all the providers and will be overseeing implementation of the recommendations at the Nottinghamshire County Safeguarding Committee.

As part of the internal audit programme a review of adult safeguarding processes was undertaken and the CCG achieved **Significant Assurance.**

Transforming Care

Following the abuse uncovered at Winterbourne View Hospital the Department of Health published 'Transforming care: A national response to Winterbourne View Hospital' (DH, 2012) which sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but are cared for in line with best practice, based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

On 18 August 2015 NHS England issued a letter to Clinical Commissioning Groups setting out key actions and immediate steps that commissioners needed to take to support delivery of the Transforming Care Programme to achieve system wide transformation for patients with Learning Disabilities and/or Autism and challenging behaviour or a mental health condition.

The aim is to reduce the inpatient cohort by a further 10% by the end of March 2016 (a reduction of 50% was required by the end of March 2015) and transfer of a further 10% to less restrictive settings. The CCG has achieved this target:

	Trajectory by end March 2016	Current Position as at end Q4	Variance from Trajectory
NNE	**1**	**0**	**-1**

The table below shows the current status of the CCG patients as at the end of March 2016:

	NNE
Total number of patients	0
CTR completed or planned within agreed timescale (within 3 months of admission and six monthly thereafter)	
Ready for discharge immediately	
Ready for discharge within 3 months	
Ready for discharge in 3-6 months	
Ready for discharge in 6-9 months	
Not ready for discharge	

Nottinghamshire has been identified as a ‘fast track’ area and therefore there is also an expectation that a reduction in inpatient beds will also be achieved. A Nottinghamshire wide Transforming Care Implementation Programme Board has been established to oversee the work required to achieve this. The focus will be on provision of community based alternatives.

Continuing Health Care (CHC)

CHC is now high on the national agenda with a potential systematic investigation by the Parliamentary Health Service Ombudsman across the NHS with regards to mishandling of Previously Unassessed Periods of Care (PUPoC) and increasing Parliamentary and Ministerial interest and concern.

The national deadline for completing outstanding retrospective reviews is March 2017. We are working closely with the retrospective CHC team (commissioned from Arden Greater East Midlands Commissioning Support Unit (Arden GEM CSU)) to ensure that the deadline for completion of retrospective reviews will be met. The CCG had a set trajectory to achieve completion by 31 March 2016 however in December we were invited to resubmit revised trajectories which achieve completion by end June 2016, it is still hoped that we will be able to achieve completion ahead of this new deadline and we have set an internal ‘stretch’ target to encourage this. The trajectories have been set using analysis of the outstanding cases by stage in process recognising that the early parts of the process are most time intensive. As a result the trajectories are more heavily weighted so show completion of cases in the latter months.

The following table shows the achievement against the national trajectory and stretch target for the CCG as at the end of March 2016.

	No of requests received by deadline	National Trajectory (planned number outstanding as at end Mar 2016)	Stretch Target (aspirational number outstanding as at end Mar 2016)	Actual number outstanding as at end Mar 2016	Comments
NNE CCG	198	14	0	1	National target exceeded and local stretch target only just missed

Care Homes

The Quality and Patient Safety Team continue to undertake joint quality monitoring visits to care homes with the local authority wherever possible. Homes of concern are supported to achieve improvements and follow up visits are undertaken until assurance is gained regarding sustained improvement. There has been a reduction in care homes of concern across the CCG from three to one over the past year now being classified as high risk – serious concerns raised/contract suspensions in place/significant non-compliance with CQC standards.

The CCG has also engaged with the care home sector in relation to readiness for Nursing and Midwifery Council revalidation which comes into effect from April 2016. This has included providing written information and resources and attending appropriate fora to provide verbal updates.

We have worked with the Patient Safety Collaborative to reduce harm in nursing and residential care from pressure damage by continuing the roll out of the successful 'React to Red' campaign and in developing quality dashboards to support quality monitoring, assurance and improvement.

Work is also currently being undertaken jointly with the Mid Nottinghamshire CCGs and the Academic Health Science Network Patient Safety Collaborative with a number of care homes across Nottinghamshire aimed at adopting the Maastricht model (LPZ) of prevalence measurement, benchmarking and reduction focussing initially on pressure ulcer risk factors and continence. The impact of this work will be evaluated during 2016/17 and if the desired outcomes are achieved consideration will be given to rolling out the approach to other care homes and possibly including other quality indicators for example falls and healthcare associated infections.

Patient Experience and Complaints Management

The voice of the patient is actively sought through ensuring robust feedback mechanisms, the continuing development and influence of patient participation groups and triangulation of patient experience data including complaints, survey results, patient stories and the Friends and Family test.

Patient Advice and Liaison Service

PALS include general enquiries and low level concerns where the referrer does not wish to make a formal complaint. During 2015/16 there were 505 calls to the shared South Nottinghamshire CCG PALS service of which 199 were anonymous and 145 were for NNE CCG

The number of anonymous calls include those logged for out of area (for example Nottingham City and Derbyshire), those which cannot be logged on the system by area due to callers wishing to remain anonymous or only giving a mobile phone number and where it has not been possible to obtain which CCG area the enquiry relates (for example e-mail enquiries). The increase in quarter 4 is associated with the PALS number being used for a number of consultations e.g. gluten-free prescribing and for registering for training events

Patient's concerns ranged from how to make a complaint, to estates issues and break down in communications between practices and patients. Each concern was dealt with individually and signposted to the appropriate team to investigate.

Complaints

The following table shows the complaints received during the last twelve months. All of the complaints were responded to in the timescale agreed with the complainant at the time of receipt. None have to date been referred to the Ombudsman. From 1st April 2015 CCGs have been provided with details of primary care complaints that are received, investigated and responded to by the Central Customer Contact Centre hosted by NHS England.

	Total
Nottingham North East	**17**
Nottingham North East Primary Care	**22**
Other	**4**
TOTAL	**43**

There is no particular recurring theme or trend in the complaints received all of which have been responded to individually.

Friends and Family Test

We have also monitored provider complaint numbers, themes and response times through Quality Scrutiny Panel meetings and monthly dashboards and triangulated this with other data sources including Friend and Family Test (FFT) data. Where themes have been identified assurance has been sought that appropriate action has been taken by the provider to reduce recurrence. As a result of poor response times to complaints at Circle Nottingham identified through CCG monitoring and during the CQC inspection of the Trust a CQUIN was developed during 2015/16 to incentivise improvement in this area. We are currently working with Nottingham University Hospitals NHS Trust to understand the reason for relatively low FFT data in maternity and to monitor the impact of initiatives the Trust has introduced to improve these for example the use of technology and volunteers to collect data.

During 2015/16 we have worked with the primary care leads with practices to increase utilisation of the FFT in primary care. One of our GP Practices was also short-listed for the NHS England 2016 FFT Awards. Across the CCG there has been a significant increase in the number of practices regularly submitting data. The CCG are now working with practices to ensure that the response rates improve and that the information is used to bring about improvements.

Freedom to Speak Up

Following recommendations made in the Francis *Freedom to Speak Up Report* published last year, we have reviewed our own Whistleblowing arrangements and Raising Concerns at Work Policy. We have ensured that mechanisms for staff, patients and carers to raise concerns about the quality or safety of services in our providers are accessible and effective ensuring that appropriate action is taken in response to concerns and that this intelligence is triangulated with other sources of information to provide a comprehensive picture of the quality of services being delivered. We have ensured that providers have appropriate systems and processes in place to support patients, their families and carers, as well as staff who have been involved in incidents and have monitored compliance with the Duty of Candour.

Quality in Primary Medical Care

During 2015/16 the South Nottingham CCGs shared Quality Team has worked with the three South Nottingham CCGs' primary care leads, primary care quality representatives from other Nottinghamshire and Derbyshire CCGs and the NHS England Team to develop a Primary Care Quality Assurance and Support Framework. This incorporating a quality dashboard, risk matrix and escalation

process and takes account of a wide range of information including CQC inspection findings, patient safety and experience measures, clinical outcomes and workforce indicators.

The CCG has established a Primary Care Quality Group and during 2016/17 it will use the primary care quality dashboard, risk matrix and other information to identify potential or actual risks to quality within primary care and to determine a Red / Amber / Green (RAG) rating for each member practice. The group will agree a response to ensure that individual practices are supported where necessary and will escalate any concerns about quality and risks to the CCG Primary Care Commissioning Committee.

CQC inspections of GP Practices have taken place or are underway. It should be noted that some delay in receipt of formal reports has been experienced due to the CQC internal quality assurance processes that must take place prior to publication of formal reports. From the reports received nine of our practices were rated as 'good', two were rated as 'outstanding' and 10 are awaiting inspection. Further details from the inspections can be found on the CQC website.

Key Quality Achievements in 2015/16

In addition to the work areas described above, further key achievements this year include:

- Development of robust harm review processes to monitor the impact of poor operational performance on quality - Emergency Department prolonged waits and delayed ambulance responses
- Development of a quality assurance framework for primary care medical services
- Recruitment of a Personal Health Budgets (PHB) Manager to support the expansion of PHBs outside of continuing health care
- Recruitment of a Designated Clinical Officer to monitor and ensure compliance with the Special Educational Needs and Disability Reforms
- Successful transfer of the current continuing health care assessment service to a new provider and established robust contract quality monitoring

Key Quality Risks

The main risks identified on the clinical risk register during 2015/16 include potential harm as a result of poor operational performance - Emergency Department and Cancer waiting times and ambulance response times - home care capacity and capability, access to mental health beds, impact of local authority budget cuts, impact of provider cost improvement programmes, quality and appropriateness of continuing health care, lack of robust monitoring of smaller contracts and continued quality concerns at Sherwood Forest Hospitals. The risks are regularly reviewed,

including presentation of deep dives to the Audit Committee, to ensure that appropriate and robust mitigating actions are in place or being implemented.

Quality Priorities for 2016/17

We will continue to triangulate a wide range of quality data - clinical outcomes, patient and staff experience and safety indicators - with other sources of feedback - from focus groups, patient participation groups, quality visits - to establish baselines and set measurable ambitions to improve the quality of care across all sectors.

In particular we will focus on achieving the following:

- Reduction in avoidable mortality
- Improved recognition and management of the deteriorating patient (in particular those with sepsis)
- Reduced incidence of avoidable harm including HCAIs, pressure ulcers and falls
- Improved diagnosis and treatment of dementia
- Improved experience of care for patients with a learning disability, in particular a reduction in patients being cared for in restrictive settings by commissioning community based services
- Improved health promotion strategies leading to reduced cases of avoidable type 2 diabetes/ obesity
- Improved choice for patients requiring end of life care
- Improvements in maternity care, in response to the national review of maternity services
- Increase in patients with access to a personal health budget and improved quality monitoring of continuing healthcare funded home care packages and care home placements
- Increase in response rates to patient and staff surveys (in particular Friends and Family Test in low response areas such as Emergency Department, Maternity and Primary Care)
- Increased evidence of patient and staff feedback being used to bring about improvements
- Improvement in the timeliness of complaint handling and complainant satisfaction with the process and outcome, including reduced referrals to the Ombudsman
- Improving workforce indicators e.g. reduced sickness, reduced turnover/ vacancies, increased fill rates
- Improvements in staff cultural barometer findings and evidence of effective staff health and well-being strategies
- Reducing clinical variation in primary care and utilisation of RightCare to identify priority areas for focus

Delegated Functions

The CCG Assurance Framework is the mechanism for assuring NHS England of the CCG's performance across a number of specific areas. The framework for 2015/16 sets out a new assurance process that takes account of specific additional assurances required from CCGs who have taken responsibility for the commissioning of primary medical care services under delegated authority. It also covers out of hours primary medical services, which is a directed rather than delegated function.

Compliance is measured against five key areas:

- • Outcomes
- • Governance and the management of potential conflicts of interest
- • Procurement
- • Expiry of contracts
- • Availability of services

Over the year the CCG has reported quarterly to NHS England via a self-certification template which formed part of the CCG quarterly assurance checkpoint and annual review. As part of the self-certification the CCG reported on the following programmes of work;

- The development of the Primary Care Strategy and Work Plan
- The Quality Framework which was developed and approved by our members
- Improving access by using the Prime Minister's Challenge Fund to implement Telephone Triage Services
- Tackling unwarranted variation by the implementation of a Map of Medicine available within all of our practices
- Targeted practice support
- Primary Care Workforce Development
- Out of Hours services

The CCG has achieved a rating of Good throughout the year.

There was no procurement or contract expiry activity during the year however notice was given on a branch surgery.

No Practices were under-performing and there were no issues raised during the year impacting on availability of services to patients.

Sustainability

The CCG are committed to using a 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 established 2013/14 as a baseline for our emissions. We have calculated our corporate emissions baseline to be 41.42 tCO_2e and carbon influence through contracts for commissioned healthcare services and procurement of non healthcare products and services to be 48,965 tCO_2e.

The Corporate emissions for 2015/16 is 41.17 tCO_2e, in comparison with our baseline, this is a 0.6% carbon reduction. 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. Our SDMP has been developed to set out our vision for becoming a leading green and sustainable organisation, and our key drivers for implementing this vision. It is the framework on which we will effectively respond to the current and emerging environmental, social and economic challenges and risks posed by climate change. Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The organisation has included an action in our SDMP to develop an adaptation plan for future climate change risks affecting our area.

The CCG have appointed the Chief Finance Officer as the Governing Body lead for sustainability. The CCG monitors progress on sustainable development in financial, social and environmental terms with our SDMP action plan. This includes the Good Corporate Citizenship (GCC) assessment tool indicators relevant to CCGs.

The CCG has calculated baseline emissions as a result of commissioned healthcare activities. We have also calculated baseline emissions as a result of the organisation procuring non-healthcare products and services. Based on this, we will embed sustainability into our procurement policy and support our suppliers to have a simple environmental management system. We have sent out letters to all our providers and suppliers to encourage them to develop their own SDMP or have a simple

environmental management system. We will continue to report on the percentage of suppliers that routinely publish their sustainability report or do have an EMS in place.

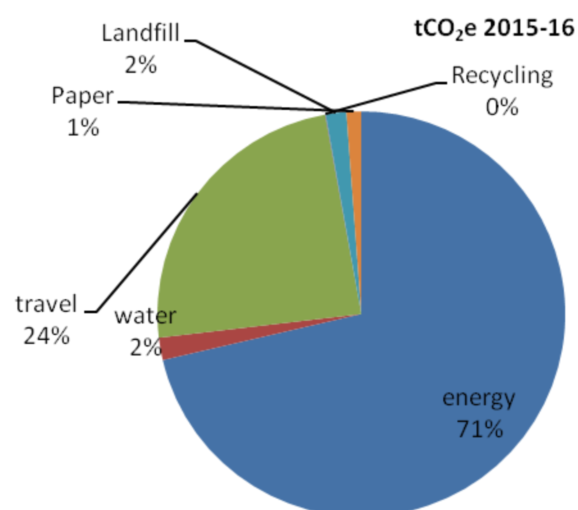
The CCG is working closely with key partners and stakeholders to embed sustainability and carbon reduction into everything we do, from our internal activities to delivering and commissioning frontline services in the communities we serve. We are part of the Nottinghamshire Community Sustainable Network where we engage and learn from partners. NetPositive, a social enterprise, is supporting us to integrate sustainability in our organisation's processes.

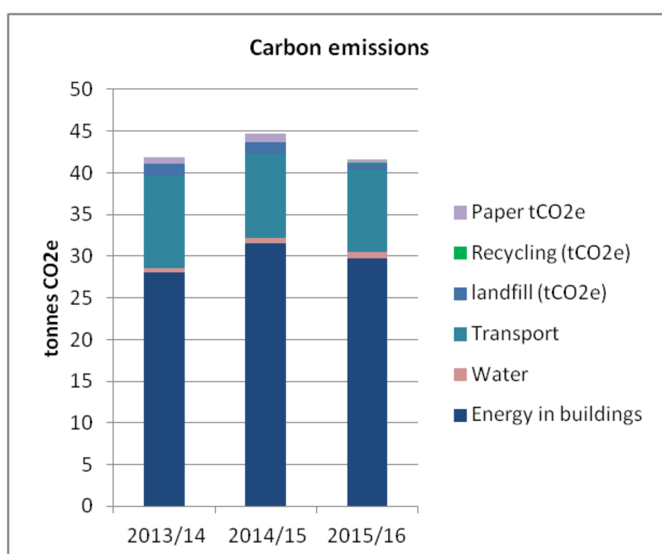
The CCG is also a member of the Investors in the Environment Network, which supports organisations to reduce their direct reliance on increasingly expensive energy and natural resources, cutting costs and emissions, while gaining a visible externally verified quality mark to evidence their progress.

Based on the CCG's commitment to improving our environmental performance and ensuring environmental management - an integral part of healthcare provision, we were formally presented with the Investors in the Environment Silver Award Accreditation in May 2015 and renewed our accreditation April 2016.

Nottingham North and East CCG – Summary of sustainability performance

Area (totals)		2013/14	2014/15	2015/16
GHG emissions (tCO2e gross)		42.25	45.09	41.66
Energy in buildings	**Use (kWh)**	77,230	80,379	82,730
	tCO_2e	28	31	30
	tCO_2e/ WTE	0.68	0.69	0.65
Water	**Consumption** (m^3)	636	704	702
	tCO_2e	0.58	0.64	0.74
	tCO_2e/ WTE	0.014	0.014	0.016
Transport	**Mileage (Km)**	48,754	43,805	45,232
	tCO_2e	11	10	10
	Expenditure (£)	20,297	18,237	25,330
Waste	**Recycling (tonnes)**	0.809	0.89	1.11
	Recycling (tCO_2e)	0.017	0.019	0.023
	Landfill (tonnes)	7.29	7.29	7.29
	landfill (tCO_2e)	1.451	1.451	0.678





Paper	A4 Sheets	165000	216000	135500	
	A3 Sheets	5000	4800	4500	
	tCo_2e	0.83	1.07	0.49	

Reducing Inequality

The CCG has actively participated in the challenge to improve health and reduce health inequalities. In order to do this, a multi-faceted approach has been adopted:

During 2015/16 the CCG has worked directly with the Health and Wellbeing Board to review the health inequalities data, consider the evidence and agree priorities for the local areas. The CCG has reviewed the outcomes of this work with the district and borough councils and will be implementing action plans during 2016/17. The CCG has also held sessions with its district and borough councils to discuss the indicators and actions that can be taken to better address health inequalities. The CCG is also working directly with the Health and Wellbeing Board on identified areas including air quality and housing.

The CCG routinely considers equity of access and uptake in its commissioning of local services, and in actively supporting the work of other parts of the system (e.g. screening and immunisation team). At a county-wide level this includes working with other stakeholders in the Nottinghamshire Health and Well Being Board on the wider determinants of health, as well as having a direct role in health care associated interventions.

There are many diseases which may not cause death but cause a significant health burden and have a negative impact on quality of life e.g. musculoskeletal problems and mental health. During 2015/16 the CCG was active in managing these in a proactive way either within a primary care setting and/or by working with local experts, e.g. IAPT. The CCG has worked closely with its member practices to identify areas of worse health outcomes and experiences of care. In 2015/16 member practices used eHealthScope to review referral patterns and highlight quality issues. The CCG implemented Map of Medicine which has helped to support identification of health outcomes and help shape the development of appropriate pathways of care.

NNE CCG undertook Connecting Communities and as a result has been working with two local communities with higher levels of deprivation. The CCG has sponsored and is leading on C2, Connecting Communities, in two distinct geographical areas of the CCG. C2 uses insights from complexity science as the theoretical lens through which to view, understand and deliver transformative community change. 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. The CCG identified two areas to launch the C2 programme through crime, health and wellbeing data and in agreement with the relevant district/borough councils. The focus in these areas is on collaborative health creation to harness the collective creative powers of residents working as equals with Police, Education, Housing Associations and District/Borough Councils across the spectrum. The benefits in partnership working were immediately evident and the end result will be self-managing, well supported, stronger and healthier communities. This is achieved within 12-18 months using the practical C2 7-Step Framework to create new relationships between residents and agencies, embedding the values of trust, humility, compassion and respect from 'high level to street level'.

As its full title suggests, C2 connects communities in three different ways:

- Within themselves -creating networks and mutual co-operation
- With local service providers -building a parallel 'community'
- With other C2 communities across the UK, getting and giving inspiration and peer learning directly from one place to another

In addition, the CCG has used, and will continue to use, local information derived from the existing JSNA to determine key priority areas where patient outcomes could be improved. The CCG has also used the Right Care Commissioning for Value insight pack to identify areas where the local population has worse outcomes compared to other comparable CCG areas. The Commissioning for Value pack also enables the CCG to identify priority areas which offer the best opportunities to improve healthcare for the CCG population. This is both in terms of improving the value that patients receive from their healthcare, and improving the value that populations receive from investment in their local health system. During 2015/16 the CCG used Right Care to:

- support the identification of local opportunities for improvement in health outcomes, patient experience or spend
- access, analyse and understand relevant clinical data
- understand how the CCG compares when outcomes are benchmarked against similar populations elsewhere

- identify the most beneficial intervention and service change opportunities through clinical, financial and workforce modelling.

Equality and Diversity

To reduce health inequalities the CCG recognises its responsibilities to meet the Public Sector Equality Duty and during 2015/16 has continued to deliver against its equality objectives and understand how people fare through using the EDS2.

The CCG has the following equality objectives which will be carried forward into 2016/17:

- 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 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 (EDS2) over the past four years, the CCG has continued to deliver against its action plan during 2015/16. Working in partnership with neighbouring CCGs in south Nottinghamshire including NHS Rushcliffe CCG and NHS Nottingham North and East CCG, and Nottingham University Hospitals NHS Trust, 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 CCGs governance structure as a sub-group of the Quality and Risk Committee, chaired by a Lay Member.

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 2015/16 include:

- A review of the cancer pathway, including access and treatment for cancer for Black and Minority Ethnic (BME) population, the outcome of which was very positive.
- The development of the 'In the Pink' publication aimed at improving health promotion to the Lesbian, Gay, Bisexual and Transgender (LGBT) population.
- Implementation of the actions identified to ensure the CCG delivers on its pledges in the BSL Charter.
- Links built with local employers (Chetwynd Barracks and British Gypsum) to improve awareness of health services available to the local population, particularly men and mental health services.

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.

Patient and Public Involvement

Involving people is at the very heart of what we do and we are committed to open and transparent engagement with our patients.

We believe that working with patients and putting their views at the centre of what we do will help us to commission the high quality services needed to meet the health needs of our local population and ensure better quality care for all now and in the future.

Effective communications and engagement with local people will not only help us improve health outcomes, it will also help us, in challenging times, to make the best use of our financial resources. If we communicate effectively with patients and engage them early in the commissioning cycle, we can ensure that the implications of change and other options are considered when making key decisions about local health services.

Over the last year, our engagement and communications plans have continued to develop 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.

This year we have put more focus on reaching out to people where they are rather than expecting them to come to us. For example, we held a drop-in consultation sessions at local libraries and supermarkets as part of a consultation on the future of gluten free foods on prescription. We also regularly attend local group meetings in the community, for example the Gedling Asian Elders.

There have been a number of large scale consultations, and related communications, particularly notable has been a surgery closure, community services re-procurement and the future of gluten free foods on prescription. While these projects have dominated our year, we've also been able to do smaller pieces of consultation around respiratory services, winter health, selfcare; embark on a number of communications campaigns and maintain our ongoing engagement and communications work.

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. Our communications plan is available on our website

Overarching communications activity

- We continue to use technology 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 and surveys via Survey Monkey.
- 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 to 1,400 followers on Twitter and to 382 on Facebook. We also manage the NHS South Notts Facebook page, which we have grown to 1305 followers. We utilise these social media channels to push our messages out but also to encourage people to engage with these messages, comment and feedback. The key areas for debate over the last year have been gluten free, the closure of Colwick Vale Surgery, medication waste and A&E pressures.
- We involved patients with the development of our communications campaigns
- Over the year, we have delivered regular branded bulletins to the patients on our member databases to let them know about training and involvement opportunities and our local events.
- We developed a communications vehicle for all the news about the community services contracts. A new e-newsletter 'Community Catch-up' was created with the aim of connecting community and primary Care.
- We send out regular media releases to ensure that the public are up-to-date with developments and campaigns
- We have supported a wide-range of public health and awareness week campaigns via our digital communications channels and media relations
- We have promoted events and consultations, developing messages, designing collateral and supporting the Patient Engagement Manager with the event set up and plans.

- We have taken regular editorial space in each of the Gedling Contacts Magazines published over the year with four pages in Winter and Summer, two in Spring and Autumn, to promote our services and get key messages out to every resident in Gedling. We plan to do the same in Ashfield over the coming year.
- We have provided our GP Practices with media packs at key points of the year - Easter, Winter, Summer with some key messages and stories for their websites, relevant posters for their noticeboards and images and suggested tweets and posts to share on their social media.

Key 2015-2016 Campaigns

We supported the National Stay Well this Winter campaign with local targeted advertising, poster and leaflet campaign and digital promotion using facebook to target different audiences (for example mothers of 1-5 across South Notts postcodes).

Shared Decision Making - we developed a communications plan to promote Shared Decision to our GPs and patient population. Patients were involved in designing, and helping to write the copy for, the campaign collateral. We developed a creative look and feel and shared our collateral and resources with the other South CCGs. We are currently developing videos to further promote this.

IAPT – we developed a comprehensive communications and tactical activity plan to promote talking therapies to our GP Practices and to our patients for self-referrals. We developed a creative look and feel and shared our collateral and resources with the other South CCGs.

We supported the #dontjustticktheboxcampaign and a photo of the medication returned to one pharmacy over a three-week period which we took and shared (Nottingham North and shared on our Facebook and the South Notts Facebook page we manage and it reached over 70,000 people, 236 comments, 630 shares

Patient involvement

We actively promote individual participation in care and treatment through commissioning activities by involving patients and public in all service design and redesign work. As a result, we listen and act upon patient and carer feedback at all stages of the commissioning cycle. In 2015/16, we have conducted a number of targeted consultations to help inform CCG strategy

Our patient involvement plan is linked to our commissioning intentions and all activity is reported to the service improvement teams and People's Council.

We are continuing to develop our approach to engaging with our diverse communities across the CCG and to reach out to those who are seldom heard. The approach involves working with the local voluntary and community sector and existing groups we are already linked into to reach further into their communities.

We are particularly interested in engaging more people of a working age, children and young people and ethnic minorities, who as key stakeholders of the NHS should be actively involved as we design and develop services for the future.

Over the year 2015/16, we have run activities aimed at getting the views of these groups, particularly through our work with schools, community events and social media. The approach we plan to take in the future will build in this and also involve working with the local voluntary and community sector and existing groups we are already linked into to reach further into their communities.

Key public consultations and events 2015-16

Formal Consultations

- Community services re-procurement across the South Nottinghamshire area
- Respiratory services
- Closure of Colwick Vale Surgery - full consultation report can be found here
- The future of Gluten Free prescribing - full consultation report can be found here

Events

- We held regular events, which are open presentations and discussions on the local NHS and the progress of the CCG. Topics covered over the last year include: stay well this Winter (Winter Warmer event), gluten-free food on prescription, respiratory consultation events.
- We also attended large-scale local events including the Arnold Carnival, Gedling Country Show, Hucknall South Re-Vision Vintage Picnic and Nottingham Pride
- We continued to facilitate 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 worked with two schools - Carlton Le Willows in Gedling and the National Academy in Hucknall – to get feedback about the NHS and what services young people would like to see. Based on this feedback we put on two question time style events at the schools where local GPs, nurses, public health, carers experts and CCG staff were grilled by sixth formers about issues ranging from local health services and mental health provision to what to do to help you sleep, dealing with exam stress and planning for University.
- We held our Annual Public Meeting in September, which was well attended (with over 70 people) and looked back on our year but also used a more

relaxed approach starting with food from local group The Asian Elders and a chance to browse a variety of partner stands.

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 for patient and public involvement 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 has a representative from each of the twenty one member practice's patient participation groups. 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.

The areas that we have focused on 2015/16 are:

- Gluten free prescribing, community health services, IAPTs, Shared Decision Making, respiratory and transformation. We have also have ongoing, more general consultation about what people like, 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.
- 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.
- Actively working with Healthwatch by sitting on the Healthwatch Advisory Group as the South Nottinghamshire CCG representative.

Case study: closure of Colwick Vale Surgery

Trentside Medical Group's five year contract to deliver GP services at Colwick Vale Surgery came to an end Thursday 31 March 2016.

The Group had made the decision not to continue to deliver services at the site due to unsustainable costs. The practice announced their decision at a public meeting on Wednesday 2 December. At the same meeting, an eight week consultation was launched to look at the impact that the closure of the surgery might have on patients.

The surgery didn't have a dedicated list and all patients who used the site also had the option of using the Netherfield Medical Centre. The plan was that patients who use the Colwick surgery would from April always use the Netherfield base.

The consultation was led by Nottingham North and East CCG and Trentside Medical Practice, with the help and support of the Trentside Patient Participation Group. The aim was to gather the views of patients, partners and the wider public to understand the potential impact on patients of the Practice's plan to stop delivering services in Colwick.

Consultation surveys were available online, via telephone, post, and at both the surgeries. Communications collateral, including posters and flyers, were distributed to shops and the local pharmacies. Websites and social media channels were utilised, including Facebook and Twitter, and to further engage with patients we held two public events - one at the start of the consultation and one towards to the end of the process.

A total of **160** responses were received during the consultation period. This included: 158 web and paper survey responses, one local MP letter (sent to the Practice), one patient letter (sent to NHS England)

In addition, 121 people attended the public meetings and a lot of views and opinions were shared on social media sites most notably Street View and Facebook. All of this feedback was taken into consideration in the report.

The outcomes:

Patient's main concerns were:

- waiting times for appointments – will Netherfield be able to accommodate the extra patients?
- distance to travel
- fear that they may lose their community pharmacy as a result.

In response we, the Practice and the CCG, were able to ensure the following:

- There will be no less appointments - and appointments will be available through the middle of the day
- Morning walk-in service
- Work ongoing with PPG to improve triage processes
- Plans afoot for a new, modern health building in Netherfield which will host the practice and other health services
- All patients who need a home visit will get one
- Gedling Borough Council to look at bus routes

- We will work with the pharmacist to ensure they are maximising their NHS income.

Greater Nottingham Health and Care Partners (GNHCP)

The CCG has led on patient and public involvement for GNHCP. The transformation programme has had patient and public involvement from the start and has been working on the basis of co-production. During 15/16 this work included:

- Ensuring citizens are involved in the co-design of services
- Development and implementation of the lay leaders programme
- Support integration of lay leaders and clinicians into effective population working groups
- Citizens Advisory Group (CAG) give assurance and comment on development of programme
- CAG representatives sit on working groups and offer peer support

Coordinated Public Engagement strategy across the GNHCP

- GNHCP Engagement Leads Group (ELG) meets monthly to co-ordinate, develop and implement public engagement strategy.
- Share resources for public engagement events and collective use of feedback
- CAG chair attends and provides link between CAG and ELG

Ongoing meaningful engagement

- Development of population segment profiles and public engagement strategy, per population segment, to focus on patient outcomes
- Implementation of public engagement activities to support work streams groups
- CAG give assurance and comment on strategy and activities

C2, Connecting Communities

C2 was introduced to Daybrook, Arnold and Butlers Hill/Broomhill, Hucknall in November and during 2015/16 we have been working in partnership with residents and agencies to make a difference.

The aim is to inspire and support people to reconnect and establish a long term, resident led Partnership with service providers to improve health, well-being and local conditions via the co-creation of a 'people and services partnership. The aim is to break though long standing barriers to achieve lasting change within hard-pressed communities

The method connects communities in three ways

1. With themselves – network and co-operation amount local residents.
2. With local service providers and public agencies – building a parallel community of interest amongst the front-line workers and others.

3. With other communities – getting and giving inspiration directly from one place to another.

In both areas we have had monthly partnership meetings which have been attended by local residents and service providers to tackle the priority issues raised. Sub groups were also introduced to the groups to tackle each priority.

In Hucknall over the past 12 months we have held various litter picks, some of these 'The Welbeck spruce up' were targeted at certain streets and included getting the road sweeper out to attract adult residents to get involved and some 'litter and lolly' events were aimed to attract the local children.

To tackle the ASB problems that were raised and also to work with the Ashfield Locality plan to redevelop the Bestwood Road Recreation Ground we also organised a 'Vintage Picnic'. We raised funds to be able to hold a fun day to attract all residents. We had activities and games for the children, such as a tug of war competition. The Local PCSO and CPSO had a team of children each and this really helped to build up relationships between the authorities and the local children. The Tenants and Residents Association had a cake stall and the local Youth Club served drinks. Many of the service providers such as ADC, Ashfield Homes, Homestart, Sure Start and First Art came to talk to residents and promote their services. The feedback from the day had some great responses and the general feel from residents was that they wanted more community events to happen in their area.

We also arranged for some of the local children to take a 'Bikeability' course as the school in the area were not doing this and a lot of concerns were raised about the children riding their bike unsafely in the area.

Hucknall South re-Vision Partnership are continuing to build up connections with other groups in the area such as Butler's Hill Tenants and Residents Association to encourage more residents to get involved and have their say about what is happening in the area where they live.

In Daybrook we have also tackled the priority points. A letter was put together to ask local businesses for their support in tackling the parking issues, as it was raised that the cars parked were from local businesses.

To tackle the dog fouling issue, local residents went into the local primary school and launched a completion for the pupil to design an anti-fouling sign for Daybrook. These were then turned into a sign and attached to lampposts in the area. Poop bag containers were also made up and regular walkabouts have been carried out by the group to give these out and talk to dog owners.

Over the summer holidays a 'litter pick and picnic' was organised to encourage the local kids to come and spend an hour keeping the streets clean. They were then

rewarded by a picnic and some fun activities on the green. Local shops donated crisps, biscuits and juice to the event.

Both Communities have discussed and agreed in principle to becoming fully constituted partnerships – a significant step towards becoming self-organising groups. There is a realisation that they can make vital contribution to improve the health and wellbeing of the Community. Social connections and having a voice in local decisions are all factors that underpin good health, however inequalities persist and too many people experience the effects of social exclusion or lack social support.

Signature of the Accountable Officer

I certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the NHS Act 2006

Sam Walters
Accountable Officer

Signature: ______________________

Date: __________________________

Accountability Report

Corporate Governance Report

Members' Report

Our GP Practices

The Membership of our CCG is composed of the following member practices who are working together to plan and pay for local health services for 150,000 patients.

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 Governing Body Membership 2015/16

Dr Paul Oliver	Chair *(until February 2016)*
Dr Parmijit Parnesar	Joint Clinical Chair *(from February 2016)*
Dr James Hopkinson	Joint Clinical Chair *(from February 2016)*
Sam Walters	Chief Officer
Jonathan Bemrose	Chief Finance Officer
Nichola Bramhall	Registered Nurse and Director of Nursing and Quality

Dr Mohammed Al-Uzri Secondary Care Doctor
Terry Allen Lay Member – Finance and Governance
Mike Willkins Lay Member – Patient and Public Involvement *(until February 2016)*
Janet Champion Lay Member – Patient and Public Involvement *(From January 2016)*
Paul Mckay Observer
Stephen Storr Observer

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.

The Audit and Governance Committee Membership 2015/16

Terry Allen Lay Member - Financial Management & Audit
Mike Willkins Lay Member – Patient and Public Involvement *(until February 2016)*
Janet Champion Lay Member – Patient and Public Involvement *(From January 2016)*
GP Member Governing Body

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.

Conflicts of 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 declaration of interest register which is publically available on the NNE website and can be provided upon request.

The Conflicts of Interest Register can be found here:

http://www.nottinghamnortheastccg.nhs.uk/wp-content/uploads/2015/09/Register-of-Interests-ALL-GROUPS-updated-24.09.15-BM.pdf

Information on personal data related incidents where these have been formally reported to the information commissioners

During 2015/16 there has been one personal data related incidents reported; however, it was not rated as being serious in nature and appropriate action was promptly taken, lessons learnt were implemented and there have been no further re-occurrences. These incidents are shown in the following table:

Category	Nature of Incident	Total
I	Loss of inadequately protected electronic equipment,	0

	devices or paper documents from secured NHS premises	
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper Documents	0
IV	Unauthorised disclosure	1
V	Other	0

Statement as to disclose 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.

The Statement of Accounting Officer’s Responsibilities

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

I confirm that as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware and that I have taken all the steps I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Sam Walters
Accountable Officer

Governance Statement

Introduction and Context

NHS Nottingham North and East Clinical Commissioning Group (the “CCG) was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2015, the clinical commissioning group was licensed without conditions.

The CCG is made up of a membership of 21 local GP practices covering Arnold, Burton Joyce, Calverton, Carlton, Colwick, Daybrook, Gedling, Giltbrook, Hucknall, Lowdham, Mapperley, Netherfield, and Newthorpe. These member practices have worked closely together since April 2007 culminating in bringing high quality care closer to home and through the establishment of strong clinical relationships and local partnerships.

The CCG is responsible for the commissioning of high quality local health services to improve the health outcomes of people registered with one of the member practices and to provide emergency services for unregistered patients who live in the locality. This is achieved through effective, efficient and economical commissioning for services including:

- Planned and emergency acute hospital care, mainly from Nottingham University Hospitals NHS Trust (NUH), but also from Sherwood Forest Hospitals Foundation Trust.
- Rehabilitation and community care services from County Health Partnerships.
- Urgent and emergency care – for example out of hours care and ambulance services.
- Mental health and learning disability services from Nottinghamshire Healthcare NHS Trust.
- Primary Medical Care from GP Practices.

Scope of Responsibility

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

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

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 footprint and to ensure efficiencies and effectiveness through the shared resources.

Compliance with the UK Corporate Governance Code

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

Our assessment has been reviewed by the CCG's internal auditors and reported to the Audit Committee in March 2016 and will be reported in turn to the Governing Body as part of the Committee's annual report.

Whilst the report made some recommendations, it can be confirmed there were no departures from the provisions of the UK Corporate Governance Code which we deem relevant.

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.

In accordance with legislation, the CCG has a Constitution which sets out:

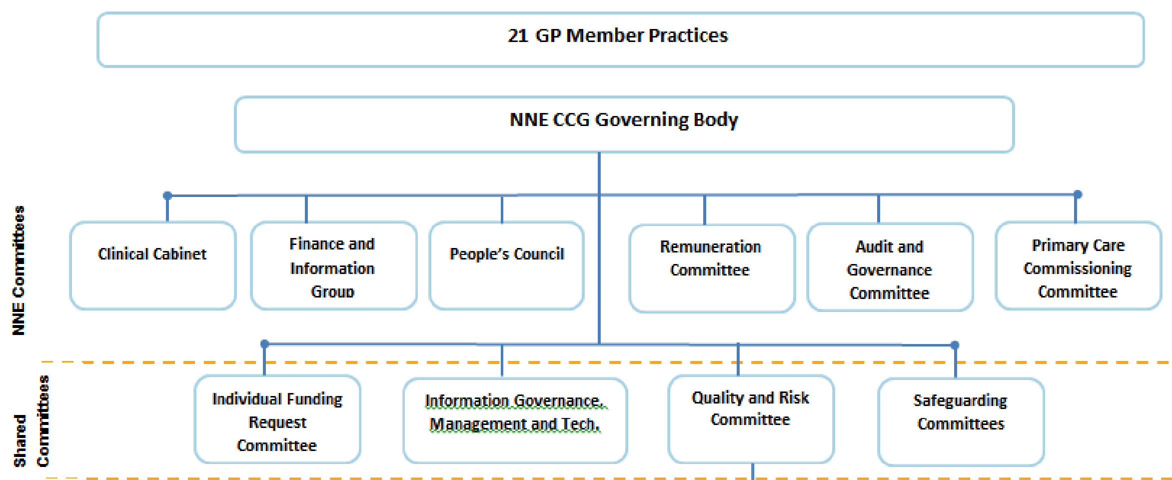
- the arrangements that it has made to discharge its functions and those of its Governing Body;
- its key processes for decision making, including arrangements for securing transparency in the decision making of the CCG and its Governing Body;
- the arrangements made for discharging its duties with regard to registers of interest and managing conflicts of interest.

The CCG involves its member practices in designing their arrangements to discharge their responsibilities as set out in their Constitution.

The Constitution applies to the following, all of whom are required to adhere to it as a condition of their appointment:

- the group's Member practices
- the group's employees
- individuals working on behalf of the group
- anyone who is a member of the group's Governing Body
- anyone who is a member of any other committee(s) or sub-committees established by the group or its 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 joint committees with NHS Nottingham West CCG, NHS Rushcliffe CCG, NHS Mansfield and Ashfield CCG and NHS Newark and Sherwood CCG. The structure of the Committees has withstood the challenges of the year and all have been able to provide assurance to the Governing Body on delegated responsibilities.



The Membership Body

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, Netherfield and 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 membership body met during 2015/16 to discuss GMS and PMS contracts including remuneration per patient, Friends and Family Test, Primary Care Home.

The Governing Body

The Governing Body is recognised and constituted as described in section six of the Constitution of the CCG. 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 Chair of the Governing Body resigned in February 2016.

During 2015/16 the Governing Body met whilst quorate in six public sessions and held three development sessions. Membership of the Governing Body and their attendances are recorded below:

Governing Body Member	**Governing Body Positions**	**Total/ possible**
Dr Paul Oliver	Chair *(until February 2016)*	*4/6*
Dr Parmijit Parnesar	Joint Clinical Chair *(from February 2016)*	*5/6* *1 as chair*
Dr James Hopkinson	Joint Clinical Chair *(from February 2016)*	*6/6* *1 as chair*

Sam Walters	Chief Officer	6/6
Jonathan Bemrose	Chief Finance Officer	6/6
Nichola Bramhall	Registered Nurse and Director of Nursing and Quality	6/6
Amelia Ndrika	GP Representative *(from*	3/5
Dr Mohammed Al-Uzri	Secondary Care Doctor	5/6
Terry Allen	Lay Member – Financial Management & Audit	5/6
Adrian Kennedy	Allied Health Professional *(until September 2015)*	0/2
Mike Willkins	Patient and Public Involvement *(Until January 2016)*	3/6
Janet Champion	Lay Member – Patient and Public Involvement *(From January 2016)*	2/2
Caroline Baria	Observer (until September 2015)	1/3
Paul Mckay	Observer (from September 2015)	1/3
Stephen Storr	Observer	6/6

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

Governing Body Performance and Effectiveness

The Governing Body membership provides a strong team of executive, clinical and lay membership as evidenced through performance and the successful delivery of functions and duties.

Training for Governing Body members has been carried out through development sessions that have focused on horizon scanning, transformation, strategic planning, what makes great boards great, internal and external risks. The Governing Body is also invited to CCG and senior management team time outs that are held throughout the year. During 2015/16 the Governing Body also welcomed the opportunity to be involved in a peer review with NHS Hardwick CCG providing further insight and opportunities for development. Lay Members have attended NHS England development sessions including the Audit Chairs forum.

Clinical Cabinet

The Clinical Cabinet has been delegated responsibility for clinical decision making (within limits and subject to appropriate scrutiny and oversight by the Governing Body). To ensure robust clinically led decision making it is attended by a GP representative from each of the member practices.

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.

The membership of the Clinical Cabinet includes the following:

- Chair and Clinical Lead
- Assistant Clinical Chair

- NNE GPs – 1 Per Practice
- 1 Practice Manager
- 1 Practice Nurse
- Governing Body GPs
- Governing Body Secondary Care Consultant
- Public Health Consultant
- Governing Body Lay Member PPI and Deputy Chair
- Upper Tier Local Authority Representative
- Patient and Public Representative
- Chief Officer
- Chief Finance Officer
- Deputy Chief Officer
- Clinical Director

Cumulative record of member practice representation at the Clinical Cabinet Group 2015/16:

Practice	Total/ possible	Practice	Total/ possible
Apple Tree Medical Practice	9/12	Stenhouse Medical Centre	8/12
Daybrook Medical Practice	9/12	Torkard Hill Medical Practice	11/12
Giltbrook Surgery	10/12	Trentside Medical Practice	10/12
Highcroft Surgery	7/12	Unity Surgery	8/12
Jubilee Practice	1/12	West Oak Surgery	4/12
Newthorpe Medical Centre	9/12	Westdale Lane Surgery	11/12
Oakenhall Medical Centre	4/12	Whyburn Medical Practice	12/12
OM Surgery	12/12	Willows Medical Centre	5/12
Park House Medical Centre	6/12	Practice Manager	9/12
Plains View Surgery	10/12	Practice Nurse	6/12
Peacock Practice	1/2		
None practice Representation			
Name and Role	**Total/ possible**	**Name and Role**	**Total/ possible**

Dr Mohammed Al-Uzri **Secondary Care Consultant**	4/12	Dr Parmajit Panesar **Assistant Clinical Chair and Ivy Medical Group Representative**	10/12
Jonathan Bemrose **Chief Finance Officer**	12/12	Sharon Pickett **Deputy Chief Officer**	11/12
Lay Member Patient and Public Representative	12/12	Dr John Tomlinson **Public Health**	7/12
Dr James Hopkinson **Assistant Clinical Chair and Calverton Practice Representative**	9/12	Paul Oliver **GP Lead and Chair** *(until Feb 2016)*	7/10
Paul McKay **Local Authority**	1/7	Adrian Kennedy **Allied Health Professional**	2/5
Sam Walters **Chief Officer**	10/12	Dr Emma Pooley **Clinical Director**	4/6

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

- Each meeting included a finance and activity update with risks on performance
- Each meeting included a Chief Officer and Chairs report to highlight key updates both internally and externally to the CCG and a locality meeting update from the member practices
- Commissioning intentions, QIPP plans, primary care strategy
- Service changes including physiotherapy and Atrial Fibrillation
- Service procurements including mental health and Alcohol case management,
- Prescribing including over the counter medicines, gluten free prescribing, care homes, SIP feeds
- Patient choice including shared decision making, medial interoperability gateway
- Primary care delivery including GP responsiveness service, Primary Care Home, QOF exception reporting
- Transformation

Primary Care Co-Commissioning Committee

The Governing Body of the CCG has resolved to establish a committee to be known as the Primary Care Commissioning Committee in accordance with Schedule 1A of the NHS Act. The Committee functions as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers

The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The responsibilities of the Committee include:

- GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing branch/remedial notices, and removing a contract);
- Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services");
- Design of local incentive schemes as an alternative to the Quality Outcomes Framework (QOF);
- Decision making on whether to establish new GP practices in an area;
- Approving practice mergers;
- Making decisions on 'discretionary' payment (e.g. returner/retainer schemes).
- Making decisions based on Primary Care needs assessment

The Committee will also ensure that the CCG carries out the following activities:

- To plan, including needs assessment when required, primary care services in Nottingham North and East CCG
- To co-ordinate a common approach to the commissioning of primary care services generally
- To manage the budget for commissioning of primary care services in NHS Nottingham North and East CCG
- PCCC will oversee delivery against milestones and targets, escalating issues and concerns as appropriate

The membership of the Primary Care Commissioning Committee includes the following:

- Lay Member - Audit
- Lay Member - Patient and Public Involvement
- 2 GPs
- Chief Finance Officer
- Director of Nursing and Quality
- Deputy Chief Officer
- Secondary Care Consultant

There have been ongoing attendances and standing invitations for the following:

- Healthwatch
- Health and Wellbeing Board
- Local Medical Committee
- Primary Care Contracting Team of NHS England

During 2015/16 the Committee met whilst quorate in five public sessions. Attendances are recorded below.

Committee Member	Total/ possible
Mike Wilkins **Lay Member PPI** *(Chair)*	4/4
Terry Allen **Lay Member Financial Management and Audit**	4/4
Nichola Bramhall **Director of Nursing and Quality**	4/4 3 Deputy
LMC Representative	4/4
Sharon Pickett **Deputy Chief Officer**	3/4
Jonathan Rycroft **Head of Primary Care, NHS England**	3/4
Healthwatch Representative	4/4
Dr Mohammed Al-Uzri **Secondary Care Consultant**	1/4
Jonathan Bemrose **Chief Finance Officer**	4/4
Dr Parm Panesar **GP Representative**	3/4
Dr Caitriona Kennedy **GP Representative**	1/4

Key areas of work during 2015/16 for the Primary Care Co-Commissioning Committee have been:

- Opening budgets and primary care finance report
- Primary care strategy
- Updates on contract changes
- Guiding principles for considering requests for financial support from primary medical services
- Calverton practice boundary
- Self-certification of compliance
- GP patient survey
- Colwick branch closure
- Local enhanced services
- Primary care transformation fund
- Estates strategy

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:

- 360 Assurance undertake our Internal Audit reviews and have covered: finance; information management and technology; performance and data quality; clinical quality; governance, risk and legality; management of contracts.
- Specific reviews for 2015/16, including discussions on issues raised, recommendations and completion of actions discussed are as follows:
    - Budgetary Control, Financial Reporting and Key Financial Systems
    - Information Governance Toolkit
    - Data management Arrangements
    - Joint Data Quality Review
    - Safeguarding Adults
    - Primary Co-commissioning Arrangements
    - Partnership Working – Better Care Fund
- In 2015, new standards were released for Counter Fraud. These standards set the work plan for Counter Fraud and progress was monitored through the Audit and Governance Committee.

- Governing Body Assurance Framework
- Review of Conflicts of Interests
- Monitored the timetable and delivery of the Annual Report and Accounts
- Received updates from the Chief Finance Officer on the financial positions, risks, mitigations and work throughout the year.

Cumulative record of the Audit and Governance Committee members' attendance 2015/16:

Committee Member	Total/ possible
Terry Allen **Lay Member – Financial Management and Chair**	4/4
Mike Wilkins **Lay Member – Patient and Public Engagement**	2/2
Janet Champion **Lay Member – Patient and Public Engagement**	2/2
GP Governing Body Representative	4/4

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:

- Review of remuneration policies
- Review of amounts paid
- Confirmation of “off-payroll” engagements
- Clinical Lead and Chair remuneration

Cumulative record of the Remuneration Committee members’ attendance 2015/16:

Committee Member	Total/ possible
Terry Allen	1/1
Mike Wilkins	1/1

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
- Assess financial risk and recommend mitigating actions to 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.
- Consider topic specific issues as required

Membership on the Finance and Information Group includes:

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

Cumulative record of the Finance and Information Committee members' attendance 2015/16:

Name, Title, designation	Total/ possible
Terry Allen **Lay Member Financial Management & Audit**	9/10
Hazel Buchanan **Director of Operations**	9/10
Maxine Bunn **Director of Contracting Nottingham West, NNE and Rushcliffe CCGs**	5/10
Ian Livsey **Deputy Chief Finance Officer South CCGS**	8/10
Dr Paul Oliver	8/9

Clinical Chair	
Sergio Pappalettera **Systems Analyst**	9/10
Sharon Pickett **Deputy Chief Officer**	8/10

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 2015/16 and 2016/17
- NHS England Cash Regime

People's Council

The Peoples Council is established in accordance with Nottingham North East Clinical Commissioning Group constitution.

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

Cumulative record of the People's Council attendance 2015/16:

Name, Title, designation	Total/ possible
Mike Wilkins **Lay member NNE CCG**	7/9
Hazel Buchanan **Director of Operations NNE CCG**	8/9
Calverton PPG	10/10
Bruce Cameron **Independent Patient Rep**	8/10
Janet Champion **Lay member NNE CCG**	1/1
Daybrook PPG	0/10
Michael Ellis **NNE - Stakeholder Engagement Manager**	4/7
Giltbrook Medical Practice PPG	2/10
Highcroft PPG	3/10
Ivy Medical Practice PPG	9/10
Mariea Kennedy **NNE PALS & PET South CCGs**	10/10
Newthorpe PPG	10/10
Oakenhall PPG	0/10
Dr Paul Oliver **NNE Clinical Lead/Chair**	5/9
Peacock PPG	6/10
Plains View PPG	8/10
Stenhouse Medical Centre PPG	9/10
Trentside PPG	8/10
Torkard PPG	6/10

Unity PPG	8/10
Sam Walters NNE Chief Officer	8/10 6 – Deputy
Westdale Lane PPG	10/10

Items covered during 2015/16 include:

- Service improvement including telephone triage, care delivery groups, pain pathway, acupuncture, irritable bowel disorder, respiratory review, phlebotomy, Parkinson's nurse, patient transport service, tele-dermatology, gluten free prescribing
- Primary care including GP referral rates, Carers Champions, standards for GP practices, Primary Care Strategy,
- Patient involvement including shared decision making, patients in control. GP patient survey, friends and family test
- Information Governance, Management and Technology strategy, data sharing

Quality and Risk Committee

The Clinical Commissioning Group has established a joint Quality and Risk Committee under a memorandum of understanding with Rushcliffe 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 promotes 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 EDS2
- Complaints and PALS
- Health and Safety

Key areas of work during 2015/16 for the Quality and Risk Committee:

- Provider Quality Dashboards, Quarterly CCG Quality Reports and minutes from the provider Quality Scrutiny Panel meetings were reviewed to provide assurance regarding the quality of commissioned services and highlight any

key areas of work. During 2015/16 this included harm impact reviews undertaken at Nottingham University Hospital's and East Midlands Ambulance Service as a result of continued failure to achieve ED/ cancer access targets and ambulance response times.

- During 2015/16 quarterly H&S incident reports, EDS2 action plan updates and a reducing avoidable admissions from care homes project proposal were received by the committee.
- The Clinical Risk Register has been reviewed and updated at each meeting.
- A log of Quality Impact Assessments (QIA) has been received by the Committee. The Director of Nursing and Quality has delivered training to over 40 senior managers and project leads to support appropriate completion of QIAs.
- Francis- the committee oversaw completion of the Quality Team and individual CCG Francis action plans in response to the Mid Staffordshire scandal and received a gap analysis and action plan updates against the recommendations of latest Francis report, 'Freedom to Speak Up'.
- The Morecambe Bay Report into maternity care was received along with the findings from a review of maternity services at Nottingham University Hospitals. Regular progress updates against the resulting action plan have also been received.
- A Home Care Position Paper was received outlining the current risks and mitigating actions with an update on plans to further reduce risk in future.
- A Report into Lay Representatives Involvement in Quality Visits was received and a number of recommendations to further maximise the valuable contribution of this group were agreed.
- The Primary Care Quality Assurance Framework was received along with terms of reference for Primary Care Quality Sub Groups which it was agreed would report to the Primary Care Commissioning Committees.

Cumulative record of the Quality and Risk Committee members' attendance 2015/16:

Name, Title, designation	Total/ possible
Susan Bishop , Lay Member **(Chair)**	4/4
Nichola Bramhall, Director of Nursing and Quality	4/4
Max Booth, Patient Rep	3/4
Michael Rich, Patient Rep	4/4
Lynne Sharp, Head of Governance and Engagement	2/4 1 Deputy
John Tomlinson, Deputy Director of Public Health, NCC	2/4
Hazel Buchanan, Director of Operations	4/4
Becky Stone, Deputy Director of Nursing and Quality	3/4
Dr Ram Patel, GP Rep	3/4
Craig Sharples, Head of Quality, Engagement and Governance	1/4 1 Deputy
Dr Paramjit Panesar, GP Rep	2/2
Gail Colley-Bontoft, Head of Quality and Adult Safeguarding	1/2
Esther Gaskill, Head of Quality, Patient Safety and Experience	2/2

Information Governance, Management and Technology Committee

The Information Governance, Management and Technology (IGM&T) Committee is established on behalf of NHS Rushcliffe (RCCG), NHS Nottingham North and East (NNE), NHS Nottingham West (NW), NHS Mansfield and Ashfield (M&A) and NHS Newark and Sherwood (N&S) CCGs in accordance with the joint arrangements detailed in their respective Constitutions and referred to in these terms of reference as 'the CCGs'.

The purpose of the Information Governance, Management and Technology Committee is to support and drive the broader information governance (IG) and information management & 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

- Developing IM&T to improve communication between services for the benefit of patients

Key areas of work for the IGMT Committee in 2015/16 included:

- Continuing progression of the implementation of the necessary changes to ensure compliance with changes in statutory legislation.
- Further progression of the use of Data Services for Commissioners will move the CCGs to align with organisations supplying data services under the Lead Provider Framework.
- The publication of a Data Management Strategy in order to provide assurance to CCGs that sensitive and confidential data is being processed in accordance with the requirements for encryption and pseudonymisation.
- Reviewing Cyber Security to ensure CCGs and GP Practices are well placed to mitigate any risk associated with malicious attempts to breach security arrangements.
- Monitoring the CCGs' progress of completion of the Information Governance Toolkit.
- Maintaining an information governance risk register for the CCGs.
- 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 a range of policies and procedures.
- Agreed relevant information governance, information management and information technology policies with amendments as necessary reflecting changes in legislation or local ambition.
- Maintaining the contract management arrangements with Nottinghamshire Health Informatics Service (NHIS) in order to demonstrate improvements to the delivery of services to the agreed standards.

Cumulative record of the Information Governance, Management and Technology Committee members' attendance 2015/16:

Name, Title, designation	Total/ possible
Andy Hall, **Director of Outcomes and Information and Senior Information Risk Owner (SIRO) Rushcliffe CCG (Chair)**	6/6
Alexis Farrow, **Head of Information Governance, GEM**	6/6 1 Deputy
Paul Gardner, **Head of Information Governance, Nottingham City CCG**	6/6

Petra O'Mahony, **Freedom of Information Lead, GEM Until 31st December 2015**	1/4
Nichola Bramhall, **Caldicott Guardian South CCGs**	5/6 1 Deputy
Ei-Cheng Chui, **Caldicott Guardian Newark and Sherwood CCG (Deputy Chair) Until 27/11/2015**	2/4
Mike O'Neil, **General Practitioner Nottingham West CCG and Senior Information Risk Owner (SIRO) Nottingham West**	6/6
Hazel Buchanan, **Senior Information Risk Owner (SIRO) Nottingham North and East**	6/6 1 Deputy
Elaine Moss, **Caldicott Guardian Mansfield and Ashfield CCG and Newark and Sherwood CCG**	6/6 6 Deputy
Sarah Bray, **Senior Information Risk Owner (SIRO) for Mansfield and Ashfield CCG and Newark and Sherwood CCG From 8th June 2016**	5/5 3 Deputy
Paul Morris, **Governing Body Lay Members of Newark & Sherwood CCG**	4/6
Dr Sean Ottey, **General Practitioner Rushcliffe CCG**	1/6
Jaki Taylor, **Head of Transformation**	5/6
Eddie Olla, **Director of Health Informatics at NHIS**	4/6
Marcus Pratt, **Interim Senior Information Risk Owner (SIRO) for Mansfield and Ashfield CCG and Newark and Sherwood CCG Until 22/05/2015**	0/1
George Ewbank, **Clinical Safety Officer Until 26th May 2015**	1/1

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.

Highlights of the work undertaken by the committee in 2015/16 are shown below:

- Contributing to and implementing recommendations from national guidance relating to Female Genital Mutilation
- Contributing to and implementation recommendations from national guidance relating to Child Sexual Exploitation
- Reviewing and revising CCG responsibilities relating to Multi Agency Public Protection Arrangements (MAPPA) and raising the profile of MAPPA across primary care
- Identifying available safeguarding performance information to enable the Safeguarding Committee to agree quality scrutiny priorities and report to local safeguarding boards
- Progressing the implementation of secure e-mail information sharing between agencies, including primary care
- Progressing the PREVENT anti-terrorist agenda as per national requirements
- Monitoring of risks relating to child and adolescent mental health service provision and influencing commissioning arrangements
- Monitoring and influencing the quality of health services relating to children in care of the local authority
- Ensuring a process is in place for CCGs to gain assurance of individual organisational action plans and implementation of recommendations from serious cases reviews and domestic homicide reviews.

Cumulative record of Safeguarding Committee member's attendance 2015/16:

Committee Member	Total/ possible
Elaine Moss **Chief Nurse and Director of Quality for Newark and Sherwood and Mansfield and Ashfield CCGs (Chair)**	5/5 2 Deputy
Nichola Bramhall **Director of Nursing and Quality, South Notts CCGs (Vice Chair)**	5/5 3 Deputy
Rebecca Stone **Deputy Director of Nursing and Quality, South Notts CCGs (member until July 2015)**	2/2
Gail Colley- Bontoft **Head of Quality and Adult Safeguarding, South Notts CCGs** (member from September 2015)	3/3
Amanda Callow **Deputy Chief Nurse, for Newark and Sherwood and Mansfield and Ashfield CCGs** (post vacant since September 2015)	*2/2* 1 Deputy
Chris West (until August 15) Rosa Waddingham (from Oct 15) **Head of Quality and Patient Safety for Newark and Sherwood and Mansfield and Ashfield**	*2/3* 1 Deputy
Cathy Burke **Nurse Consultant Safeguarding (Designated Professional Adults and Children) for Bassetlaw CCG**	5/5 1 Deputy
Val Simnett **Designated Nurse Safeguarding Children for 5 Nottinghamshire CCGs**	5/5
Nicola Ryan **Deputy Chief Nurse for Bassetlaw CCG**	5/5
Amanda Jones Adult **Safeguarding Lead for South Nottinghamshire CCGs**	5/5 2 Deputy
Dr Fiona Straw **Designated Doctor Safeguarding Children, South Nottinghamshire CCGs**	0/5
Dr Becky Sands **Designated Doctor Safeguarding Children, North Nottinghamshire CCGs**	1/5
Amanda Edmonds (until January 2016) Kathryn Higgins (from March 2016) **Designated Nurse Children in Care for 5 Nottinghamshire CCGs**	4/5
Dr Victoria Walker **Designated Doctor Children in Care , North Nottinghamshire CCGs**	5/5 2 Deputy
Dr Emma Filimore (until January 2016) Dr Melanie Bracewell (from March 2016) **Designated Doctor Children in Care, South Nottinghamshire CCGs**	5/5 3 Deputy

Dr Jane Selwyn (from March 2016) **General Practitioner**	1/1
Mary Corcoran **Consultant in Public Health nominated by the Director of Public Health, Nottinghamshire County Council**	3/5
Gary Eves (until January 2016) Kerrie Adams (from March 2016) **Public Health Manager (children lead) nominated by the Director of Public Health, Nottinghamshire County Council**	4/5

Individual Funding Request Panel

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

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

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

Key areas of work during 2015/16 for the IFR Panel:

- There were 16 Individual Funding Request applications processed in accordance with the IFR Policy eligibility criteria.
  - The IFR Panel considered two requests on behalf of NHS Rushcliffe CCG.
  - One request 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.
  - Six cases were redirected/returned
- Six previously approved cases were reviewed for clinical benefit (See Appendix 1)
- Two patient complaints received in response to IFR applications where funding was declined at the screening process. One request was subsequently considered by the IFR panel and approved for treatment. The other request is currently progressing through the complaints process.

- Three MP enquiries were received in support of IFR applications that were declined at the screening stage during 2015-2016. Clarification was provided as to why funding had been declined.
- During 2015/16 the IFR team dealt with six Freedom of Information (FOI) requests. The requests received were in connection with prescribing data for patients with multiple sclerosis, cosmetic surgery, high costs drugs for non-NICE funding, provision of wigs for patients with alopecia, dermatology conditions resulting in loss of hair and IVF.
- A quarterly IFR report was provided to each CCG detailing all requests for funding including commissioned and noncommissioned procedures e.g. IVF, assessment for Asperger's, European Healthcare Requests for Treatment Abroad.
- During 2015/16 IFR Panel members undertook refresher training on the process for screening IFR submissions, and also Robert Wilson, Consultant in Public Health Medicine, Specialised Commissioning (East Midlands) NHS England attended an IFR panel meeting and gave a training session on ethical decision making and 'rule of rescue'. IFR training is regularly refreshed to ensure that all panel members maintain the appropriate skills and expertise to function effectively

Cumulative record of the IFR Panel member's attendance 2015/16:

Individual Funding Request Committee Role	**Total/ possible**
Chair Lay Representative	3/3
Nominated Deputy Chair Lay Representative	3/3
Consultant in Public Health Medicine, Public Health Nottinghamshire County	3/3
Chief Officer NHS Nottingham West CCG	1/1
Deputy Chief Officer NHS Nottingham North and East CCG	2/3
Chief Officer NHS Rushcliffe CCG	1/1
GP – Lombard Medical Practice NHS Newark and Sherwood CCG	3/3
GP – West Bridgford Medical Practice NHS Rushcliffe CCG	3/3

GP – The Manor Surgery NHS Nottingham West CCG	1/3
Health Economist The University of Nottingham	0/3
Consultant in Public Health, Public Health Nottinghamshire County	1/1
Senior Prescribing Advisor (South) NHS Mansfield and Ashfield CCG	3/3
IFR Manager NHS Mansfield and Ashfield CCG	3/3

The Clinical Commissioning Group Risk Management Framework

Prevention of Risk

The CCG is committed to achieving an integrated approach to risk management, ensuring where possible the union of both clinical and non-clinical risk. The Integrated Risk Management Framework describes the CCG's arrangements for ensuring all risks, potential or otherwise, are correctly identified and that necessary controls are in place to mitigate those risks to the organisation or that of any stakeholder impact. The CCG appreciates that the management of risk is based on an element of prediction. Consequently, however robust the process, there can never be an absolute guarantee that untoward events will not occur. However, practicing risk management ensures it is much less likely that an untoward incident will occur, and this strategy intends to build on existing good practice to bring together the intelligence gained from incident, complaints and claim reporting to provide a holistic approach.

Risk appetite is one element of the CCG's assessment of its ability (or capacity) to take and manage risks and is an integral and iterative part of the risk management process in order to inform decisions about the willingness to accept risks in pursuit of strategic objectives. This is recorded in the Risk Assurance Framework as a target risk rating. The assessment of appetite is informed by factors such as impact on patients or staff, value of assets lost or wasted in the event of adverse impact, stakeholder perception of impact, the balance of cost of control and the extent of exposure and the balance or potential benefits to the gained or loses to be with stood. Hence the risk appetite for different risks, even within the same category, may vary.

Implementation of the Integrated Risk Management Framework is coordinated and monitored by the CCG senior management team. The framework clearly states the processes that the Clinical Commissioning Group follows when identifying,

assessing and addressing a risk. The process ensures that strategic risks progress through to the Risk Assurance Framework with a systematic approach presented for the management of corporate and operational risks. The Audit and Governance Committee has a role to ensure that the framework is embedded in the day to day business of the CCG.

Risk management is embedded into the wider working of the CCG, examples of which are the use of equality impact assessments, privacy impact assessment and quality impact assessment of policies and service procurements and developments. These impact assessments are reviewed by the respective senior officer in the CCG prior to presentation at the relevant committee of the Governing Body to provide assurance. The CCG also operates an incident reporting system across the three South Nottinghamshire CCGs to ensure that NHS Nottingham North East CCG is informed of any incidents reported and ensure that any risk to the organisation is considered, escalated to the risk register or Risk Assurance Framework as appropriate.

It is not the intention of the CCG's Integrated Risk Management Framework to eliminate all risk. The organisation promotes a balanced and mature approach to risk where, in certain situations, the likely impact of the risk is weighted up with the potential benefits of a particular course of action. The organisation does not tolerate unnecessary risk in relation to quality and patient safety but the risks associated with a business venture would be weighted up against the potential benefits of the course of action.

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 regularly 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 2015/16, the CCG have presented to the Nottinghamshire Joint Health Scrutiny Committee and the Gedling Borough Council Scrutiny Committee

Deterrent of Risks

Counter Fraud

The clinical commissioning group has a Local Counter Fraud Specialist Advice Service and robust arrangements in place to protect NHS resources from fraud, corruption and bribery in line with NHS Protect compliance guidance. The CCG has a Governing Body approved fraud, bribery and corruption policy and has produced a risk assessment and work plan across the four key areas of work:

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

The work plan for 2015/16 included the new NHS Protect Standards for Commissioners and the completion of the Self-Review Tool (SRT) by which the CCG has assessed its own compliance against each standard with the results reported to NHS Protect. An improvement action plan was developed and progressed throughout the year with a focus on creating an anti-fraud bribery and corruption culture. This significant progress will be reflected in the SRT for 2016/17, the completion of which will assist in identifying areas requiring further action.

Staff are the best source of information in countering fraud, bribery and corruption and have completed the eLearning module on Counter Fraud. Budget holder and HR eLearning modules have also been developed for relevant staff. Fraud Awareness month took place in November 2015 with site visits by the Counter Fraud Specialist as part of a programme of activities.

In order to measure the effectiveness of awareness work, staff understanding of their responsibilities and the overall strength of the anti-crime culture, a Counter Fraud survey was issued. The results showed that very significant progress had been made in developing staff knowledge and were used to inform the development of the Counter Fraud work plan for 2016/17.

Data Security

Risks to data security are specifically managed and controlled through internal processes. The NNE CCG Caldicott Guardian and all staff assigned responsibility for co-ordinating and implementing the confidentiality and data protection work programme have been appropriately trained to carry out their roles. Assurance on the adequacy of information governance arrangements established was provided by Internal Audit in February 2016 whose audit provided assurance on the evidence, systems and process in place to support the Information Governance Toolkit submission for level 2 for 2015/16.

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 2015 and March 2016.

During 2015/16 the clinical commissioning group undertook an assessment to determine its level of resilience in respect to potential cyber security threats. This included the successful completion of Stage 1 of the national Cyber Essentials Scheme (as part of the Cyber Essentials Assurance Framework), a review of related policies, an educational session for the Governing Body, a review of the technical infrastructure and operational procedures.

Management of Current Risks

The Governing Body uses the Risk Assurance Framework as its primary strategic risk management tool for the identification of risk. Risk registers are maintained for corporate, clinical, financial, safeguarding and information governance risks. These are reviewed in the relevant committees and are owned by Directors of the CCG.

In addition to the governing body assurance framework facilitating risk identification from a top down approach, the governing body agenda items are linked directly to the strategic objectives and risks. Any operational risks that are linked to delivery of the strategic objectives are highlighted through the discussions on the risks

Risk Assessment

The risks identified that threaten the achievement of the CCGs strategic objectives are presented in the table below. These risks will continue to be managed through the risk management and assurance processes throughout 2016/17. Where appropriate, the CCG will discuss risks which threaten the achievement of objectives with providers, our partners in healthcare and social services, the local authority, voluntary bodies and through the involvement of patients and their representatives.

Nottingham North East Strategic Risks

Strategic Objective	Identified Risks	Controls and Mitigating Actions
The CCG has effective and appropriate financial management including stretching itself financially, efficient financial controls and processes and good governance	The CCG is unable to deliver against plan due to continually increasing activity, unexpected costs and an inability to maintain QIPP savings.	• Financial Reporting to the Clinical Cabinet • Governing Body representation on the Finance and Information Group • NHS England assurance includes details on the financial position • Detailed risk management arrangements
The CCG has effective and appropriate financial management including stretching itself financially, efficient financial controls and processes and good governance	The fragility of the system impacts on the capability of the CCG to deliver against its financial duties.	• Regular meetings with providers • The Greater Nottingham Health and Care Partners includes finance and performance in the governance structure • Collaborative agreements in place to ensure partnership working across Health and Social Care
The CCG has comprehensive and achievable plans as both a CCG and as part of a wider system.	Capacity and demands impacting on short term performance hinder the capability to support transformation, the footprint and plans for the long term.	• CCG Committees review and monitor performance against objectives • Performance Reports received by the Governing Body • System Resilience Group and System Resilience Implementation Group provide comprehensive structure for managing performance
The CCG demonstrates that it is planning effectively providing a basis for transforming services,	The CCG is unable to provide confidence to its local population that it is commissioning clinically safe,	• Regular reports to the Quality and Risk Committee • Minutes and summaries to the Governing Body

improving outcomes while ensuring that patients receive the high quality, timely care that they have a right to expect today	high quality, compassionate services. Lack of adequate focus and challenge may lead to compromised quality, outcomes or inappropriate prioritisation	• Quality Impact Assessments are reviewed by the Director of Nursing
The CCG demonstrates that it is planning effectively providing a basis for transforming services, improving outcomes while ensuring that patients receive the high quality, timely care that they have a right to expect today.	1. Due to a lack of understanding and/or effort to recognise the different population segments, the CCG is unable to plan effectively and reduce health inequalities and/or demonstrate continuous improvements for the protected characteristics. 2. There is a risk that pressures and fragility within the system, ie ED, Cancer, EMAS, impact on the CCG's capability to deliver against targets.	• Equality Impact Assessments are discussed in the Equality and Diversity Forum • Lay Member PPI sits on the Governing Body • Business Cases and Service Specifications are presented to either the Service Improvement Group • Performance Reports • NHS England and the TDA actively monitor performance on key targets • Progress in monitored and reported back to the CCG through the performance report and also to the Health and Wellbeing
To ensure effective and efficient management of delegated functions and high quality primary care.	Limited engagement between member practices and with the CCG impacts on the capability to work together on delivery of transformational change, including gaining benefits through commissioning, federation and to improve the quality of primary medical services.	• Primary Care Team organise Practice Learning Time • GP representative from each of the practices is a member of the Clinical Cabinet • NHS England Assurance Framework includes a self-certification which is completed on a quarterly basis

To ensure a well-led organisation including strong leadership and good governance resulting in delivery of all statutory functions and duties, partnership working and a strong workforce.	1. Due to the resource and focus required as lead commissioner for NUH, leaders are not visible and are not able to focus on the short and longer term priorities of the CCG 2. Lack of succession planning in the leadership team and the Governing Body impacts on the capability to evidence robust leadership.	• Weekly executive meetings • Bi-weekly Communication Cell which is attended by all staff • Workforce reporting • Governing Body development sessions

Effectiveness of Governance Structures

Reporting lines and accountabilities between the Governing Body its committees and subcommittees are provided in the structure diagram on page 61. 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. The Chief Officer, Chief Finance Officer, Director of Nursing and Quality, Director of Operations, Deputy Chief Officer and Director of Outcomes and Information all report directly into the Governing Body and ensure robust links between the strategic and operational risks. The CCG has not faced any risks to compliance and this has been mitigated by responding effectively to change and robust management through the structures that have been embedded since the CCG became a statutory organisation.

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

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.

Control Mechanisms

The Governing Body has the ultimate responsibility for internal control and the oversight and risk management throughout the CCG. The Governing Body receives reports from the Audit and Governance Committee on its assessment of the effectiveness of internal control following the review of the Risk Assurance Framework and reports form the CCG Internal and External auditors at its meetings at least quarterly.

The CCGs strategic objectives form for the basis of the Risk Assurance Framework. The strategic objectives ensure a robust organisation and are linked to internal controls and assurance sources. Mitigating actions, controls and assurances are recorded and monitored to deliver reasonable assurance for prevention of risks, deterrent to risks arising and the management of current risks. The control mechanisms in place are

designed to minimise or eliminate the risk of failure to deliver business objectives, including robust corporate and performance management frameworks, service level agreements and contract monitoring, policies and procedures.

The quality, safety and the experiences of patients of the services commissioned are overseen by the Quality and Risk Committee. The Governing Body receives quarterly reports on the quality and safety of commissioned services from the Director of Nursing and Quality.

Specialised risk management activities, for example information governance, emergency planning and business continuity, health and safety, fire and security are operationally managed by the Director of Operations. The Director of Operations also sits on the Community Safety Partnership providing a wider community level approach to managing risk. Individual Directors also provide assurance reports on risk and compliance to the Governing Body and its committees.

Control measures ensure that all of the CCG's obligations under equality, diversity and human rights legislation are in place. These include: policies; Governing Body level leadership and a nominated lead for equality and diversity; the Equality and Diversity forum and the CCG self-assessment against the Equality Delivery System 2, demonstrating compliance and progress against equality and diversity best practice, owned by the Governing Body.

Information Governance

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

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

ensure staff are aware of their information governance roles and responsibilities.

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

Risks to data security are specifically managed and controlled through internal processes. The NNECCG Caldicott Guardian and all staff assigned responsibility for co-ordinating and implementing the confidentiality and data protection work programme have been appropriately trained to carry out their roles. Information Governance in the CCG is supported at its most senior level by the Senior Information Risk Owner (SIRO) and the Caldicott Guardian. The Caldicott Guardian and SIRO are both concerned with ensuring NHS data is protected and is not stored, accessed or used inappropriately. The CCG is part of a Data Management Group who reviews all risks to data as well as ensuring effective data management.

The Caldicott Guardian is primarily concerned with the protection of patient and service user information by ensuring it is shared only with those who have a justified need for it; and only shared through appropriately safeguarded routes.

The SIRO is concerned with identifying and managing the information risks to the organisation and with its business partners. This includes oversight of the organisation's information security incident reporting and response arrangements. The SIRO is supported in their role by one or more Information Asset Owners who have assigned responsibility for the information assets of the organisation.

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

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically. The CCG has developed and continues to refine systems and processes to effectively manage financial risks and to secure a stable financial position.

The CCG’s financial plan was developed for 2015/16, and budgets set within this plan, and signed off by the Governing Body prior to the start of the financial year. These budgets were communicated to managers and budget holders within the organisation. The Chief Finance Officer and his

team have worked closely with managers to ensure robust annual budgets were prepared and delivered.

Finance reports are presented to the Finance and Information Group, Clinical Cabinet and the Governing Body. Alongside the financial position, performance against statutory duties, risks and actions to mitigate risks are reported and discussed.

The CCG makes full use of internal and audit functions to ensure controls are operating effectively and to advise on areas for improvement. 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 also added to the corporate risk register. Action plans are tracked through the Audit tracker which goes to Senior Management for action and the Audit and Governance Committee meetings to provide performance and assurance updates.

The financial austerity which lies ahead is recognised by the CCG, and the reflected in the CCG Risk Assurance Framework, and future financial plans reflect the anticipated lower levels of growth and transfer of resource to the Local Authority, as part of The Better Care Fund. The CCG is actively engaged in discussions in this regard to ensure resources are prioritised in line with its strategic direction. The CCG also recognises the need to achieve cost reductions through improved efficiency and productivity and work is ongoing to develop schemes to achieve the QIPP targets which form part of future financial plans.

The Internal Audit Plan for 2015/16 contained a number of audits specifically related to financial management and governance. The outcomes of those audits were reported to the Audit and Governance Committee and provided significant assurance on the systems and processes in place.

In accordance with its constitutional framework, the CCG is required to have adequate arrangements in place for countering fraud, corruption and bribery. During 2015/16 the CCG commissioned a counter fraud service from 360 Assurance. The Local Counter Fraud Specialist has regularly met with the Chief Finance Officer and presents regular reports to the CCG's Audit and Governance Committee. These reports aim to inform the Committee of the work carried out by the Counter Fraud Specialist across the four areas of Counter Fraud work:

- Strategic Governance

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

In addition, staff have access to online Counter Fraud training and have completed a Counter Fraud survey and receive regular bulletins to raise awareness, vigilance and reporting.

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

From the 1 April 2015, the CCG became responsible (with full delegated authority from NHS England) for the commissioning of primary medical services contracts – primary care co-commissioning.

The key functions delegated include:

- Decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts;
- Approval of practice mergers;
- Planning primary medical care services, including carrying out needs assessments;
- Undertaking reviews of primary medical care services;
- Decisions in relation to the management of poorly performing GP practices; and
- Premises Costs Directions Functions.

The CCG has established a Primary Care Commissioning Committee (PCCC) with Terms of Reference approved by the Governing Body and NHS England as part of the CCG's Constitution.

The Committee has been established in accordance with the statutory provisions to enable the members to make decisions on the review, planning and procurement of primary care services in Nottingham North and East and has delegated authority from the CCG Governing Body to make decisions about primary care on its behalf.

The PCCC meets regularly and relevant documentation is normally made available on the CCG's website. The committee has a work plan which covers the establishment of primary care co-commissioning arrangements including the "hub" arrangements with NHSE seconded staff

The CCG has a lead manager with responsibility for primary care co-commissioning, a manager with responsibility for governance issues around co-commissioning and has two GP Governing Body members actively engaged in primary care co-commissioning.

There is a policy and procedure for recording and managing conflicts of interest which is compliant with guidance; this is publicised on the CCG website has an actively managed register of interests for all staff and members of the CCG. It also has a register of declared conflicts which records each occasion on which a conflict has arisen and how that conflict was managed.

On a quarterly basis, the CCG provides NHS England with a self-certification to demonstrate how the CCG is discharging its delegated responsibilities effectively. The self-certification is subject to internal scrutiny and approval at the PCCC and the Audit and Governance Committee prior to submission to NHS England, and the self-certification forms an aspect of the quarterly assurance meetings.

During 2015/16, the CCG's internal auditors undertook an audit, the objective of which was to assess the extent to which co-commissioning governance arrangements have been established in line with guidance and are now being implemented by the CCG to ensure that organisations can effectively commission devolved services under co-commissioning arrangements. This included the arrangements the CCG has established for managing conflicts of interest. The audit provided Significant Assurance on the systems and processes in place.

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

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

Capacity to Handle Risk

As Accountable Officer, I have overall responsibility for risk management and internal control. Specific responsibilities are delegated to senior managers throughout the CCG. The Governing Body oversees risks, discusses risk appetite for high level risks on a risk by risk basis and encourages proactive identification and mitigation of risks.

Leadership and co-ordination of risk management activities is provided by the Head of Governance, Quality and Engagement, with support from all members of the Senior Management Team. Operational responsibility rests with all staff aligned to their individual roles.

Risk identification, prioritisation, mitigation or elimination occurs through assessment and grading using a nationally recognised matrix of impact and likelihood. Incident reporting is a factor in the ongoing assessment of risk and results in the instigation of changes in practice. Complaints and other

patient experience intelligence are also used and reported to the Governing Body.

Risk assessment forms part of the CCG mandatory training - incorporated with Health and Safety training.

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 annual audit letter and other reports.

Our board assurance framework 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 and the Audit and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In addition to the above, I am also informed by the outcome of the CCG Assurance Framework process operated by NHS England. 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 duration of 2015/16, the outcomes of the quarterly assurance reviews with NHS England have been that the CCG is ‘assured with support’. This is in relation to delivery of a key target – the Accident and Emergency Department 4-hour waiting time standard – and management of the urgent care system as a health community.

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 2015/16 and have managed the risks assigned to them:

Governing Body

Responsible for providing clear commitment and direction for risk management and in assuring that risk is effectively identified and that the processes and controls in place to mitigate risk, the impact risk has on the organisation and its stakeholders are managed and administered with effect.

Audit & Governance Committee

Responsible for providing an independent overview of the internal controls arrangements for integrated governance and risk management. It undertakes its own annual self-assessment of its effectiveness and reviews the outcome of Internal and External Audits.

Joint Committees

The CCG has the following Joint Committee Arrangements with neighbouring CCGs as identified in the CCG Constitution. These committees serve the collective CCGs and provide equal levels of assurance within the range of their functions.

- Individual Funding Request Panel (led by Nottingham West CCG)
- Information Governance, Management and Technology Committee (led by Rushcliffe CCG)
- Quality and Risk Committee (led by Nottingham North and East CCG)
- Safeguarding Committee (led by Newark and Sherwood CCG).
- Chief Officer - The Chief Officer is the Accountable Officer.

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.

Senior Executives

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 senior manager has the expectation of owning some of the main risks in their Team/s and personally addressing them, thus setting the tone for risk management in their areas of responsibility.

Head of Internal Audit Opinion

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

From my review of your systems of internal control, primarily through the operation of your Governing Body's Assurance Framework in the year to date, and the outcome of individual assignments also completed in the year to date, I am providing **Significant Assurance** that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently

During the year, Internal Audit issued no audit reports which identified governance, risk management and/or control issues which were significant to the organisation.

Data Quality

The CCG 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

In accordance with the Information Governance Toolkit requirements, the CCG has documented its 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 NHS England planning guidance
- Use of version control and in-built validation checks in the Financial Model
- Financial Plans submitted to the NHS England Area team and details from the Financial Modelling as and when required
- Critical evaluation via external peer review from NHS England
- Internal peer review of Financial Model and Financial Plan Templates 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.
- Subject to Internal Audit assurance as part of the Financial Management Audit.

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 with the Toolkit at level 2. As per the requirements for level 2 compliance, all staff completed their mandatory Information Governance training during 2015/16 ensuring that all staff members were aware of their responsibilities relating to information governance.

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

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 2015 and March 2016.

Discharge of Statutory Functions

Arrangements put in place by the CCG and explained within the corporate governance framework have been developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

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

Conclusion

My review confirms that NHS North East Clinical Commissioning Group has a sound system of internal control. This supports the achievement of its goals, vision, values, policies aims and objectives. No significant internal control issues have been identified.

Sam Walters
Accountable Officer
May 2016

Remuneration and Staff Report

Remuneration Report

Remuneration Policy – not subject to audit

The Chief Officer is the only senior manager not directly employed under Agenda for Change terms and conditions and was appointed in accordance with HR guidance issued by the NHS Commissioning Board and remunerated in line with: *Clinical Commissioning Groups: Remuneration Guidance for Chief Officer (where the senior manager also undertakes the accountable officer role) and Chief Finance Officers* applicable from when the CCG became the employing body on 1 April 2013. The agreed remuneration for the Chief Officer did not include any performance-related pay.

Senior managers on Agenda for Change terms and conditions will be remunerated in line with any national changes and pay awards.

Our future policy will be to remain in line with guidance issued to date or any revised guidance issued by NHS England.

All senior managers are employed on substantive contracts with a minimum notice period of three months. We do not make termination payments which are in excess of contractual obligations. There were no such payments during the 2015/16 financial year.

Lay members and clinical leads on the Governing Body have contracts for service. The term of office, notice period, grounds and arrangements for removal from office for these individuals are detailed in the CCG's constitution.

Salaries and allowances – subject to audit

Name and Title	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100 £000	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500)* £000	(f) TOTAL (a to e) (bands of £5,000) £000
Hazel Buchanan	55-60					Missing information
Samantha Walters Chief Officer	110-115	-	-	-		125-130
Jonathan Bemrose Chief Finance Officer	40-45	-	-	-		75-80
Sharon Pickett Deputy Chief Officer	75-80	-	-	-		75-80
Andrew Hall Director of Outcomes & Information	40-45	-	-	-		45-50
Maxine Bunn Director of Contracting	25-30	-	-	-		30-35
Nichola Bramhall Director of Quality and Patient Care	30-35	-	-	-		30-35
Rebecca Larder Director of Transformation	40-45					Missing information
Emma Pooley (March 2015 – February 2016) Clinical Director	70-75	-	-	-		Missing information
Janet Champion Governing Body Lay Member Patient and Public Involvement (start Jan 2016)	0-5					0-5
Mike Wilkins Governing Body Lay	5-10					5-10

Member Patient and Public Involvement (March 2015 to Jan 2016)						
Terry Allen Governing Body Lay Member – Financial Management and Audit	10-15	-	-	-		10-15
Dr Paramjit Panesar Assistant Clinical Chair – Governing Body	70-75	-	-	-		70-75
Dr James Hopkinson GP Representative – Governing Body	65-70	-	-	-		65-70
Dr Paul Oliver (March 2015 – February 2016 GP) Clinical Lead/Chair	70-75	-	-	-		70-75
Adrian Kennedy (March 2015 to June 2015) Governing Body Allied Healthcare Professional Representative	0-5	-	-	-		0-5
Dr Mohammed Al-Uzri Governing Body Secondary Care Consultant	5-10	-	-	-		5-10

*The CCG believes that the employment dates for the information it has received from the Pensions Agency is incorrect. The CCG has requested accurate information, and will publish this on its website upon receipt.

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	105-110	-	-	-
Rebecca Larder	Director of Transformation	95-100	-	-	-
Nichola Bramhall	Registered Nurse and Director of Nursing and Quality	80-85	-	-	-
Andrew Hall	Director of Outcomes and Information	95-100	-	-	-
Maxine Bunn	Director of Contracting	65-70	-	-	-

Pension Benefits – subject to audit

Certain members do not receive pensionable remuneration, therefore there are no entries in respect of pensions for lay members.

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016 (band of £1,000)	Real increase in Cash Equivalent Transfer Value (band of £1000)**	Cash Equivalent Transfer Value at 31 March 2016 (band of £1,000)	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000

The CCG believes that the employment dates for the information it has received from the Pensions Agency is incorrect. The CCG has requested accurate information, and will publish this on its website upon receipt.

**On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Notes:

As Lay (Non-Executive) Members do not receive pensionable remuneration, there will be no entries in respect of pensions for Lay Members.

A 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.

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.

Compensation on Early Retirement or for Loss of Office – not subject to audit

In 2015/16 there have been no compensation awarded for early retirement or loss of office

Payments to Past Directors – not subject to audit

In 2015/16 there have been no payments to past directors.

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 2015/16 was £110-115k. This was 2.66 times the median remuneration of the workforce, which was £42, 1261.

In 2015/16 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.

Staff Report

Our Team

We have a small core team within the CCG of 48 employees (44.77 full time equivalents).

Staff group	Numbers	Full-time equivalent	Gender	
Very Senior Manager	5	5		
Senior Managers	16	13.97		
Employees	27	25.8	**Male**	**Female**
Totals	48	44.77	10	38

In addition, for economies of scale and to reduce duplication and costs, we have a number of shared teams for performance and information, finance, quality and patient safety and contracting. The performance and information team are employed by Rushcliffe CCG with the Finance and Quality and Patient Safety and Contracting Teams being employed by NNE and included in our employee numbers above.

Our Governing Body comprises 12 members, nine are male and three are female, this changed mid-year to eight male and four female members'

More information about our Governing Body is provided in the Members' Report and on our website.

Equal Opportunities

NHS Nottingham North East CCG is committed to promoting equality, valuing diversity and combating unfair treatment.

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).

The CCG's Equality and Diversity Policy was approved by the Quality and Risk Committee in February 2016 and sets out the approach to Equality and Diversity, recognising and taking account of Equality and Diversity issues in our employment practices.

- The CCG operates fair, inclusive and transparent recruitment and selection processes which include the following measures in order to minimise the opportunity for discrimination:
- All vacancies are advertised via the NHS Jobs website
- Candidates' personal details are not made available to recruiting managers until after shortlisting has taken place
- A minimum of two people are required to be involved in the shortlisting process
- An interview is guaranteed to any candidate with a disability whose application meets all of the essential criteria for the post (Guaranteed Interview Scheme).

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.

Disabled Employees

We proactively supported our commitment to disabled employees through:

- Operating the guaranteed interview scheme for disabled candidates meeting the essential criteria.
- Continued adherence to the five commitments of the Two Ticks Positive About Disability regarding the recruitment, employment, retention and career development of disabled people, following accreditation to The Two Ticks Scheme in October 2014.
- Renewing our registering with Mindful Employer for the Charter for Employers who are Positive about Mental Health – a voluntary agreement seeking to support employers in working within the spirit of its positive approach. The CCG is continuing to work to embed the charter into existing processes.

We are not aware of any of our employees becoming disabled during 2015/16.

Workforce Race Equality Standard

The CCG has due regard of the **Workforce Race Equality Standard (WRES)** which was introduced on 1 April 2015 and seeks to tackle one particular aspect of equality – the consistently less favourable treatment of the Black and Minority Ethnic (BME) workforce – in respect of their treatment and experience. The evidence is clear that treating all healthcare staff fairly and with respect is good for patient care.

The CCG's main providers have implemented the National Workforce Race Equality Standard and have submitted a report on their progress in implementing the Standard. The CCG's Equality and Diversity Forum received copies of the reports and future monitoring of compliance of the standard has been incorporated within the Quality Schedules.

The regulators, the Care Quality Commission (CQC), National Trust Development Agency (NDTA) and Monitor, will also use both standards to help assess whether NHS organisations are well-led.

The CCG is working towards implementation of the Workforce Race Equality Standard with regard its own workforce and expects to produce a report by 1 May 2016. Clinical Commissioning Groups will be required to demonstrate progress through the annual CCG assurance process with NHS England.

Staff Survey

In October 2015 were asked to complete a Staff Survey, undertaken by the Arden and Gem CSU. We received a response rate of 94 per cent.

Overall staff felt that they had clear objects and understood how their work contributes to the performance of the CCG, staff expressed that they felt they had good working relationships with co-workers and received training to do their job well.

There were areas highlighted for improvement which included communications with other CCG teams, development opportunities and involvement in decision making, from October the CCG have made positive changes to support staff and examples of the activities undertaken include:

Workplace Award Scheme

The CCG signed up to the Nottinghamshire Wellbeing at Work: Workplace Health Award Scheme in April 2015.

The aims of the scheme are:

- To promote and enable a healthy productive workforce with optimum levels of wellbeing.
- To reduce sickness absence and improve management and recording of sickness management.
- To reduce staff turnover and increase employee retention as employees feel better supported and more valued.
- To increase productivity, efficiency and profitability through better recruitment and retention and reduce unplanned staff absence due to illness.
- To create a culture of wellness and wellbeing with a healthy working environment within the organisation.

There are five themes to this scheme: substance use/misuse, emotional health and wellbeing, healthy weight, protecting health and health and safety at work.

A key element of the award scheme is being able to demonstrate improvements to the organisation and to the health and wellbeing of its employees through a portfolio of evidence. We are currently working towards achieving a bronze accreditation – Health Promotion and Information. This involves providing easily accessible information to raise awareness about these five themes and taking part in national health campaigns, making it easy for employees to get involved.

Lunch and Learn

"Lunch and Learn" takes place every other month and includes a communal lunch and a mix of development sessions and presentations on topics that were highlighted from the Training Needs Analysis.

On-Site Health

The CCG has received on-site health and wellbeing visits which included:

- Stress and mental health workshop
- Flu clinic

Sickness Absence

NNE CCG recognises the valuable contribution made by each employee to the delivery of its services and is committed to the promotion of employee health, safety and wellbeing. 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 ill health 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.

The table below shows staff sickness and ill health retirements for 2015/16 for Nottinghamshire County Teaching Primary Care Trust, the CCG's predecessor organisation. The data cannot be disaggregated to NNE CCG level.

	2015/16 Number
Total days lost	78
Total staff years	24
Average working days lost	3.3

For more details please see the staff sickness absence table in the annual accounts.

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.

As of 31 March 2016 there were 4 off-payroll engagements for more than £220 per day and that lasted longer than six months.

Exit Packages

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

There have been three exit packages in 2015/16 for NNE CCG.

Exit Package	£
1	5,714.91
2	4,840.00
3	9,893.52

Signature of the Accountable Officer

I certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the NHS Act 2006

Sam Walters
Accountable Officer

Signature: ______________________

Date: __________________________

Data entered below will be used throughout the workbook:

Entity name:	NHS Nottingham North & East CCG
This year	2015-16
This year ended	31-March-2016
This year commencing:	01-April-2015

These account templates are a proforma for a set of NHS England Group Entity Accounts, this is not a mandatory layout for local accounts.

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

	Note	**2015-16 £000**	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	2,646	2,369
Operating Expenses	5	196,111	167,767
Other operating revenue	2	(2,191)	(2,206)
Net operating expenditure before interest		**196,566**	**167,930**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**196,566**	**167,930**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**196,566**	**167,930**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	2,340	1,953
Operating Expenses	5	579	785
Other operating revenue	2	(6)	(18)
Net administration costs before interest		**2,913**	**2,720**
Programme Income and Expenditure			
Employee benefits	4.1.1	307	415
Operating Expenses	5	195,531	166,982
Other operating revenue	2	(2,185)	(2,188)
Net programme expenditure before interest		**193,653**	**165,210**

Other Comprehensive Net Expenditure		**2015-16 £000**	2014-15 £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			
On disposal of available for sale financial assets		0	0
Total comprehensive net expenditure for the year		**196,566**	**167,930**

The notes on pages 5 to 27 form part of this statement

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	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	1,490	1,449
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	47	42
Total current assets		**1,536**	**1,491**
Non-current assets held for sale	21	0	0
Total current assets		**1,536**	**1,491**
Total assets		**1,536**	**1,491**
Current liabilities			
Trade and other payables	23	(7,445)	(6,794)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(136)	(117)
Total current liabilities		**(7,581)**	**(6,911)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(6,045)**	**(5,420)**
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		**(6,045)**	**(5,420)**
Financed by Taxpayers' Equity			
General fund		(6,045)	(5,420)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(6,045)**	**(5,420)**

The notes on pages 5 to 27 form part of this statement

The financial statements on pages 1 to 4 were approved by the Audit & Governance Committee on 25th May 2016 and signe

Chief Accountable Officer

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(5,420)	0	0	**(5,420)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(5,420)**	**0**	**0**	**(5,420)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(196,566)			(196,566)
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 Yea	**(196,566)**	**0**	**0**	**(196,566)**
Net funding	195,941	0	0	195,941
Balance at 31 March 2016	**(6,045)**	**0**	**0**	**(6,045)**

	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 of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0
Adjusted NHS Commissioning Board balance at 1 April 2014	**(6,044)**	**0**	**0**	**(6,044)**
Changes in NHS Commissioning Board taxpayers' equity for 2014-15				
Net operating costs for the financial year	(167,930)			(167,930)
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	**(167,930)**	**0**	**0**	**(167,930)**
Net funding	168,554	0	0	168,554
Balance at 31 March 2015	**(5,420)**	**0**	**0**	**(5,420)**

The notes on pages 5 to 27 form part of this statement

NHS Nottingham North & East CCG - Annual Accounts 2015-16

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

	Note	**2015-16 £000**	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(196,566)	(167,930)
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	(40)	466
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	652	(1,122)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	19	60
Net Cash Inflow (Outflow) from Operating Activities		**(195,936)**	**(168,526)**
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		**(195,936)**	**(168,526)**
Cash Flows from Financing Activities			
Grant in Aid Funding Received		195,941	168,554
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		**195,941**	**168,554**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**5**	**28**
Cash & Cash Equivalents at the Beginning of the Financial Year		**42**	**14**
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		**47**	**42**

The notes on pages 5 to 27 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 Charitable Funds

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

1.6 Pooled Budgets

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

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

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

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

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

- 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 that have the most significant effect on the amounts recognised in the financial statements:

- Partially Completed Spells £916,000 (14/15: £916,000)

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 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Plus 0.80% (2014-15: minus 2.20%)

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

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

1.22 Clinical Negligence Costs

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

1.23 Non-clinical Risk Pooling

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

1.24 Continuing healthcare risk pooling

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

1.25 Carbon Reduction Commitment Scheme

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

1.26 Contingencies

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

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

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

Notes to the financial statements

1.27 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.27.1 Financial Assets at Fair Value Through Profit and Loss

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

1.27.2 Held to Maturity Assets

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

1.27.3 Available For Sale Financial Assets

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

1.27.4 Loans & Receivables

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

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

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

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.28.1 Financial Guarantee Contract Liabilities

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

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

1.28.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.28.3 Other Financial Liabilities

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

Notes to the financial statements

1.29 Value Added Tax

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

1.30 Foreign Currencies

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

1.31 Third Party Assets

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

1.32 Losses & Special Payments

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

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

1.33 Subsidiaries

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

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

1.34 Associates

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

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

1.35 Joint Ventures

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.36 Joint Operations

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

1.37 Research & Development

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

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

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

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

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

2 Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	13	0	13	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	1,091	4	1,087	754
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	1,088	2	1,086	1,453
Total other operating revenue	**2,191**	**6**	**2,185**	**2,206**

3 Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
From rendering of services	2,191	6	2,185	2,206
From sale of goods	0	0	0	0
Total	**2,191**	**6**	**2,185**	**2,206**

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4. Employee benefits and staff numbers

4.1.1 Employee benefits

2015-16	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	2,142	2,085	57	1,912	1,909	3	231	176	54
Social security costs	210	210	0	180	180	0	30	30	0
Employer Contributions to NHS Pension scheme	294	294	0	248	248	0	46	46	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,646**	**2,589**	**57**	**2,340**	**2,337**	**3**	**307**	**252**	**54**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,646**	**2,589**	**57**	**2,340**	**2,337**	**3**	**307**	**252**	**54**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,646**	**2,589**	**57**	**2,340**	**2,337**	**3**	**307**	**252**	**54**

4.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	1,897	1,897	0	1,556	1,556	0	341	341	0
Social security costs	192	192	0	161	161	0	31	31	0
Employer Contributions to NHS Pension scheme	280	280	0	236	236	0	44	44	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,369**	**2,369**	**0**	**1,953**	**1,953**	**0**	**415**	**415**	**0**
Less recoveries in respect of employee benefits (note 4.1.2)	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**	**415**	**415**	**0**
Less: Employee costs capitalised	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**	**415**	**415**	**0**

4.1.2 Recoveries in respect of employee benefits

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

4.2 Average number of people employed

	2015-16 Total Number	2015-16 Permanently employed Number	2015-16 Other Number	2014-15 Total Number
Total	**48**	**48**	**0**	46
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

	2015-16 Number	2014-15 Number
Total Days Lost	78	702
Total Staff Years	24	156
Average working Days Lost	**3.25**	**4.5**

The numbers above for 2014/15 are the total for the old Nottinghamshire County PCT area, of which the CCG was a part.
These figures are unable to be split. The 2015/16 figures are for Nottingham North & East CCG.

	2015-16	2014-15
	Number	Number
Number of persons retired early on ill health grounds	0	0
	£000	£000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme.

4.4 Exit packages agreed in the financial year

	2015-16 Compulsory redundancies Number	2015-16 Compulsory redundancies £	2015-16 Other agreed departures Number	2015-16 Other agreed departures £	2015-16 Total Number	2015-16 Total £
Less than £10,000	0	0	3	20,448	3	20,448
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**3**	**20,448**	**3**	**20,448**

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

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

Analysis of Other Agreed Departures

	2015-16 Other agreed departures Number	2015-16 Other agreed departures £	2014-15 Other agreed departures Number	2014-15 Other agreed departures £
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	3	20,448	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	**3**	**20,448**	**0**	**0**

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

Where the CCG has agreed early retirements, the additional costs are met by the CCG 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 Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

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

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

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

4.5.1 Full actuarial (funding) valuation

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

For 2015-16, employers' contributions of £293,600 were payable to the NHS Pensions Scheme (2014-15: £276,300), were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014.

5. Operating expenses	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	2,161	1,854	307	1,963
Executive governing body members	486	486	0	406
Total gross employee benefits	**2,647**	**2,340**	**307**	**2,369**
Other costs				
Services from other CCGs and NHS England	16,272	100	16,172	15,898
Services from foundation trusts	31,013	0	31,013	8,458
Services from other NHS trusts	79,210	41	79,169	100,470
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	22,927	0	22,927	16,993
Chair and Non Executive Members	0	0	0	0
Supplies and services – clinical	0	0	0	0
Supplies and services – general	3,228	10	3,219	1,322
Consultancy services	126	18	108	44
Establishment	658	187	471	785
Transport	40	7	33	32
Premises	1,132	103	1,029	1,178
Impairments and reversals of receivables	1	1	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				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	54	54	0	72
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	22,671	0	22,671	21,846
Pharmaceutical services	0	0	0	0
General ophthalmic services	0	0	0	0
GPMS/APMS and PCTMS	17,924	0	17,924	243
Other professional fees excl. audit	24	24	0	(23)
Grants to other public bodies	0	0	0	0
Clinical negligence	1	1	0	1
Research and development (excluding staff costs)	13	0	13	0
Education and training	38	34	4	55
Change in discount rate	0	0	0	0
Provisions	19	0	19	60
Funding to group bodies		0	0	0
CHC Risk Pool contributions	718	0	718	240
Other expenditure	42	1	42	94
Total other costs	**196,111**	**579**	**195,531**	**167,767**
Total operating expenses	**198,758**	**2,919**	**195,838**	**170,136**

6.1 Better Payment Practice Code

Measure of compliance	**2015-16 Number**	**2015-16 £000**	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	1,815	34,819	1,675	19,757
Total Non-NHS Trade Invoices paid within target	1,805	34,680	1,654	19,676
Percentage of Non-NHS Trade invoices paid within target	**99.45%**	**99.60%**	**98.75%**	**99.59%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,953	127,247	1,874	129,071
Total NHS Trade Invoices Paid within target	1,906	126,866	1,847	128,441
Percentage of NHS Trade Invoices paid within target	**97.59%**	**99.70%**	**98.56%**	**99.51%**

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

There were no late payments of commercial debt during the year (2014/15: £nil).

7 Income Generation Activities

There were no income generation activities during the year (2014/15: £nil).

8. Investment revenue

There was no investment income during the year (2014/15: £nil).

9. Other gains and losses

There was no other gains and losses during the year (2014/15: £nil).

10. Finance costs

There were no finance costs during the year (2014/15 £nil).

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 gains(loss) on transfer by absorption during the year (2014/15: £nil).

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense				**2015-16**				2014/15
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	£000
Payments recognised as an expense								
Minimum lease payments	0	1,113	0	**1,113**	0	1,163	0	**1,163**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**1,113**	**0**	**1,113**	**0**	**1,163**	**0**	**1,163**

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

12.1.2 Future minimum lease payments				**2015-16**				2014/15
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	£000
Payable:								
No later than one year	0	0	0	**0**	0	-	-	**0**
Between one and five years	0	0	0	**0**	0	-	-	**0**
After five years	0	0	0	**0**	0	-	-	**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

12.2 As lessor

12.2.1 Rental revenue	**2015-16**	2014/15
	£000	£000
Recognised as income		
Rent	0	0
Contingent rents	0	0
Total	**0**	**0**

12.2.2 Future minimum rental value	**2015-16**	2014/15
	£000	£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 (2014/154: £nil).

14 Intangible non-current assets

There CCG has no intangible non-current assest at the year end (2014/15: £nil).

15 Investment property

The CCG has no investment property at the year end (2014/15: £nil).

16 Inventories

The CCG has no inventories at the year end (2014/15: £nil).

17 Trade and other receivables

	Current 2015-16 £000	Non-current 2015-16 £000	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	562	0	233	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	572	0	926	0
NHS accrued income	136	0	0	0
Non-NHS receivables: Revenue	159	0	118	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	22	0	106	0
Non-NHS accrued income	22	0	0	0
Provision for the impairment of receivables	(1)	0	0	0
VAT	17	0	66	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	0	0
Total Trade & other receivables	**1,490**	**0**	**1,449**	**0**
Total current and non current	**1,490**		**1,449**	
Included above:				
Prepaid pensions contributions	0		0	

17.1 Receivables past their due date but not impaired

	2015-16 £000	2014-15 £000
By up to three months	198	46
By three to six months	0	32
By more than six months	1	0
Total	**199**	**78**

£198,000 of the amount above has subsequently been recovered post the statement of financial position date.

17.2 Provision for impairment of receivables

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	(1)	0
Transfer (to) from other public sector body	0	0
Balance at 31-March-2016	**(1)**	**0**

	2015-16 £000	2014-15 £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 (2014/15: £nil).

19 Other current assets

The CCG has no other current assets at the year end (2014/15: £nil).

20 Cash and cash equivalents	**2015-16**	2014-15
	£000	£000
Balance at 01-April-2015	42	14
Net change in year	5	28
Balance at 31-March-2016	**47**	**42**
Made up of:		
Cash with the Government Banking Service	47	42
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	**47**	**42**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31-March-2016	**47**	**42**
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 (2014/15: £nil).

22 Analysis of impairments and reversals

The CCG has no impairments and reversals during the year (2014/15: £nil).

23 Trade and other payables

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	994	0	856	0
NHS payables: capital	0	0	0	0
NHS accruals	1,139	0	632	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	4,549	0	3,990	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals	652	0	942	0
Non-NHS deferred income	0	0	0	0
Social security costs	33	0	26	0
VAT	0	0	0	0
Tax	41	0	29	0
Payments received on account	0	0	0	0
Other payables	37	0	318	0
Total Trade & Other Payables	**7,445**	**0**	**6,794**	**0**
Total current and non-current	**7,445**		**6,794**	

Other payables include £44,000 outstanding pension contributions at 31 March 2016 (2014/15 £26,000).

24 Other financial liabilities

The CCG has no other Financial Liabilities at the year end (2014/15: £nil).

25 Other liabilities

The CCG has no other liabilities at the year end (2014/15: £nil).

26 Borrowings

The CCG has no borrowings at the year end (2014/15: £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 (2014/15: £nil).

28 Finance lease obligations

The CCG has no finance lease obligations at the year end (2014/15: £nil).

29 Finance lease receivables

The CCG has no finance lease receivables at the year end (2014/15: £nil).

30 Provisions

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	136	0	117	0
Other	0	0	0	0
Total	**136**	**0**	**117**	**0**
Total current and non-current	**136**		**117**	

	Pensions Relating to Former Directors £000s	**Pensions Relating to Other Staff £000s**	**Restructuring £000s**	**Redundancy £000s**	**Agenda for Change £000s**	**Equal Pay £000s**	**Legal Claims £000s**	**Continuing Care £000s**	**Other £000s**	**Total £000s**
Balance at 01-April-2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**117**	**0**	**117**
Arising during the year	0	0	0	0	0	0	0	19	0	19
Utilised during the year	0	0	0	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	0	0	0	0	0	0
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Balance at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**136**	**0**	**136**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	136	0	136
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**136**	**0**	**136**

31 Contingencies

	2015-16	2014-15
NHS Property Services	302	779

During 215/16, 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 2014/15 charges. At the date of the Accounts, NHSPS has not responded to this request. A Contingent Liability has been receognised in the accounts in the event that NHSPS do not agree to the CCG proposal.

32 Commitments

32.1 Capital commitments	**2015-16**	2014-15
	£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:

	2015-16	2014-15
	£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 the 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 NHS Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

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

33.1.3 Liquidity risk

The 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' 2015-16 £000	**Loans and Receivables 2015-16 £000**	**Available for Sale 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	698	0	698
· Non-NHS	0	182	0	182
Cash at bank and in hand	0	47	0	47
Other financial assets	0	0	0	0
Total at 31-March-2016	**0**	**926**	**0**	**926**

	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**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	**Other 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,133	2,133
· Non-NHS	0	5,195	5,195
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2016	**0**	**7,328**	**7,328**

	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**

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 31st 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.

The Memorandum Account for the Pooled Budget is:

	2014-15 £000	**2015-16** **£000**
Balance Brought Forward	**541**	**94**
Nottingham City Council	1,201	1,310
Nottinghamshire County Council	2,377	2,249
Bassetlaw CCG	362	419
Nottinghamshire County CCGs	2,400	2,655
Nottingham City CCG	1,189	1,289
Other	192	231
	8,262	**8,247**
Expenditure		
Partnership Management & Administration Costs	366	536
Contract Management Fee	1,191	1,410
ICES Equipment	5,452	5,516
Continuing Healthcare Specialist Equipment	235	250
Minor Adaptations	846	419
Project Provision Expenditure	78	6
	8,168	**8,137**
Remaining Balance under/(overspend)	**94**	**110**

The Nottingham North and East CCG contribution to the pool is £438,000 (2014/15 £774,000).

Better Care Fund pooled fund note

The Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. In 2015/16 an additional £1.1bn was transferred from NHS England Area Teams for former Section 256 schemes to Clinical Commissioning Groups to create the total fund at £3.8bn. In 2015/16, the Clinical Commissioning Group received an additional £3.1m allocation and put £9.1m towards creation of a Better Care Fund pooled fund in Nottinghamshire of £57.818m in 2015/16.
Assessment of the operation of the Better Care Fund pooled fund identified that it does not constitute a joint arrangement and therefore the requirements of IFRS11 are not met and does not satisfy the criteria of a pooled budget.

	Bassetlaw CCG **£000**	**Mansfield and Ashfield CCG** **£000**	**Newark & Sherwood CCG** **£000**	**Nottingham North and East CCG** **£000**	**Nottingham West CCG** **£000**	**Rushcliffe CCG** **£000**	**Nottingham-shire County Council** **£000**	**Total** **£000**
Balance brought forward	0	0		0	0	0	0	0
Partner contribution	**7,532**	**14,274**	**8,769**	**9,115**	**6,180**	**6,780**	**5,168**	**57,818**
Payments received from the pool	**4,736**	**9,552**	**5,973**	**5,059**	**3,249**	**3,880**	**25,369**	**57,818**
Scheme expenditure								
A - Seven Day Working	0	0	0	619	420	461	0	1,500
B - GP Access	**0**	**0**	**0**	720	488	535	0	1,743
C - Proactive and Personalised Care	0	0	0	1,020	692	759	99	2,570
D - Community Care Co-ordination	0	0	0	962	472	833	196	2,463
E - Support for Carers	0	0	0	108	72	80	1,131	1,391
F - Protecting Social Care Services	0	0	0	0	0	0	16,167	16,167
G - Rehabilitation/ Reablement Servic	0	0	0	1,155	783	859	182	2,979
H - Additional Support to Social Care	0	0	0	0	0	0	397	397
I - Transformation	0	0	0	475	322	353	0	1,150
J - Disabled Facilities Grant	0	0	0	0	0	0	3,204	3,204
K - Locality Integrated Care Teams	0	3,213	2,371	**0**	0	0	0	5,584
L - Self Care Service	0	249	190	0	0	0	0	439
M - Specialised Integrated Care Team	0	3,805	2,327	0	0	0	0	6,132
N - Improved Primary Care Access an	0	605	96	0	0	0	0	701
O - Better Together Implementation S	0	1,614	942	0	0	0	0	2,556
P - Communications	0	66	47	0	0	0	0	113
Q - Neighbourhood Teams and 7 Day	780	0	0	0	0	0	0	780
R - Mental Health Liaison	436	0	0	**0**	0	0	0	436
U - Discharge/Assessment incl. Interm	2,993	0	0	0	0	0	0	2,993
V - Respite Services	39	0	0	0	0	0	0	39
W - Improving Care Home Quality	85	0	0	0	0	0	0	85
X - Telehealth	403	0	0	0	0	0	0	403
Y - Social Care Capital	0	0	0	0	0	0	1,964	1,964
Z - Care Act Implementation	0	0	0	0	0	0	358	358
Total	**4,736**	**9,552**	**5,973**	**5,059**	**3,249**	**3,880**	**23,697**	**56,146**
Net balance	**0**	**0**	**0**	**0**	**0**	**0**	**1,672**	**1,672**
Balance carried forward	**0**	**0**	**0**	**0**	**0**	**0**	**1,672**	**1,672**

36 NHS Lift investments

The CCG has no NHS LIFT investments at the year end (2014/15: £nil).

37 Intra-government and other balances

	Current Receivables 2015-16 £000	Non-current Receivables 2015-16 £000	Current Payables 2015-16 £000	Non-current Payables 2015-16 £000
Balances with:				
· Other Central Government bodies	14	0	8	0
· Local Authorities	124	0	50	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	0	0	0	0
· NHS bodies within the NHS England Group	415	0	888	
· NHS Trusts and Foundation Trusts	855	0	1,245	0
Total of balances with NHS bodies:	**1,270**	**0**	**2,133**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	82	0	5,254	0
Total balances at 31-March-2016	**1,490**	**0**	**7,445**	**0**

	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				
· Bodies external to Government	241	0	5,305	0
Total balances at 31 March 2015	**1,449**	**0**	**6,793**	**0**

38 Related party transactions

Details of related party transactions with individuals are as follows:

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

Details of related party transactions with individuals are as follows:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
The Ivy Medical Group	518	-	27	-
The Calverton Practice	1,198	-	52	-
The Peacock Practice	773	-	74	-

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:

• NHS England;	17,721	1,630	886	415
• NHS Foundation Trusts;	31,204	38	792	-
• NHS Trusts;	79,323	158	453	855
• Health Education England	-	-	-	-
• NHS Special Health Authorities	5	-	-	-
• NHS Property Services/Community Health Partnerships	1,113	-	8	14

39 Events after the end of the reporting period

After a period of financial difficulty Central Nottingham Clinical Services (CNCS) filed a notice of intent to appoint an administrator on 4th May 2016 and subsequesntly ceased trading on the 12th May 2016.

Services provided by CNCS include:
- Out of Hours (to boteh Leicestershire and Nottinghamshire)
- Loughborough Urgent Care Centre
- Various urgent primary care service in Mid-Nottinghamshire.

Caretaking arrangements have been put in place to ensure patient services are not disrupted. CQC have been informed and are working with the health economy to ensure the quality and safety fo services is not affected by the provider change.

40 Losses and special payments

40.1 Losses

The total number of NHS Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2015-16 Number	**Total Value of Cases 2015-16 £'000**	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Administrative write-offs	1	1	0	0
Total	**1**	**1**	**0**	**0**

There were no cases exceeding £300,000. (2014/15: £nil).

40.2 Special payments

There were no Special Payments in the year. (2014/15: £nil).

41 Third party assets

The CCG held no third party assets. (2014/15: £nil).

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:

	2015-16 Target	**2015-16 Performance**	2014/15 Target	2014/15 Performance
Expenditure not to exceed income	200,558	198,757	172,223	170,136
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	198,368	196,566	170,017	167,930
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	3,228	2,913	3,654	2,720

43 Impact of IFRS

There has been no impact of IFRS on the CCG during the year. (2014/15: £nil).

44 Analysis of charitable reserves

The CCG has no charitable reserves at the end of the year. (2014/15: £nil).