Creating a healthier Hull

NHS
Hull Clinical Commissioning Group

A year of creating a healthier Hull

Annual Report and Accounts 2013/14

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Foreword from the Chairman and Chief Officer

We are delighted to welcome you to the first Annual Report of NHS Hull Clinical Commissioning Group (CCG). The CCG was established with the vision of Creating a healthier Hull and over the past twelve months we have continually been inspired by the energy, enthusiasm and passion shown from CCG members, staff, partners and the public to achieving this vision.

There is, of course, much more to do if there is to be enduring and sustainable improvement in the health, wellbeing and aspirations of the people of Hull, however we hope that this report gives some sense of the many foundations that have been established by the CCG over the past twelve months in order to deliver our vision.

The first part of the report provides a summary of our business, performance and work programmes over the past year, as well as commentary on wider events which have shaped our work and priorities as an organisation. The second part is the financial accounts for the year 2013/14.

NHS Hull CCG is a membership organisation and its 57 member practices use their unique local knowledge and insight to support clinically-led local commissioning. The CCG Constitution re-affirms the tenet that the whole is greater than the sum of its parts and the experience from the first twelve months of operation has extended this precept far beyond the membership to encompass our many NHS and public sector partners, the voluntary sector, our ambassadors, our staff and the public.

We know we have a tremendous challenge ahead to ensure that local health services continue to meet the ever changing needs and aspirations of the local population within a challenging financial environment, however, we are confident that in establishing the Hull 2020 transformation programme with our partners we have laid the foundations for future success. We are delighted that some of the early work of the CCG has already received national recognition and this is highlighted within the report.

We positively welcome feedback on your experience of local health services as well as your views about how best to shape local health care to meet local needs. You can find out more about how to share your experiences and views within the report.

On behalf of the entire CCG Board we commend our annual report to you and place on record our sincere thanks to our members and staff as well as all those who have helped us deliver a successful first twelve months as a CCG.

Dr Dan Roper
CCG Clinical Chair

Emma Latimer
CCG Chief Officer

Member Practices' Introduction 2013/14

Member Practices' Introduction

As the 57 GP practices serving the people of Kingston upon Hull we form the membership of NHS Hull Clinical Commissioning Group (CCG). We work together to apply our knowledge and unique insight into the health needs of local communities in order to commission services which help us achieve our vision of Creating a healthier Hull. This introduction sets out our independent reflection on the first 12 months of formal operation as a CCG.

The CCG was authorised by NHS England without any conditions and was established as a statutory body from April 2013. The membership approved a Constitution and formal governance structure as part of its establishment. This has been further reviewed, updated and subsequently sanctioned by NHS England during the year.

As members we have met formally on a bi-monthly basis via our Council of Members meetings. In addition there are a range of informal networks through which we can contribute to the work of the CCG. We approved the CCG Commissioning Strategy and have received regular updates on the key programmes of work that underpin the strategy throughout the year.

Hull is ranked as the 10th most deprived city in the UK and the health challenges for Hull are both significant and longstanding, for example:

- 34% of adults across the city smoke;
- 70% men and 61% women are overweight or obese;
- There are just over 53,000 binge drinkers and a further 18,700 higher risk drinkers;
- Life expectancy is low, at an average of 75.7 years for men and 80.2 years for women, compared with the national averages of 78.6 and 82.6 years respectively; and
- Hull 2011/12 Health and Lifestyle Survey states that 8.5% of residents self-reported poor health; 29.1% of women reported poor mental health along with 23.4% of men.

We recognise that working closely together with our partners in the wider public sector and the people of Hull themselves is essential if they are going to be able improve their own health and wellbeing and achieve their aspirations for the future.

The CCG has a well-established commissioning strategy and annual plan that sets out the priorities for the CCG. The existing strategy sets out four key programmes of delivery; namely planned care, unplanned care, primary care and partnerships. We have received regular performance updates as to progress against the strategy and further details can be found within the Strategic Report on page 7.

During 2013/14, the Hull 2020 transformation programme has been developed in order to address these challenges. The programme is still evolving and we will continue to shape it in order to ensure that it remains the definitive means through which local health priorities and wider community ambitions can be met.

Regular updates of progress against the key performance indicators of the CCG are a standing item on the Council of Members meetings. The CCG has performed well throughout the year, meeting all its statutory financial duties and performing strongly in the quarterly assurance reviews undertaken by NHS England, where four out of the six key measures to assess CCG performance rated as 'assured' and the remaining two as 'assured with support'.

We continue to review our effectiveness as a membership body and a comprehensive development programme has been established for both the Council of Members and CCG Governing Body (Board). The Chair of the membership body has led an evaluation of the Council of Members. This has led to an increase in the proportion of time given by the Council of Members to matters of interest from the floor at each of our meetings. In addition, further opportunities have been identified for direct clinical involvement from members, outside the Governing Body, on a range of programmes and workstreams for the CCG.

There is a great deal more work to do but we have taken the important first steps to creating a healthier Hull in the first twelve months of operation as a CCG.

NHS Hull CCG Council of Members
April 2014

Strategic Report 2013/14
Creating a healthier Hull

Getting to know your local CCG

NHS Hull Clinical Commissioning Group (CCG) was established on 1 April 2013 without any conditions or directions to its authorisation.

We are a clinically-led organisation, which brings together 57 local GP practices and other health professionals to plan and design services to meet local patients' needs.

Our GP practices serve a registered population of 288,000 across 23 wards. We had an allocated budget of £376 million for 2013/14, with a required surplus of £9 million.

Map of Hull showing location of GP practices

We commission (or buy) a range of services for the Hull population, including urgent care (such as A&E services and the GP out of hours service), routine hospital treatment, mental health and learning disability services, community care including district nursing and continuing health care.

Our headquarters are at Wilberforce Court, Hull. We share the same boundary as Hull City Council, and, where appropriate, we will jointly commission services with partners such as neighbouring East Riding of Yorkshire CCG or Hull City Council.

We also work with other providers with whom we have contractual arrangements for services, including:

- Hull and East Yorkshire Hospitals NHS Trust
- Yorkshire Ambulance Service NHS Trust
- Humber NHS Foundation Trust
- Spire Hull and East Riding Hospital
- City Health Care Partnership Community Interest Company (CIC)
- Hull City Council

We work with Healthwatch Hull, the independent champion for local people who use health and social care services. The new body has greater powers to strengthen the patient and public voice in local services and will also provide information and signposting about local services. A representative of Healthwatch is a full member of the Hull Health and Wellbeing Board.

As a publicly accountable body, we are committed to being transparent with staff, partners, patients and the public. We hold six Board meetings and an Annual General Meeting each year, all of which are open to the public. For dates, times and venues, please contact us or visit our website: **www.hullccg.nhs.uk**

You can contact NHS Hull CCG in the following ways:

NHS Hull Clinical Commissioning Group
2nd Floor
Wilberforce Court
Alfred Gelder Street
Hull HU1 1UY

Tel (switchboard): **01482 344700**
Email: **HULLCCG.contactus@nhs.net**
Website: **www.hullccg.nhs.uk**
Twitter: **@NHSHullCCG**

Information contained in this report can also be requested in other languages or formats – please see the end of the document for details. If you would like additional copies of this report, please contact us via the details above. An electronic copy of this report is also available online at **www.hullccg.nhs.uk**

Our priorities and progress

NHS Hull CCG's three strategic health priorities are:

- **Developing 21st century primary care.**
- **Integration** - working together with other health and social care providers to deliver better health outcomes and natural economies of scale.
- **Next generation healthcare** – we want to help young people take control of their own health earlier, so they continue to make healthier choices throughout their lives.

The CCG's Commissioning Strategy 2012 – 2015 set out the aims and objectives of the CCG and described how these would be achieved through the delivery of programmes of work that had been prioritised and developed by the CCG's clinical leaders.

The full strategy is available at www.hullccg.nhs.uk

Progress in 2013/14 against the Hull CCG Commissioning Strategy

There were a number of key achievements against this strategy during 2013/14, which include:

- Extra investment in the expansion of the Hull Royal Infirmary Emergency Department and agreed model for co-located services including Primary Care.
- Health and social care reablement services for the elderly, including Thornton Court, have been expanded (read more about this on page 29).
- Ongoing development of Telehealth has successfully enhanced the ability of our patients with long term conditions to manage their care closer to home.
- Self-Care and Social Prescribing have been forefront in the primary care agenda (more in Building Health Partnerships - page 20).
- The End of Life 'Fast Track' Pathway has enabled more people to fulfil their wish to die in their preferred place and with their choice of support.
- The Healthier Hull Community Fund has enabled a considerable number of local community groups to generate local health and wellbeing benefit that far outweighs the CCG investment (read more about this on page 19).
- A new Community Pain Management Service has been commissioned.
- The programme of Healthier Hull Listening Events has evolved to include opportunities for the public to engage with the CCG on a range of initiatives (more on page 20 of this report).

Hull 2020

Making a better future together

In continually reviewing how best to meet the needs and aspirations of the people of Hull within a financially challenging environment, the CCG has come together with other public sector partners in Hull to create the Hull 2020 transformation programme.

The aim of Hull 2020 is to radically change the services we offer to meet the needs of the whole population and work towards a better and healthier future for the people we serve.

By 2020:

- People will experience services that fit their lifestyles and needs, designed in partnership with them.
- Public organisations will work closely together to deliver services that make sense, without the waste and inefficiency that frustrate people.
- The services that are important to local people will be delivered by individuals who are trained, skilled, caring and valued in their own organisations.
- Services will be provided in a coordinated way that is fair and consistent for everyone.
- The people of Hull will be able to see the results for themselves.

Why change needs to happen

People in Hull currently have poorer health than in many other parts of the country. This needs to change if we hope to achieve a better future for people living in the city.

We can make a difference if:

- Children have the best start in life.
- Fewer people take up smoking and many are helped to quit.
- Communities work together to keep themselves safe.
- People in Hull feel positive about their future.
- People know how and where to get help when they need it.
- Older people live longer and healthier lives.
- People take greater responsibility for their lifestyle choices.

Meeting the challenge

To meet the challenges facing us, we will:

- Work with communities to give individuals greater choice and control.
- Be open and upfront about the complex challenges we face and respect different points of view.
- Listen to what people actually need from their services to avoid duplication and confusion.
- Educate, help and empower people to make informed lifestyle changes to improve their own health and wellbeing.
- Improve communication between staff working across different organisations.
- Recruit and maintain a highly skilled workforce by working with schools and higher education institutions to encourage local people to stay in the area and contribute to local public services.
- Ensure services are provided in places that are appropriate, accessible to all and meet people's needs.

The vision for Hull 2020 is being led and delivered by a partnership of public sector organisations which include:

Hull Clinical Commissioning Group NHS · Hull City Council · Humber NHS Foundation Trust · healthwatch Kingston upon Hull

Yorkshire Ambulance Service NHS Trust · Hull and East Yorkshire Hospitals NHS Trust · Humberside Fire & Rescue Service

City Health Care Partnership CIC a co-owned business · Humberside Police · University of Hull

…and people in Hull.

Over the coming months you will be hearing a lot more about Hull 2020 and there will be plenty of opportunity for you to get involved and put forward your views. You can find out more at www.hull2020.org

If you have any questions or want to tell us your views.

Tel: **(01482) 344700**
Email: **contactus@hullccg.nhs.uk**
Follow us: **@hull2020**

Commissioning safe, high quality care

One of the most significant events of 2013 was the publication of the second Francis Report into the public inquiry of Stafford Hospital.

In June 2013, NHS Hull Clinical Commissioning Group and NHS East Riding of Yorkshire Clinical Commissioning Group brought together a local Francis 2 Stakeholder Board with local NHS providers and partners to work together on the key recommendations from the Report.

The Stakeholder Board provides an opportunity for sharing good practice across the health economy and drawing up a set of principles around Duty of Candour, Complaints and Experience. These principles will be adopted by all partner organisations to overcome some of the barriers identified by the second Francis report that prevented staff from listening to patients, and other organisations from responding to staff raising significant concerns about Mid Staffordshire Hospitals Trust.

The member organisations of the Francis 2 Stakeholder Board are:

- vNHS Hull Clinical Commissioning Group
- NHS East Riding of Yorkshire Clinical Commissioning Group
- Hull and East Yorkshire Hospitals NHS Trust
- Humber NHS Foundation Trust
- Spire Hull and East Riding
- Hull City Council
- East Riding of Yorkshire Council
- City Health Community Partnership CIC
- NHS Yorkshire and Humber Commissioning Support Unit
- Healthwatch Hull and East Yorkshire
- University of Hull

The first phase of work for the sub-groups has each produced a key output:

Duty of Candour – has reviewed national definitions and practice guidance on Duty of Candour and making a case for a local Duty of Candour to cover NHS care in Hull and East Riding.

Complaints – will build on the outcomes of the Clwyd/Hart review of the NHS complaints process and put forward a set of local complaints 'pledges' to put the patient at the centre of all our complaints processes and adopt the key lessons from the Clwyd/Hart review.

Experience – has reviewed local and national guidance on the role of staff in patient experience – focusing on staff attitude and skills and how they impact on a patient's direct experience. A range of good practice has been shared through this work group.

The CCG's Commissioning for Quality Strategy was refreshed in line with the publication of the Francis 2 report and "Hard Truths' the government's response to the Francis 2 report.

The Stakeholder Board has links with the Post Graduate Deanery and the University of Hull, and will be receiving the information from research work on quality of training with student nurses and its impact on quality of care.
Looking towards 2014-15:

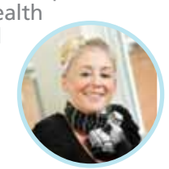
- A Leaders' Summit will adopt the principles from the Duty of Candour and NHS Complaints sub-groups and review good practice
- A public event planned for July 2014 will allow members of the public to hear more about what the NHS has done locally to improve care and patient outcomes across Hull and East Riding and will also enable members of the public to be involved in shaping the next steps.
- A staff event in autumn 2014 will provide an opportunity for practice-sharing, networking and discussion and take forward the principles and outputs across organisations

Sarah Smyth, Hull CCG's Director of Quality and Clinical Governance is Vice-Chair of the Hull and East Riding Francis 2 Programme Board:

"For Hull CCG the Francis 2 report was not viewed as a "big bang" of 290 recommendations. Work had already been developing over some time to strengthen governance arrangements, and provide assurances relating to quality and safety, value for money, and performance within all services commissioned by the CCG."

"We were pleased to be invited to share this approach to commissioning for quality with a range of government, NHS and public sector representatives at the leading NHS Confederation conference in 2013."

"We will continue to work in partnership to ensure patients to feel confident in the health services we commission, and for all partners to be engaged in the shared goal of delivering high quality, safe patient care across the city."



The health inequalities challenge

Some of the health challenges in Hull are clear. For example, the life expectancy of people living in some parts of Hull is up to 10 years less than it is in other places within the same city. 34% of adults across the city smoke, 70% of men and 61% of women are overweight or obese, with 53,000 binge drinkers and a further 18,700 higher risk drinkers.

To address these health challenges the CCG works closely with patients, local communities and Hull City Council through the Hull Health and Wellbeing Board to achieve its vision of Creating a healthier Hull.

Working to address health inequalities in Hull

In order to better understand the health inequalities in Hull, a comprehensive study **"A Tale of Two Wards"** is being undertaken focused on determining the underlying socio-economic, health, aspirational and wellbeing factors that contribute to the 10 year life expectancy gap between the most (St Andrews) and least (Beverley) deprived wards in the city. This insight will allow the CCG, and its partners, to recognise what motivates and influences people to make the life choices they do, and inform the development of strategies to best support people to fulfil their potential.

The CCG has also commissioned a piece of work to better understand the nature of attitudes and aspirations of young people in the city.

This provided a great deal of insight into opportunities in terms of improving outcomes and wellbeing for this key priority group.

"Improving health and wellbeing in Hull is a fundamental part of the ambition to be a successful and thriving city with a workforce that is fit and healthy and ready to take on the challenges of the next ten years."

Dr Dan Roper, Chair of NHS Hull CCG

Health and Wellbeing Strategy

The Hull Health and Wellbeing Board is committed to reducing health inequalities between people in different parts of the city, and between Hull and England as a whole.

The CCG significantly contributed to the development, consultation and final approval of the Hull Health and Wellbeing Board Strategy – the CCG Board itself supported the final draft document at its public Board meeting held in March 2013.

The Health and Wellbeing Board Strategy is centred around 9 strategic aims:

1. Families in Hull live a healthy life, have a healthy weight and don't smoke. Mums are encouraged to breastfeed their babies and children get the injections they need to protect them from disease.
2. Children under 5 are healthy, happy and ready to start school.
3. Young people are confident and are able to deal with problems they might face.
4. People know that there are lifestyle changes they can make which will reduce their chances of getting, and dying from, cancer or heart disease. They know that screening tests are available. They know what it means to live a healthy life and to try and keep well. People know when they should seek support and where from, in terms of maintaining good mental health and general wellbeing. They understand the strong link between physical health and mental health and wellbeing.
5. People understand how to reduce the risk of cancer and heart disease; know what the early signs are, and when to attend the doctors. They know that the sooner they get help, the greater their chance of getting better.
6. No matter where people live, they will be able to receive the health services that they need.
7. People who have been unwell or in hospital, get the help they need to live safely at home. This might include using special equipment to make things easier.
8. People with dementia have the help they need to live safely in their home. All of the care and help that they and their families get will be good quality.
9. People of all ages who care for someone who is unwell, or who has a disability, will get the help they need.

The CCG is able to support the delivery of all 9 strategic aims and during 2013/14 has focussed on reablement and independence through personal health budgets, Telehealth care, supporting carers including those caring for someone with dementia.

Jointly with Hull City Council we have developed a Mental Health and Wellbeing Strategy for children and young people in order to support the development of the emotional resilience they need to face challenges and ensure that they make the right choices. We will look to make significant delivery against this strategy in 2014/15.

There is a significant programme of joint commissioning that supports the delivery of the Hull City Plan and the Hull Health and Wellbeing Strategy as well as the CCG Commissioning Strategy.

The Joint Health and Wellbeing Strategy 2013-2016 is available to download at **www.hullccg.nhs.uk** A copy of the CCG annual report was presented to the Hull Health and Wellbeing Board at its meeting in July 2014.

Involving local people and partners

NHS Hull CCG is committed to involving local people in its decision-making, with patient and public engagement embedded into the commissioning process.

Here are some examples of the way we involved our stakeholders and communities to enhance the delivery of CCG programmes and projects in 2013/14.

People's Panel: Joint membership with Hull City Council

The People's Panel, launched in April 2013, is a partnership between NHS Hull CCG and Hull City Council that helps seek views on issues that affect the health and wellbeing of the city. Over the year views have been sought from around 8,000 people. The panel provides a real opportunity for local residents to comment and contribute to the development of public services in Hull.

Throughout the year the panel members responded to quarterly questionnaires that focused on people's general experiences of health services, their experiences of raising concerns and complaints and their views on out of hours and emergency care.

people's panel
making your voice count

The outcome of the surveys are published on our website **www.hullccg.nhs.uk** and presented to the Senior Leadership Team and included as part of the Patient Experience Report to Quality and Performance Committee. Action taken as the result of the survey responses is reported back to the public via quarterly newsletters.

NHS Hull CCG and Hull City Council have also been cited as an example of best practice within NHS England's "Transforming Participation in Health & Social Care" for its work on the People's Panel.

You can join the panel:

Call: 01482 300300
Text: '**panel**' and your message to **07795 563000**
Email: **panel@hullcc.gov.uk**

Read the latest People's Panel newsletter at www.hullccg.nhs.uk

Hull Ambassadors

The Hull Ambassadors are a team of specially trained volunteers and are a valuable resource in terms of supporting the CCG with much of its community engagement work.

Over the past year the Ambassadors have worked with Commissioning Managers to support key areas of work which include:

- Musculo-Skeletal service.
- Child and Adolescent Mental Health Services (CAMHS).
- Maternity Services.
- Multi-agency discharge.
- Service review of vasectomy, community gynaecology and neurology.
- CORRS - Community Ophalmology.
- Liver Quest.
- Young Health Ambassadors.
- Unplanned Paediatric Pathway.
- East Hull Community Integrated Care Centre – site evaluation.
- Depression and Anxiety Services (previously IAPT) Project Group.
- Learning Disability Services.

The Ambassadors have supported the CCG's general engagement programme and have been invaluable in supporting the Healthier Hull Listening Events, as members of the public often feel more at ease talking to 'non NHS staff' about their experiences.

The Ambassador programme was highly commended in NHS England's "Excellence in Participation Awards" in March 2014.

The Ambassadors will also play a key role in supporting the Hull 2020 engagement activity.

To find out more about becoming an Ambassador contact 01482 344869 or visit **www.hullccg.nhs.uk**

Graham Gedney - Hull Ambassador

Having worked in trade and industry in Hull for many years Graham Gedney is now one of Hull CCG's 29 Ambassadors, providing a vital public perspective to the CCG's decision making.

Graham says:

"It's a very fulfilling role, working closely with people and groups, and taking time to gather their experiences as patients to help improve services. I use local health services myself, and this is one way I can help give something back to ensure that health care in Hull is the best it can be."

Healthier Hull Community Fund

The Healthier Hull Community Fund, NHS Hull CCG's participatory budgeting programme, allowed community groups and organisations to bid for up to £5,000 each for locality based initiatives, and £15,000 each for citywide projects. All groups had to demonstrate that their ideas will help to create a healthier Hull.

Four public voting events were held in late October/early November 2013 with members of the local community voting for projects they felt should be funded - putting the decision making into the hands of local people. The public vote involved 250 people voting live at the events, and 500 accessing the online voting facility for the citywide projects. £360,000 in funding was awarded to 79 projects across the city with an estimated reach of 22,500 people.

All projects have received their funding and a number of projects were under way in 2013/14. A community directory, a bespoke page on the CCG website, a Facebook page and Twitter feed have helped to promote projects and share success stories. Search **#healthierhull**.

CCG staff members have also volunteered to support projects as part of NHS Change Day.

Review of Child and Adolescence Mental Health Services (CAMHS)

Targeted engagement formed part of the initial review of CAMHS and helped to inform the development of the CAMHS/Hull Children and Young People's Mental Health and Wellbeing Strategy. The information gathered during this engagement exercise highlighted key elements that service users felt were important, such as; a single point of telephone contact, offering flexibility and personalisation of services, and giving a choice about where services can be accessed.

As a follow up to the initial engagement, a number of feedback sessions were held during December 2013 and January 2014 with groups of children and young people, parents and carers and professionals working with young people. During these sessions an overview of the draft strategy and what this would actually mean in terms of service provision was given. There was strong support for the strategy as a whole and comments made will be taken into account as part of the on-going monitoring of the new CAMHS service.

Healthier Hull Listening Events

The Healthier Hull 'Listening Events' took the CCG into the heart of communities across the city, and in particular those areas identified as being most in need.

Use of a bespoke Health Bus and other established community venues provided settings for conversations with the people about their current experiences of health care and their aspirations for services in the future.

Around 1000 people were engaged with as part of this activity and just over 400 surveys were conducted. Members of the public were invited to prepare their own healthy smoothies on a pedal powered bike and information about local health services and various health conditions were distributed.

BBC Radio Humberside broadcast live from one of the city centre events and this provided an opportunity for further studio based interviews to highlight the work and the priorities of the CCG.

Further Listening Events in other community venues are planned during 2014/15. For further informationn visit www.hullccg.nhs.uk

Building Health Partnerships

NHS Hull CCG and the Voluntary, Community and Social Enterprise (VCSE) Sector worked together to develop the Building Health Partnerships programme which aims to build effective community involvement into commissioning, and to deliver programmes to improve health outcomes for their communities.

The CCG is supporting the VCSE organisations to develop a model of 'Social Prescribing', which enables GPs to refer patients with social, emotional or practical needs to a range of local, non-clinical services.

A very successful listening event was held in September 2013 where over 100 VCSE organisations attended and provided input to the development of the Social Prescribing delivery model.

Two volunteer co-ordinators have been recruited and hosted by North Bank Forum to lead on the development of the pilot programme, recruit and arrange training for the volunteers and monitor the outcomes of the pilot. Delivery of the pilot programme started in April 2014.

Work with BME groups - Humber All Nations Alliance (HANA)

The CCG worked in partnership with Humber All Nations Alliance (HANA) to improve the opportunity to access health information for BME (Black, Minority, Ethnic) groups.

For more information about this see Promoting Equality on page 38.

Listening to our Workforce

A fundamental component of any health and care provision across Hull is the role played by General Practitioners and their teams. A 'Listening to the Workforce' report was commissioned with the support of the Council of Members and gave a chance for practices that took part to feed in their opinions with regard to Primary Care workforce issues; both those currently faced and those anticipated in the future.

The CCG has also provided regular opportunities to engage with the process of developing the Hull 2020 Strategy through the Council of Members meetings, CCG Board and the recently formed Hull 2020 Clinical and Professional Reference Group. The latter includes clinical leaders from across a wide range of acute, primary and community care providers. This group will be instrumental in the continuing work underway to identify areas of clinical priority as well as evaluating the efficacy and safety of planned changes.

Jason Stamp - Patient Champion

Jason's role as CCG Board member for Patient and Public Involvement is to ensure that the voice of patients and members of the public is reflected in all aspects of its work. Working with clinicians and CCG teams he focuses on developing an on-going relationship with local communities to support them to take a more active role in shaping health services and sharing ideas about how health in Hull can be improved.

Jason said:

> "I believe that the only way we can make a real difference is by developing a strong partnership between our local communities and the people who commission and provide the services they receive."

Future Engagement

Engaging for transformational change - Hull 2020

NHS Hull CCG is leading an ambitious transformation programme focused on the vision for the delivery of health and other public services in 2020.

There will be a phased approach to engagement within the Hull 2020 Programme. Phase 1 will communicate an overview of the programme and seek overall public support for the principles. The second phase will involve more detailed engagement and where appropriate public consultation on specific projects within the overarching programme.

A multi-agency Communications and Engagement Working Group has been established and tasked with developing the delivery plan for communications and engagement.
The initial focus will include agreeing internal communications strategies, developing public facing communications materials including a website, holding a public launch event, and engaging with as many key stakeholders as possible utilising partners' existing networks.

For more information on Hull 2020 see page 12.

City-wide Patient Participation Group Network

Practice Participation Groups (PPGs) provide a mechanism for individual practices to engage with their own patient population to discuss ideas to improve the running of the practice and gain feedback on a variety of practice related issues. Currently, 55 out of the city's 57 practices have a PPG, which is a much greater percentage than any neighbouring CCG.

Initial work with the PPGs has identified a desire to work more collaboratively. During 2014/15 we aim to develop a city-wide PPG network which can come together to discuss ideas of mutual interest, share ideas and develop a mechanism for collective feedback to the CCG.

We welcome your feedback

We welcome feedback on your experience of local health services. You can contact the Patient Relations Service, which works on behalf of NHS Hull CCG, with concerns, complaints and compliments using the details below:

Patient Relations Service
Health House
Grange Park Lane
Willerby HU10 6DT

01482 335409
Email: **HULLCCG.PALS@nhs.net**

2013/14 - A year of creating a healthier Hull

2013»

April 2013

CCG ready for the challenge of creating a healthier Hull

1 April 2013 marked the start of a new era in health with CCGs putting local clinicians at the forefront of planning and designing health services, using their insight into what patients want and need, to feed back into decision making at Board level.

Chief Officer Emma Latimer said:

> Patients and GPs are our eyes and ears and they will bring a wealth of knowledge and information to the commissioning process. The new CCG will see clinicians, managers and other partners working much more closely alongside each other in with the shared aim of improving health, wellbeing and quality of life for people in Hull.

May 2013

CCG launches *"How to get the most from your local health services"*

The well-received booklet featured a range of useful information about NHS healthcare in Hull, plus other services people can access to help them keep fit, safe and healthy.

50,000 copies
of the booklet were distributed throughout Hull.

The Patient Prospectus insert outlined the CCG's vision and its priorities for transforming services towards Creating a healthier Hull.

You can view our Patient Prospectus at **www.hullccg.nhs.uk**

The booklet is available in 67 languages via the Humber All Nations Alliance (HANA) website **www.hanaonline.org.uk**

June 2013

Maternity care for a healthier Hull

NHS Hull CCG launched its new strategy to ensure local maternity care is safe, high quality and delivered at the right time, in the right place to give every child in the city the best start in life.

The strategy outlined the vision for maternity care in Hull and how maternity care providers would deliver improved patient experience and clinical outcomes.

You can read the Maternity Care Strategy at **www.hullccg.nhs.uk** and visit our facebook page at:

facebook.com/maternityservicesreview

2013»

July 2013

New C.diff card to help prevent infection

In July the CCG and City Healthcare Partnership CIC launched the C.diff Card to protect patients at risk of re-occurrence of the infection.

Dr James Moult, local GP and Hull CCG lead for Clinical Quality, said:

> As a GP, patients tell me that they want to be more actively involved in managing their own health. The C-diff Card is a very welcome development that supports clinicians, to make the best decisions, with their patients, about their on-going health care, particularly if they have a history of C.difficile.

Healthier Hull Community Fund launches

Voluntary and community groups with great ideas about making the city a healthier place were invited to bid for funding from NHS Hull CCG to get their ideas off the ground. Groups across the city invited to apply for funding for projects that aim to:

- Improve the health of their community.
- Get people active.
- Improve ways to help people look after their own health/self-care.

This exciting, participatory scheme featured a voting process that put the final decision in the hands of the public.

Jason Stamp, lay member for Patient and Public Involvement said:

> Our aim is to involve local people, wherever we can, in deciding where money is spent in their own neighbourhood. We were delighted to see some imaginative ideas and projects coming forward from the community to help us in our ultimate goal of creating a healthier Hull.

August 2013

Healthier Hull on the road

The Healthier Hull Listening Events took to the road for the first time in a bespoke 40ft Health Bus. The first events were held in Queen Victoria Square, North Point Shopping Centre in Bransholme and The Greenway in Gipsyville.

Over the four days of the events, CCG staff and Ambassadors **spoke with hundreds of members of the public**, gathering their experiences of health services and their priorities for services in the future.

Visitors to the Health Bus were able to gather information about health services and support available as well as jump onto a specially designed bicycle and use 'pedal power' to prepare their own fruit smoothies.

September 2013

HeadStart

The Big Lottery Fund chooses Hull as one of only 12 areas in the UK to participate in its £75m HeadStart programme, aimed at helping children from 10-14 years by giving them the support and skills to cope with adversity.

Julia Mizon, CCG Director for Commissioning and Partnerships and Co-Chair of the Hull Children and Families Board, said:

> Hull CCG will deliver HeadStart in partnership with schools, families, communities and partner organisations.
>
> The emotional well-being of children and young people is just as important as their physical health. That's why we want young people in our city to have an opportunity to benefit from this early support, to help give them the skills to lead happier and healthier lives.

2013»

October 2013

Local swimming pool funded to March 2015

The CCG awarded £219,000 of funding to allow the swimming facilities to remain open at Ennerdale Leisure Centre until March 2015. This decision meant the Council, in conjunction with the CCG, had further time to consider leisure provision in the city.

Dr Dan Roper, Chair of NHS Hull CCG, said:

> Even moderate physical activity helps prevent a huge range of both physical and mental health issues and swimming is one of the best all round forms of exercise. We will work over the coming months with Hull City Council colleagues to consider how to get the best for Hull residents from a co-ordinated approach to health and leisure services.

November 2013

Dr Dan Roper officially appointed as CCG Chair

Dr Dan Roper, GP Principal at Springhead Medical Centre, was appointed as Chair of the CCG Board. Dan is passionate about improving the city's health and has a long history of working with local organisations to promote health issues and equality of opportunity. His areas of clinical specialty are cardio-vascular and minor surgery.

Dan said:

> I think we are in for some very exciting times ahead in Hull. It is a real honour to enjoy the confidence of all the GPs, and, as GPs, we are very fortunate to have a dedicated and hardworking team of staff behind us, committed to helping achieve our aims to improve the health and wellbeing of our local population.

Dan's appointment runs through to 31 March 2016.

December 2013

Supporting and re-abling patients through the winter

NHS Hull CCG secured additional capacity within the community to support patients on discharge from hospital. Hull's Thornton Court increased beds from 14 to 18 to offer intensive rehabilitation for older people to return home after a period of hospital care.

Thornton Court, a partnership initiative between the CCG and Hull City Council, provides a combined nursing, therapist and social care that supports people to recover from illness and regain their independence to confidently return to their own homes.

Erica Daley, Strategic Lead Planning and Integration said:

> We want patients to get the best possible care in the most appropriate setting. Closer working of NHS and public service teams across Hull has helped ensure that patients receive the extra support they really need during the difficult winter months.

2014»

January 2014

Love Your Liver This January

The CCG backed the British Liver Trust's Love Your Liver Month to encourage people to get their liver back into tip-top condition for the year ahead.

Dr Mark Follows, a GP with special interest in liver disease and NHS Hull CCG GP lead for Planned Care explained:

"The majority of liver disease is preventable and stems from lifestyle trends, often relating to alcohol and obesity. If we can encourage people to combine healthy eating and regular exercise with sensible drinking habits we can hopefully prevent levels of liver disease increasing."

February 2014

Public feedback supports depression and anxiety service redesign

Tenders were sought in January for a new seven-year contract to provide a first class service for adults in Hull with mild to severe depression and anxiety.

Commencing from 1 October 2014, the service will be expected to see around 8,000 people each year. It will offer rapid, easy access to a range of different therapy providers, through one lead provider, with greater flexibility and choice over timing and location of sessions.

Dr Dan Roper, Chair of NHS Hull Clinical Commissioning Group, said:

"The engagement with service users has given Hull CCG a better understanding of what works well, and what needs to be improved, so that the new service offers the best possible outcomes for people experiencing depression and anxiety."

March 2014

CCG Chief Officer and staff pledge support for creating a healthier Hull

To support NHS Change Day 2014, staff members of the CCG pledged to volunteer their time to support community groups helping to make Hull a healthier place.

Emma Latimer, CCG Chief Officer, volunteered at Longhill Link Up Trust's older people's Meet and Eat Lunch Club, which helps to combat feelings of social isolation in older people in the Longhill area of Hull.

Emma said:

"We had an incredibly diverse range of local groups bidding for funding for their projects aimed at making their own communities a healthier place. The Lunch Club is a great example of where funding is making a real difference in the Longhill area.

I had a great time washing up, serving food and chatting to people; it was really good to see the work of the CCG having a real effect on real lives.

I was chatting to 3 sisters who were saying that they always looked forward to the Lunch Club, seeing people and having some home cooked food was one of things that kept them going.

It was really humbling and I hope to go back soon to help out."

CCG staff member Laura volunteered with another one of our Healthier Hull Community Fund projects - the KIDS 'Learn to Talk Together' session at Marfleet Children's Centre.

Laura had this to say about her volunteering experience:

"I had lots of fun at KIDS Learn to Talk Together session at Marfleet Children's Centre. We did lots of singing (with actions!) and playing with playdough and musical instruments. The staff, children and parents were lovely and very welcoming – thank you very much to KIDS for having me for the morning."

Looking to the future – transformational change in healthcare

New community health and social care facility for Hull

The CCG and Hull City Council are working together on plans for a new health and social care building to be located for the east of the city.

If given the go ahead, the new facility will offer a much needed local base where citizens and care professionals alike can meet, plan, deliver and receive the right care and advice. The plans include a commitment to locate a range of health services in a community setting. The services being planned include some that people currently have to access in hospital. Work is underway to identify the best location that could accommodate the new and relocated services.

These services will focus on the needs of the elderly and are likely to include, therapy services, specialist clinics, x-ray and other community based care.

This facility, as part of the wider transformation programme, should address significant gaps in service such as local access to assessment and diagnostic services, particularly in the east of the city. Higher numbers of first and follow-up hospital appointments and community based re-ablement services would reduce the dependency on the acute hospital and its beds, with initial analysis suggesting that about 70 beds are currently used by individuals who would be better cared for in the community if services were available.

Better Care Fund for Hull

By working in partnership to deliver the Better Care Fund, NHS Hull CCG and Hull City Council will ensure that service commissioning is fully joined up. By fully integrating health and social care systems, the people of Hull will benefit by improved health, resilience and wellbeing.

'People in Hull will expect better care and better care will be organised around them.'

One of the principle objectives of the Better Care Fund in Hull is to achieve a shift of care across a range of services. Admission to hospital and a reliance on residential care will no longer be the default option; this will require a major change to the way services are currently delivered and a strong collaborative approach to co-ordination, joint commissioning, contracting, care delivery and market management. This will lead to more personalised support for those who require it. Many more people will be in control of and managing their own care.

Underpinning these two programmes, the Hull 2020 transformational programme promotes the vision for a better future for Hull, where all organisations work together as one system.

More information on Hull 2020 is available on page 12.

Our development and performance in 2013/14

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

There are significant financial challenges to the NHS as a whole driven by the changing demographic profile, increasing demand, the introduction of new technology and the rising expectations of patients. This is set against a backdrop of flat funding which, if services continue to be delivered in the same way as now, will result in a national funding gap which could grow to £30bn between 2013/14 to 2020/21.

NHS Hull CCG experiences year on year cost growth as a result of these national issues but also has its own specific challenges to delivering patient care within the resources allocated to it. Based on historic patterns of use and adjusting these for projections in underlying growth in demand (both demographic and non-demographic) we would expect to see health economy cost growth exceed funding awarded to the CCG by around £21m in 2014/15.

This challenge falls to both the CCG and the providers of services who are planned to contribute circa £14m and £7m respectively towards this shortfall. The CCG meets its challenge through its Quality, Innovation, Productivity and Prevention or QIPP programme which is a programme of transformation which will enable the CCG to fund its delivery plans.

The principles underpinning QIPP are integral to everything that we do. One of our aims is to ensure that we receive value for money for every pound spent. Through innovation and transformation CCG QIPP plans aim to prevent more costly interventions, both now and in the future, and improve quality of patient care.

Importantly for the CCG this means meeting rising healthcare needs from the same resources without detrimentally affecting performance or health status. We are also acutely aware of the financial position that the NHS finds itself in and are conscious that in order to live within our means, with a growing elderly cohort of patients we need to make real sustainable changes through transformation which will deliver quality improvements for our patients as well as driving value for money.

The Annual Report and Accounts have been prepared on a 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.

If the clinical commissioning group ceases to exist, its functions will continue to be provided (using the same assets, by another public sector entity).

A review of our performance

Our performance is assessed quarterly by NHS England in relation to a large number of indicators through the CCG Assurance Framework.

The CCG assurance process has been designed to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high-quality and sustainable services within their resources. NHS England has assessed our overall performance at quarter 3 as **Assured**.

Assured means:

- The CCG is open and honest regarding key areas of development needs and challenge and provides insight into the root cause of these.
- The CCG can demonstrate there is a clear action plan in place to mitigate any challenges identified, with measurable outcomes.
- The CCG actively manages against agreed plans and takes action when timescales are not met to support progress.
- The level of risk is being actively managed by the CCG.

Assured with support means:

- Support can include every action from providing information and advice to providing additional expertise and capacity to resolve performance concerns. It is not an indication that the CCG is failing, and should not be viewed as such.

The assurance uses key measures to assess CCG performance within the 6 published domains, our results are:

	Assurance Level
Domain 1: Are patients receiving clinically commissioned, high quality services?	Assured with Support
Domain 2: Are patients and the public actively engaged and involved?	Assured
Domain 3: Are CCG plans delivering better outcomes for patients?	Assured with Support
Domain 4: Does the CCG have robust governance arrangements?	Assured
Domain 5: Are CCGs working in partnership with others?	Assured
Domain 6: Does the CCG have strong and robust leadership?	Assured

The latest full CCG Assurance Report (quarter 3) from NHS England is available on our website at:
www.hullccg.nhs.uk

Performance against health outcomes areas:

Indicator	2013/14 Targets	Latest Position	Status
Local Priorities:			
Rate of persons aged over 18 with chronic conditions admitted to hospital as an emergency admission (rate per 100,000 population)	At least maintain 2012/13 level 1476	National data (Oct 12 – Sep 13) 1491	Not achieved (Local data indicates achieved)
Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions	Reduce admissions for an ambulatory care sensitive condition by 1% from 2012/13 baseline	National data (Oct 12 – Sep 13) 1152	Achieved (Local data indicates achieved)
Estimated diagnosis rate for people with dementia	To be Increased to 46% by April 2014 (as a percentage of prevalence)	Primary care data is not currently available.	Unknown
National Outcomes Framework Measures:			
Potential years of life lost from causes considered amenable to healthcare: adults, children and young people	At least maintain 2012/13 level of 2277	National data not available until 2014/15	Unknown
Reducing avoidable emergency admissions: - Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions	At least maintain 2012/13 level of 1210 per 100,000 population (Directly Standardised Rate)	National data (Oct 12 – Sep 13) 1152	Achieved (Local data indicates achieved)
- Unplanned hospitalisation for asthma, diabetes and epilepsy	At least maintain 2012/13 level of 503 per 100,000 population (Directly Standardised Rate)	National data (Oct 12 – Sep 13) 477	Achieved (Local data indicates achieved)
- Emergency admissions for acute conditions that should not usually require hospital admission	At least maintain 2012/13 level of 1476 per 100,000 population (Directly Standardised Rate)	National data (Oct 12 – Sep 13) 1491	Not achieved (Local data indicates achieved)
- Emergency admissions for children with lower respiratory tract infections (LRTIs)	At least maintain 2012/13 level of 465 per 100,000 population (Directly Standardised Rate)	National data (Oct 12 – Sep 13) 483	Not achieved (Local data indicates achieved)

National Outcomes Framework Measures Continued:			
Friends and Family Test	Assurance that all relevant local providers of services commissioned by a CCG have delivered the nationally agreed roll-out plan to the national timetable with an improvement in average FFT scores for acute inpatient care and A&E services between Q1 2013/14 and Q1 2014/15 for acute hospitals that serve Hull CCG's population	National data not available until 2014/15	Unknown (Local data indicates not achieved)
Incidence of MRSA bacteraemia	There should be no incidences of MRSA in the year	Up to March 2014 1 incidence	Not achieved
Incidence of C. Difficile	The number of incidences of C. Difficile in the year should be 77 or less.	Up to March 2014 69 incidences	Achieved

Managing our resources

NHS Hull CCG will receive approximately £376m of resources in 2014/15. Of this £7m is allocated for the running of the CCG and £9m is the return of the 2013/14 surplus. In order to manage these resources the CCG establishes specific budgets that are created using a combination of past expenditure, agreed contracts and planned investments. These are set out in a financial plan that is approved by the CCG Board and submitted to NHS England. Performance against these budgets is monitored on a continual basis with regular reports being submitted to the Quality and Performance Committee, the Integrated Audit and Governance Committee and the CCG Board.

Significant risks to the achievement of the financial plan include the level of demand for both secondary care and continuing healthcare growing at rates over and above the levels anticipated. In addition to this 2014/15 will be a transitional year in which a significant amount of work will be undertaken alongside the local council as part of the national 'Better Care Fund' initiative. Should the level of planned integration not deliver as expected there is a risk that the level of dual running could be costly.

As well as maintaining a contingency fund of approximately £2m the CCG continually monitors and forecasts levels of expenditure and where financial pressures are identified it reduces/delays the planned investments to take account of this. The CCG also has a risk management policy in place, with the Risk Register and Board Assurance Framework regularly updated and presented to relevant committees and the Board.

A resource (or funding limit) is set annually for the NHS by Parliament and each NHS organisation receives a share of that total to spend in delivering its responsibilities. It is expected that those funds are spent in full, but they must not be exceeded.

We are pleased to report that the CCG managed to operate within its revenue resource limits achieving a surplus of £9,071k against its revenue resource limit of £376,080k as planned.

The CCG spent £6,802k on the administration of the organisation in 2013-14. This represented an underspendof £200k against a maximum budget of £7,020k (£25 per head of population).

Building a sustainable NHS

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

We are committed to shaping a more sustainable NHS by:

- **Developing** a "whole systems" approach to commissioning;
- **Understanding** our role in improving the sustainability of healthcare; and
- Using the commissioning cycle to increase sustainability and to implement the NHS Carbon Reduction Strategy.

Sustainability is particularly embedded within the following business processes and procedures:

Area	Is sustainability considered?
Travel	Yes
Procurement (environmental)	Yes
Procurement (social impact)	Yes
Suppliers' impact	Yes

In addition, we have developed and implemented a Sustainability Impact Assessment tool and guidance for use by staff to help identify the likely sustainability implications of either:

- The introduction of a new policy, project, or function or,
- The implementation of an existing policy, project, or function within the organisation.

Once sustainability implications have been identified, steps can be taken to amend the proposed policy, project or function or amend the way in which it is currently implemented to ensure it is inclusive and does not discriminate (either deliberately or accidentally).

As a part of the NHS, it is our duty to contribute towards the goal set in 2009 of reducing the carbon footprint of the NHS by 10% (from a 2007 baseline) by 2015. We are required to report our progress in delivering against sustainable development indicators. However, since the 2007 baseline year, the NHS has undergone a significant restructuring process and, as our CCG was only established in April 2013, we do not currently have an established baseline. Therefore, we are working with NHS Property Services – the organisation which owns the property where we house our headquarters – to ensure systems are in place to gather information on waste, water and energy use, and it is intended that we will report on this in future annual reports.

Through this work, we will ensure we comply with our obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

Please refer to the Annual Governance Statement on page 68 for sustainable development obligations.

Promoting Equality

At NHS Hull CCG, we are committed to developing, supporting and sustaining a diverse workforce that is representative of the community it serves. Equally, we are committed to commissioning (buying) a health service that respects and responds to the diversity of the local population.

During early 2013, we reviewed our local equality objectives for the NHS in Hull and developed an Equality and Diversity Plan and Objectives for 2013/14 to 2015/16. This work built upon previous discussion with clinicians, stakeholders and diverse groups through attendance at meetings such as the Disability Choices and Rights, Humber All Nations Alliance, Sure Start, Hull City Council, Age Concern, Hull Community Network, Lesbian Gay Bisexual and Transgender Forum and Hull's People Panel. We published our objectives in May 2013, in line with the requirements of the Public Sector Equality Duty.

Our equality plan and objectives focus on how we will positively contribute to a fairer society and good relations in the way we work in Hull, with the population, statutory organisations and the voluntary, community and social enterprise organisations to deliver our vision of "Creating a healthier Hull".

To achieve these objectives, we have a number of key delivery actions in place and a full update is available on the equality pages of our website.

A summary of the key highlights, in terms of progress made to achieve these objectives in 2013/14, follows:

Staff awareness and training

All our staff have access to a computer based training package which includes Equality and Diversity training. This is mandatory for all staff to complete and, as at 15 March 2014, 100% of staff had completed this training – this is in addition to bespoke equality impact analysis (EqIA) training which was commissioned in November 2012.

Engagement

Our Director of Commissioning and Partnerships is now a member of the Divisional Independent Advisory Group and routinely attends the quarterly meetings. The meeting is run by the Humberside Police D-Division and provides an opportunity for a wide range of multi-agency professionals to meet with local community representatives, including representatives of diverse groups/communities.

All engagement events / patient feedback reports contain equality and diversity information and a specific question asked around sharing services to meet the diverse needs of the population.

Work with Humber All Nations Alliance (HANA)

We have regular and on-going meetings with HANA officers. These provide the opportunity for HANA to raise any issues of concern to Black and Minority Ethnic (BME) communities. In addition, proactive work has included presentations by the CCG and seeking views on proposals at HANA public events. Recent examples include consultation on content requirements for the Patient Guide, which was developed into the "How to get the most from your local Health Services booklet".

This booklet was subsequently translated into the 5 most needed languages (not spoken) following consultation with HANA communities and GP practices. The copy from this leaflet is also available on the HANA website which has the facility to translate it into 67 different languages. http://hanaonline.co.uk/your-nhs/

Specific work in relation to refugees and asylum seekers has been led by our Director of Commissioning and Partnerships through the Hull Health and Wellbeing Board leading to changes in the way the needs of this group are met in primary care.

Provider Compliance

Systems are in place to monitor healthcare provider compliance with the Equality Act. This starts at the service specification development stage, is checked as part of procurement and monitored through regular and robust contract monitoring arrangements.

Complaints/Incidents

Systems are in place to monitor complaints and incidents both at the CCG and at service provider level. These are specifically monitored through Contract Management Boards in relation to equality and diversity issues. In 2013/14, there have not been any complaints or incidents relating to accessibility issues.

Primary Care Translation Service

In September 2013 we awarded the Translation and Interpretation services contract to a new company. In addition to improving services to our local population a number of new jobs were created as the company relocated some of their corporate departments to Hull.

The revised translation and interpretation services and system was introduced across primary care following extensive consultation with organisations and individuals who support potential users of the translation service. A particular gap in relation to the availability of interpreters who could support clients with British Sign Language was addressed as part of this procurement.

Website

A new CCG website **www.hullccg.nhs.uk** has been launched and is fully compliant with the Web Content Accessibility Guidelines. As we continue to develop the site we will work with diverse groups to ensure that the site meets their needs.

Policies

As an employer, we recognise and value people as individuals and accommodate differences wherever possible by making adjustments to working arrangements or practices. We actively work to remove any discriminatory practices, eliminate all forms of harassment and promote equality of opportunity in our recruitment, training, performance management and development practices. Policies and processes in place to support this include:

- Managing Performance.
- Disciplinary / Conduct.
- Grievance.
- Staff Induction.
- Bullying and Harassment.
- Flexible working.
- NHS Code of Conduct for Managers.
- Job descriptions (including statements regarding equality and diversity expectations).
- Health policies.
- Annual appraisals with staff.
- Employment equality monitoring forms.

We actively encourage people with disabilities to apply for positions in our organisation. We have a commitment to interviewing job applicants with disabilities where they meet the minimum criteria for the job as well as making 'reasonable adjustments' to avoid any disabled employee being put at a disadvantage compared to non-disabled people in the workplace. Staff who have disabilities have the opportunity to discuss their development through our Personal Development and Review process. An equality impact analysis is undertaken on all newly proposed Human Resources policies to determine whether it has a disparate impact on disability and, where identified, action is considered to mitigate this.

All our staff have access to a computer based training package which includes Equality and Diversity training as well as bespoke training appropriate to individual staff roles.
For more information, and to see our full year end equality report, please visit the equality and diversity section of our website at:
www.hullccg.nhs.uk

Gender Analysis

At the end of 31 March 2014 the following breakdowns for NHS Hull CCG in terms of gender of CCG employees and the CCG Board were as follows:

	Female	Male
The number of persons of each gender who were on the CCG Board	7	10
The number of persons of each gender who were employees of the clinical commissioning group	33	9
The number of persons of each gender who made up the membership (Council of Members)	11	46

Emma Latimer, Chief Officer
NHS Hull CCG,
4 June 2014

Members' Report 2013/14

Our Council of Members

We are a clinically-led organisation, which brings together 57 local GP Practices and other health professionals to plan and design services to meet local patients' needs. Our GP practices serve a registered population of 288,000 across 23 wards.

The following practices comprise the members of NHS Hull Clinical Commissioning Group at the time of its authorisation. *(Amendments since August 2013 in italics)*

Practice Name	Address
The Avenues Medical Centre	The Avenues Medical Centre, 149 – 153 Chanterlands Avenue, Hull HU5 3TJ
Awan & Partners	480 Hall Road, Hull HU6 9BS *(now Orchard 2000 Medical Centre)*
Bridge Group Practice	The Orchard Centre, 210 Orchard Park Road, Hull HU6 9EX
The Calvert Practice	110a Calvert Lane, Hull HU4 6BH
Chestnut Farm Surgery	174 Dunvegan Road, Hull HU8 9LF
Choudhary AK	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Chowdhury GM	Park Health Centre, 700 Holderness Road, Hull HU9 3JR
Cook BF	840 Beverley Road, Hull Hu6 7HP
Datta AK	The Surgery, Littondale, Sutton Park, Hull HU7 4BJ
Dave G	Laurbel Surgery, 14 Main Road, Bilton, Hull HU11 4AR
East Park Practice	Park Health Centre, 700 Holderness Road, Hull HU9 3JR
Foulds & Partners	Sydenham House Practice, Boulevard, Hull HU3 2TA
Ghosh, Raghunath & Partners	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW *(now St Andrews Group Practice)*
Gopal KV	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Hendow GT	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Hussain SG & Partners	Wilberforce Health Centre, 6 – 10 Story Street, Hull HU1 3SA *(now Wilberforce Surgery)*
Joseph JC	Longhill Health Care Centre, 162 – 164 Shannon Road, Hull HU8 9RW
Kingston Health	Kingston Health, Wheeler Street, Hull HU3 5QE
Kingston Medical Centre	Kingston Medical Centre, 151 Beverley Road, Hull HU3 1TY
Kingswood Surgery	Kingswood Health Centre, 10 School Lane, Hull HU7 3JQ
Macphie, Raghunath & Partners	Newington Health Centre, 2 Plane Street, Hull HU3 6BX
Malczewski GS	Longhill Health Care Centre, 162 – 164 Shannon Road, Hull HU8 9RW
Mallik MK	919 Spring Bank West, Hull HU5 5BE
Miller & Partners	The Oaks Medical Centre, Council Avenue, Hull HU4 6RT
Musil J	Princes Court, 2 Princes Avenue, Hull HU5 3QA *(now Princes Medical Centre)*
Nayar JK	Newland Health Centre, 187 Cottingham Road, Hull HU5 2EG
Newland Group Practice	Alexandra Health Centre, 61 Alexandra Road, Hull HU5 2NT
Northpoint	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Orchard Park Surgery	The Orchard Centre, 210 Orchard Park Road, Hull HU6 9BX *(now Haxby Group Orchard Park Surgery)*
Palooran, George & Koshy	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Morrill Street Group Practice	Morrill Street Health Centre, Morrill Street, Hull HU9 2LJ
Percival & Partners	Alexandra Health Centre, 61 Alexandra Road, Hull HU5 2NT

Poulose NA	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW *(now Poulose NA, Awan and Basheer)*
Priory Surgery	Priory Surgery, Priory Primary School, Priory Road, Hull HU5 5RU *(now Haxby Group Priory Surgery)*
Quays Medical Centre	Wilberforce Health Centre, 6 – 10 Story Street, Hull HU1 3SA
Raghunath & Partners	St Andrews Group Practice, Marmaduke Street, Hull HU3 3BH *(now at Elliott Chappell Health Centre, 215 Hessle Road, Hull HU3 4BB)*
Raghunath & Partners	Newington Health Centre, 2 Plane Street, Hull HU3 6BX *(now St Andrews Group Practice, Newington Health Care Centre)*
Raut Partnership	Highlands Health Centre, Lothian Way, Hull HU7 5DD
Rawcliffe & Partners	New Hall Surgery, Oakfield Court, Cottingham Road, Hull HU6 8QF
St Andrews Northpoint	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Rej AK	Southcoates Medical Centre, 255 Newbridge Road, Hull HU9 2LR
Richardson & Partners	Burnbrae Surgery, 445 Holderness Road, Hull HU8 8JS *(now Burnbrae Medical Practice)*
Riverside Medical Centre	Riverside Medical Centre, The Octagon, Walker Street, Hull HU3 2RA
Roper & Partners	Springhead Medical Centre, 376 Willerby Road, Hull HU5 5JT
Shaikh M	Longhill Health Care Centre, 162 – 164 Shannon Road, Hull HU8 9RW
Singh & Partners	Wolseley Medical Centre, Londesborough Street, Hull HU3 1DS
Story Street Practice & Walk-In Centre	Wilberforce Health Centre, 6 – 10 Story Street, Hull HU1 3SA
Sutton Manor Surgery	St Ives Close, Wawne Road, Hull HU7 4PT
Tak, Stryjakiewicz & Sadik	Newington Health Centre, 2 Plane Street, Hull HU3 6BX
Tang & Amin	Morrill Street Health Centre Morrill Street, Hull, HU9 2LJ

Chauhan & Partners	Clifton House Medical Centre, 263 - 265 Beverley Road, Hull HU5 2ST
Venugopal J	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW *(now Venugopal J and Partners)*
Weir & Partners	Marfleet Group Practice, Preston Road, Hull HU9 5HH
Witvliet L	358 Marfleet Lane, Hull HU9 5AD
Wong & Partners	Faith House Surgery, 723 Beverley Road, Hull HU6 7ER
Wright & Partners	Diadem Medical Practice, 2 Diadem Grove, Bilton Grange, Hull HU9 4AL
Yagnik RD	Park Health Centre, 700 Holderness Road, Hull HU9 3JR

Our CCG Board

The CCG Board meets in public on a bi-monthly basis. It is responsible for agreeing and overseeing delivery of NHS Hull CCG's priorities.

It makes sure the CCG works effectively, efficiently and economically.

NHS Hull Clinical Commissioning Group Board Membership 2013/14

(All memberships run from 1 April 2013 to 31 March 2014 inclusive unless stated otherwise)

Chair
Dr Dan Roper
(November 2013 - March 2014)

*Interim Chair from (August 2013 - November 2013)

GP members

Dr Vince Rawcliffe

Dr Mark Follows

Dr John Parker

Dr Raghu Raghunath

Dr Dan Roper

Dr Leen Witvliet

Dr James Moult

Dr Amy Oehring
(12 March 2014 - 31 March 2014)

Secondary Care Doctor
Dr Richard Grunewald

* **Chair** - Dr Tony Banerjee (April 2013 - July 2013)

Lay Members

Paul Jackson
(Lay Member for Strategic Change)

Karen Marshall
(Lay Member for Audit and Remuneration)

Jason Stamp
(Lay Member for Patient and Public Involvement)

Practice Manager Representative
Carole Robinson
(12 March 2014 onwards)

Chief Officer
Emma Latimer

Chief Finance Officer
Emma Sayner

Director of Commissioning and Partnerships
Julia Mizon

Registered Nurse / Director of Quality & Clinical Governance
Sarah Smyth
(1 April 2013 – July 2013)

NHS Hull CCG Integrated Audit & Governance Committee

(All memberships run from 1 April 2013 to 31 March 2014 inclusive unless stated otherwise)

Chair	Vice Chair/Lay Member	GP Member
Karen Marshall	Paul Jackson	Dr Mark Follows

For membership of NHS Hull CCG's Remuneration Committee please see the Remuneration Report page 54.

Please refer to the Board Profiles and declarations of interest and conflicts section of the Remuneration Report on page 61 for details of conflicts of interest.

Pension Liabilities

For information on pension liabilities please see the accounting note 1.9.2 on page 10 of the Section B - Annual Accounts.

Sickness absence 2013/14

The sickness absence data for NHS Hull CCG between 1 April 2013 and 31 March 2014 is below:

	Number
Total days lost	184
Total staff years	40
Average working days lost	4.55

NHS Hull CCG regularly reviews reasons for absence and all sickness is managed in line with the organisation's Absence Management Policy which can be found at **www.hullccg.nhs.uk**

Sickness absence data for NHS Hull CCG between 1 April 2013 and 31 March 2014 is included in the employee benefits note to the Financial Statements in Section B - Annual Accounts page 21.

Audit Costs

Our external auditor is KPMG LLP, 21 The Embankment, Neville Street, Leeds, LS1 4DW. Auditors' remuneration in relation to April 2013 to March 2014 totalled £98,600 for statutory audit services.

This covered audit services required under the Audit Commission's Code of Audit Practice (giving opinion on the Annual Accounts and work to examine our use of resources and financial aspects of corporate governance).

The external auditor is required to comply with the Audit Commission's requirement in respect of independence and objectivity and with International Auditing Standard (UK & Ireland) 260: "The auditor's communication with those charged with governance".

Our Integrated Audit and Governance Committee receives our external auditor's Annual Audit Letter and other external audit reports.

Incidents involving data loss

NHS Hull CCG has reported that there were no incidents involving data loss or confidentiality breaches during 2013/14.

Access to Information

During the period 1 April 2013 to 31 March 2014, the CCG processed the following requests for information under the Freedom of Information Act (FOI) 2000.

Two requests took longer to comply with, in agreement with the requesters, due to their complex nature.

Our publication scheme contains documents that are routinely published; this is available on our website: **www.hullccg.nhs.uk**

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

	2013/2014
Number of FOI requests processed	210
Percentage of requests responded to within 20 working days	99%
Average time taken to respond to an FOI request	13.7

Handling complaints and principles for remedy

The complaints received by the CCG are handled in accordance with the CCG's policy on managing complaints, which is currently being revised to reflect recent guidance and reports on NHS complaints handling, including Francis 2 and the Hart Clwyd report.

NHS Hull CCG received two complaints during 2013/14. One was upheld and the other is currently in process.

The CCG endeavours to comply with the Parliamentary and Health Service Ombudsman's Principles of Remedy when considering complaints.

The CCG works to meet the 6 principles as follows:

1. Getting it right – The CCG aims to acknowledge and put right cases of maladministration and poor service that have led to injustice and hardship by considering all the relevant factors, ensuring fairness to the complainant and any others who have suffered from the same maladministration or poor service.

2. Being customer focused – the CCG aims to deal with patient complaints professionally and sensitively, where appropriately apologising and explaining poor service and maladministration.

3. Being open and accountable – the CCG aims to explain clearly in its response to any complaint its findings and the reasons for upholding or not upholding the complaint and any associated remedy.

4. Acting fairly and proportionately – the CCG aims to treat all complaints without bias, unlawful discrimination or prejudice.

5. Putting things right – where a complaint is upheld, the CCG aims to offer an appropriate remedy including an apology, an explanation and details of any remedial action to be undertaken. The CCG will consider any remedy that returns the complainant to the position they would have been in and where that is not possible, compensation will be considered.

6. Seeking continuous improvement – the CCG learns from complaints and ensures that where identified, changes are made to policies, procedures and systems and any associated staff training is carried out.

Engaging our staff

We have commenced a significant amount of work in the employee engagement strand of our Organisation Development Strategy for 2013-15 to strengthen our high performing, engaged culture, including:

- A full annual organisational climate survey and focus groups to discuss the findings.
- An Employee Engagement plan of activities.
- An Employee Engagement working group representing the workforce as an enabler to deliver planned activities.
- Brand design for the Employee Engagement theme, to be used in all internal communications, published on the CCG portal, and included in our lead employer branding.
- TeamTalkLive, a bi-monthly opportunity for the workforce to meet informally with the Board and senior leadership team to discuss any aspect of what matters to our employees

The first interim climate survey will take place in June 2014 to assess progress against the December 2013 findings and commitments to address development action plans.

Each of the Employee Engagement themes is led by a member of the Senior Leadership Team. Annually the climate survey will take place each December and the interim progress survey in June of each year. In 2014 the CCG will focus on its own organisational results. It is expected that from 2015 we will aim to benchmark our results nationally with other/similar public sectors results as part of our strategic aim to become a preferred and lead employer.

We are, we care.
Every day we are creating a healthier Hull

Consultation

Recognising the benefits of partnership working, NHS Hull CCG is an active member of the Joint Trade Union Partnership Forum organised by the Workforce Team within North Yorkshire and Humber Commissioning Support Unit.

The aim of the Joint Trade Union Partnership Forum is to provide a formal negotiation and consultation group for the CCGs and the Unions to discuss and debate issues in an environment of mutual trust and respect.

In particular it:

- Engages employers and trade union representatives in meaningful discussion on the development and implications of future policy.
- Provides a forum for the exchange of comments and feedback on issues that have a direct or indirect effect on the workforce.
- Promotes effective and meaningful communication between all parties that can be subsequently disseminated across the membership.

Disabled employees

Our policy in relation to disabled employees can be found within the Promoting Equality section on page 38.

In addition to this the CCG also has an Absence Management Policy. In the event of an employee becoming disabled then the framework provided by this policy would be used. Occupational Health, Workforce and where applicable other specialist advice would be taken and reasonable adjustments would be made to support them to continue in employment as far as possible.

Emergency preparedness

NHS North Yorkshire and Humber Area Team has incident response plans in place, which are compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. To support this, we certify that the CCG has business continuity plans in place and will provide support with capacity and control plans for incidents. The CCG is assured that the North Yorkshire and Humber Local Area Team regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan locally.

Statement as to disclosure to auditors

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and, that the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

Preparation of the Members' Report

This Members' Report has been prepared by the Integrated Audit and Governance Committee on behalf of the Council of Members and CCG Board.

Emma Latimer, Chief Officer
NHS Hull CCG,
4 June 2014

Remuneration Report 2013/14

Remuneration Committee report (not subject to audit)

NHS Hull CCG follows national guidance in remuneration (pay awarded) to very senior managers (VSMs) and the CCG Remuneration Committee was appointed by the CCG Board from amongst its members. It provides advice and recommendations to the Board about appropriate remuneration and terms of service for VSMs and proposes calculation and scrutiny of any termination payments, taking into account any relevant national guidance. All members have voting rights.

Other individuals such as the Chief Officer, Chief Finance Officer, the Chair of the CCG and external advisers such as Commissioning Support Unit representatives (notably Human Resources) have, from time to time, attended for all or part of meetings as and when appropriate.

The role of other individuals who attend and external advisors is to draw the committee's attention to best practice, national guidance and other relevant documents as appropriate.

The Remuneration Committee met twice across the financial year to address agenda requirements, at all times the process followed good principles of governance with special reference to conflicts of interest and the requirements of the terms of reference; all meetings were quorate.

Specialist advice was sought and provided when required.

Remuneration Committee membership (not subject to audit)

Membership is comprised of the following: *(All memberships run from 1 April 2013 to 31 March 2014 inclusive unless stated otherwise)*

Karen Marshall
Lay Member for Audit, Remuneration and Conflict of interest matters
(Chair of the Remuneration Committee)

Jason Stamp
Lay Member for Patient and Public Involvement

Paul Jackson
Lay Member for Strategic Change

Dr Dan Roper
Interim Chair For Hull CCG Board
(September 2013 – November 2013)

Chair of Hull CCG Board
(November 2013 – 31 March 2014)

Dr Tony Banerjee
Chair For NHS Hull CCG Board
(1 April 2013 - July 2013)

In attendance:

Emma Latimer
Chief Officer

Michael Napier
Associate Director of Corporate Affairs

Alison Dubbins
Head of Organisational Development
(September 2013 - 20 March 2014)
Associate Director of Human Resources & Organisation Development
(From 21 March 2014)

Amanda Wilcock
Director of Human Resources and Governance for North Yorkshire and the Humber Commissioning Support Unit (CSU)

Amanda Wilcock provided specialist HR advice to the Committee in her capacity as HR Director within North Yorkshire and Humber CSU via the service level agreement that the CCG has with the CSU.

The Remuneration Committee met on two occasions during the year. Attendance was as follows:

	Karen Marshall	Jason Stamp	Paul Jackson	Tony Banerjee	Dan Roper
Total meetings attended	2	2	2	1	1
Total meetings eligible to attend	2	2	2	1	1

Remuneration of senior managers at NHS Hull CCG (not subject to audit)

The CCG follows national guidance in relation to remuneration for very senior managers (VSMs). Our Remuneration Committee made up of Lay Members and a GP determines the appropriate remuneration for VSMs including any reference to performance targets.

The definition of "senior managers" is:

Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the clinical commissioning group. This means those who influence the decisions of the clinical commissioning group as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.

The CCG can confirm:

- There were no performance related payments made to senior managers in 2013/14.
- There were no senior managers service contracts awarded during 2013/14.
- There were no payments to past senior managers during 2013/14.
- There were no payments for loss of office during 2013/14.
- There were no off-payroll engagements during 2013/14.

Salaries and allowances of CCG senior managers 2013-14 (subject to audit)

Name & Title	Salary & Fees (bands of £5000) £000's	Taxable Benefits (Rounded to the nearest £00) £00's	Annual Performance Related Bonuses (bands of £5000) £000's	Long Term Performance Related Bonuses (bands of £5000) £000's	All Pension Related Benefits (bands of £2,500) £000's	Total (bands of £5,000) £000's
Dr Daniel Roper - GP Member of the Clinical Commissioning Group Board (to August 13) Chair of Clinical Commissioning Group Board (from August 2013)	60-65	0	0	0	- *	60-65
Dr Raghu Raghunath - GP Member of the Clinical Commissioning Group Board	35-40	0	0	0	- *	35-40
Dr Leen Witvliet - GP Member of the Clinical Commissioning Group Board	35-40	0	0	0	- *	35-40
Dr James Moult - GP Member of the Clinical Commissioning Group Board	35-40	0	0	0	- *	35-40
Dr John Parker - GP Member of the Clinical Commissioning Group Board	35-40	0	0	0	0	35-40
Dr Mark Follows - GP Member of the Clinical Commissioning Group Board	35-40	0	0	0	- *	35-40
Dr Vincent Rawcliffe - GP Member of the Clinical Commissioning Group Board	35-40	0	0	0	- *	35-40
Dr Richard Grunewald - Secondary Care Doctor Member of the Clinical Commissioning Group Board	05-10	0	0	0	0	05-10
Dr Tony Banerjee - Chair of Clinical Commissioning Group Board (until August 2013)	25-30	0	0	0	- *	25-30
Paul Jackson - Lay Member / Vice Chair	5-10	0	0	0	0	5-10
Karen Marshall - Lay Member	5-10	0	0	0	0	5-10
Jason Stamp - Lay Member	5-10	0	0	0	0	5-10
Emma Latimer - Chief Officer	120-125	62	0	0	230-232.5	355-360
Emma Sayner - Chief Finance Officer	95-100	30	0	0	92.5-95	190-195
Julia Mizon - Director of Commissioning and Partnerships	85-90	40	0	0	142.5-145	230-235
Sarah Smyth - Director of Quality and Clinical Governance & Executive Nurse	55-60	38	0	0	50-52.5	115-120
Tanya Matilainan - Interim Director of Quality and Clinical Governance	55-60	0	0	0	17.5-20	75-80

* It is not possible to provide the pensions related benefits in relation to the GP practitioners employed by the CCG in a senior management capacity due to errors in the data supplied by the Business Services Authority.

Pension related benefits are the increase in the annual pension entitlement determined in accordance with the HMRC method. This compares the accrued pension and the lump sum at age 60 at the end of the financial year against the same figures at the beginning of the financial year adjusted for inflation The difference is then multiplied by 20 which represents the average number of years an employee receives their pension (20 years is a figure set out in the CCG Annual Reporting Guidance).

Pension benefits of CCG senior managers 2013-14 (subject to audit)

Name & Title	Real Increase in pension at age 60 (bands of £2500) £000's	Real increase in pension lump sum at aged 60 (bands of £2500) £000's	Total accrued pension at age 60 at 31 March 2014 (bands of £5000) £000's	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5000) £000's	Cash Equivalent transfer value at 31 March 2013 £000's	Cash Equivalent transfer value at 31 March 2014 £000's	Real increase in Cash Equivalent transfer value £000's	Employer's contri-bution to partnership pension £00's
Dr Daniel Roper - GP Member of the Clinical Commissioning Group Board (to August 13) Chair of Clinical Commissioning Group Board (from August 2013)	- *	- *	- *	- *	- *	- *	- *	0
Dr Raghu Raghunath - GP Member of the Clinical Commissioning Group Board	- *	- *	- *	- *	- *	- *	- *	0
Dr Leen Witvliet - GP Member of the Clinical Commissioning Group Board	- *	- *	- *	- *	- *	- *	- *	0
Dr James Moult - GP Member of the Clinical Commissioning Group Board	- *	- *	- *	- *	- *	- *	- *	0
Dr John Parker - GP Member of the Clinical Commissioning Group Board	0	0	0	0	0	0	0	0
Dr Mark Follows - GP Member of the Clinical Commissioning Group Board	- *	- *	- *	- *	- *	- *	- *	0
Dr Vincent Rawcliffe - GP Member of the Clinical Commissioning Group Board	- *	- *	- *	- *	- *	- *	- *	0
Dr Richard Grunewald - Secondary Care Doctor Member of the Clinical Commissioning Group Board	0	0	0	0	0	0	0	0
Dr Tony Banerjee - Chair of Clinical Commissioning Group Board (until August 2013)	- *	- *	- *	- *	- *	- *	- *	0
Paul Jackson - Lay Member / Vice Chair	0	0	0	0	0	0	0	0
Karen Marshall - Lay Member	0	0	0	0	0	0	0	0
Jason Stamp - Lay Member	0	0	0	0	0	0	0	0
Emma Latimer - Chief Officer	10-12.5	30-32.5	30-35	90-95	283	451	162	0
Emma Sayner - Chief Finance Officer	2.5-5	12.5-15	15-20	45-50	141	204	60	0
Julia Mizon - Director of Commissioning and Partnerships	5-7.5	20-22.5	30-35	90-95	390	531	132	0
Sarah Smyth - Director of Quality and Clinical Governance & Executive Nurse	2.5-5	7.5-10	10-15	35-40	124	162	35	0
Tanya Matilainan - Interim Director of Quality and Clinical Governance	0-2.5	2.5-5	25-30	75-80	483	540	46	0

* It is not possible to provide the pensions related benefits in relation to the GP practitioners employed by the CCG in a senior management capacity due to errors in the data supplied by the Business Services Authority.

See next page for further information regarding the Cash Equivalent Transfer Value.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme.

This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

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 member of the Governing Body in NHS Hull CCG in the financial year 2013-14 was £120-£125K. This was 3.3 times the median remuneration of the workforce, which was £37.5K.

In 2013-14, no employees received remuneration in excess of the highest-paid member of the Governing Body.

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

NHS Hull CCG is in its inaugural year therefore no comparable prior year data is available.

Board profiles and declaration of interests and conflicts (not subject to audit)

All time periods in post relate to 1 April 2013 to March 31 2014 unless stated otherwise.

Board Member	Declaration of Interests	Time Period in Post
Dr Dan Roper - Chair (from November 2013)		
Dan Roper was born in Hull. After graduating at Edinburgh University he completed his GP training in Hull. He has been a local GP for 27 years and is currently GP Principal at Springhead Medical Centre.	• GP Partner at Springhead Medical Centre • Deputy Medical Referee Haltemprice Crematorium • GP Trainer • Honorary Senior Lecturer at Hull York Medical School	Interim from August 2013 and made permanent in post November 2013.
Dr Tony Banerjee - Chair (April to August 2013)		
	• No declarations received during this time	In post until August 2013
Emma Latimer - Chief Officer		
Emma has been Chief Officer of NHS Hull CCG since its establishment, having previously held the role of Chief Officer designate in shadow form. As part of her 24 year NHS career she has senior management/director experience in contracting, commissioning and performance management within ambulance, hospital and community based health services. In addition to being the Accountable Officer she is Programme Sponsor of the Hull 2020 multi-partner transformation programme. She also represents the CCG on a range of national, regional and local committees.	• Local Public Sector Director representing Community Health Partnerships on the City Care Board on behalf of the CCG (not remunerated). • Trustee of CatZero with the Charities Commission.	
Dr Vince Rawcliffe		
GP at New Hall Surgery and Chair of the Council of Members	• Partner of New Hall Surgery	

Board Member	Declaration of Interests	Time Period in Post
Dr James Moult		
GP at Faith House Surgery and CCG GP lead for Primary Care Programme Board. Chair of Quality and Performance Committee.	• NHS England (GP Appraiser) • Faith House Surgery – Partner (GP) • Locum GP (Adhoc) • Out of Hours GP (CHCP)	
Dr John Parker		
Retired senior partner at Morrill Street Health Centre, and CCG GP lead for Urgent Care. Chair of Planning and Commissioning Committee.	• Associate Director of Clinical Studies at Hull York Medical School • Out of Hours GP (Sessional) Humber NHS Foundation Trust (Integrated Drug and Alcohol Team)	
Dr Mark Follows		
Locum GP and CCG GP lead for Planned Care. Member of Integrated Audit and Governance Committee. Mark Follows is a graduate of Nottingham medical school. He works as a freelance GP and a GP with a special interest in gastroenterology. Mark works nationally as an assessor of endoscopy services for the Royal College of Physician's accreditation unit and as an advisor to the National Institute of Clinical Excellence (NICE) on their dyspepsia (indigestion) and irritable bowel syndrome guideline updates.	• Director of SLB Health Limited with Spouse • Freelance GP / GP with special interest in Gastroenterology • Assessor for Royal College Physicians Accreditation Unit Joint Advisory Group • My spouse and I provide Gastroenterology Services for Fountain's Medical Diagnostics Services Limited (based in West Yorkshire).	
Dr Leen Witvliet		
GP based on Marfleet Lane, East Hull, and CCG GP Lead for Prescribing. Member of Quality and Performance Committee.	• Nil return	

Board Member	Declaration of Interests	Time Period in Post
Dr Raghu Raghunath		
GP at St Andrew's Group Practice and CCG GP lead for Unplanned Care, Organisational Development Workforce/ Recruitment/ Training and Education and Research. Member of Planning and Commissioning Committee. He has strong academic, training and research interests and close links with the local Hull York Medical School in the role as Director of Clinical Studies, He is also a GP trainer as well as training Foundation Year 2 doctors. Local clinical primary care lead for research.	• Membership of a Partnership at x5 St Andrews Group Practices, Elliott Chapel Health Centre, Newington Health Centre x2 and North Point Medical Practice x2 • St Andrews have become partners with Dr Venugopal at Bransholme from 3rd February 2014 • Director of Industrial Audiometry Consultancy • GP Practice has a Stroke Medical Cover Contract with Hull CCG • Funding from Hull CCG research grant to GP Practice for the Action Potential Stimulus Pain Service Referral Project • Director of Clinical Studies at Hull York Medical School • Research Lead of the Primary Care Research Network • Board Member of the Commissioning Lead Research Network • provide some ad hoc occupational health work for Occupational Health Services Limited • Hon Senior Clinical Lecturer HYMS	
Dr Richard Grunewald - Secondary Care Doctor		
Dr Richard Grünewald is Clinical Director of Neurosciences at Sheffield Teaching Hospitals NHS Foundation Trust. He has been a Consultant Neurologist since 1995 and has spearheaded the development of epilepsy and movement disorders services in the Sheffield region. He has a special interest in medically unexplained symptoms and has co-developed innovative services to provide psychotherapy to patients within this group. Richard has served on the NICE guideline development groups for Transient Loss of Consciousness and Chronic Fatigue Syndrome/ME. He currently acts as President of the local branch of Parkinson's UK and as medical representative to the Sheffield branch of the ME Society and the NEAD Trust. He is a fellow of the Royal College of Physicians of London and is a member of the NHSE Neurology Clinical Reference Group.	• Clinical Director of Neurosciences, Sheffield Teaching Hospitals NHS Foundation Trust	

Board Member	Declaration of Interests	Time Period in Post
Karen Marshall		
Lay Member for Audit, Governance and Conflict of interest Matters Karen is a former GP practice nurse and Non Executive Director for NHS Hull who now works as an independent clinical skills trainer. Chair of Remuneration Committee Chair of Integrated Audit and Governance Committee	• Partner in Wax Lyrical Training • Director / Trustee and Chair of Hull Street Angels Trinity • Registered Nurse • Daughter in Law is a Registered Nurse working for Hull and East Yorkshire Hospitals Trust	
Jason Stamp		
Lay Member for Patient and Public Involvement. Jason is employed as a project manager for the North Bank Forum, working with a wide variety of community and voluntary sector groups. He is a member of various Department of Health advisory groups. Member of Remuneration Committee Member of Quality and Performance Committee	• Employed as a Project Manager within North Bank Forum which is a voluntary and community sector infrastructure organisation. • Appointed by the Secretary of State to be an expert advisor of the NHS Constitution • Member of the NHS National Stakeholder Forum • Member of the Humber NHS Foundation Trust • Member of Hull and East Yorkshire Hospitals NHS Trust	
Paul Jackson		
Vice Chair of CCG Board and Lay Member for Strategic Change. Paul is recently retired, having spent his career working in a range of managerial roles in the buildings and construction industry and with Hull City Council. He also spent five years as a Non-Executive Director on the Board of NHS Hull between 2007 and 2012. • Vice Chair of Remuneration Committee • Member of Integrated Audit and Governance Committee • Member of Planning and Commissioning Committee	• Nil return	

Board Member	Declaration of Interests	Time Period in Post
Emma Sayner - Chief Finance Officer		
Emma has 17 years NHS experience with over 12 years senior management experience after graduating from the NHS Graduate Financial Management Training Scheme. During this time she has held a number of senior finance roles and currently has a portfolio of responsibility covering finance, contracting, performance and procurement amongst other things. Emma is an Associate Member of the Chartered Institute of Management Accountants (ACMA) and holds a Bachelor of Arts Honours Degree.	• Partner of Burton Lodge Guest House	
Sarah Smyth - Registered Nurse / Director of Quality & Clinical Governance		
Sarah was appointed in June 2009 as the Associate Director of Clinical Quality and Patient Safety, Lead Nurse for Hull Teaching Primary Care Trust. Sarah is a first level registered nurse and holds the Diploma in Professional Studies in Nursing, a BSc in Nursing Studies and is currently completing her MSc in Managing and Leading in Health and Social Care.	• Nil return	Maternity Leave from June 2013 to March 2014
Julia Mizon - Director of Commissioning and Partnerships		
Julia was born in East Yorkshire and studied in York. She has a finance background and her career has spanned acute, mental health and community services, working across contracting, performance monitoring and commissioning, with 15 years as a senior manager in the NHS. Julia's directorate leads the transformational change programmes which form the basis of the CCG's Commissioning Strategy for 2012- 2015. Julia is committed to involving local people in decision-making with patient and public engagement embedded in the commissioning process.	• Nil return	
Tanya Matilainen - Interim Director of Quality & Clinical Governance		
	• Nil return	In post from July 2013 until April 2014

Emma Latimer, Chief Officer
NHS Hull CCG, 4 June 2014

Statement of Accountable Officer's Responsibilities

Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the 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.

Emma Latimer, NHS Hull CCG Chief Officer
Accountable Officer
May 2014

NHS Hull Clinical Commissioning Group Annual Governance Statement 2013/14

Introduction & Context

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

The CCG operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the CCG taking on its full powers.

As at 1 April 2013, the clinical commissioning group was licensed without any conditions or Directions.

The CCG has continued to actively seek improvements to its performance and delivery of its vision of Creating a Healthier Hull. It has performed strongly in the quarterly checkpoint meetings with North Yorkshire & Humber Area Team of NHS England, consistently being assessed as "assured" in the majority of domains and "assured with support" in the remainder.

The latter relate to the performance areas explained within the performance section of this Governance Statement.

The CCG Governing Body (Board) continues to oversee the performance of the CCG through the regular reports its receives as well as through the committees that support it and the performance and risk management arrangements described in this statement.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which

I am personally responsible, in accordance with the responsibilities assigned to me in ***Managing Public Money***.

I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice.

This Governance Statement is intended to demonstrate the clinical commissioning group's compliance with the principles set out in Code.

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

The CCG Governance Framework

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

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

The CCG has a Constitution and associated Standing Orders, Prime Financial Policies and a Scheme of Delegation, all of which have been approved by the CCG's membership and the Board of NHS England. The following section provides further detail on how the CCG has established and maintained a good governance framework during 2013/14.

Key Features of the CCG Constitution

The CCG is a membership organisation and each of the 57 member practices nominate a representative to sit on the Council of Members. The Council of Members and the Governing Body approved the CCG Constitution in March 2013. This was subsequently updated to reflect further NHS England guidance in-year to all CCGs and was approved by NHS North of England in August 2013.

The Constitution sets out the group's Standing Orders, Prime Financial Policies and Scheme of Reservation and Delegation. It defines:

a) those decisions that are reserved to the Council of Members;

b) those decisions that are the responsibilities of its Governing Body (and its committees), the CCG's committees and sub-committees, individual officers and other employees.

The CCG remains however accountable for all of its functions, including those that it has delegated.

The CCG governance framework for 2013/14 is shown below. This maintains a robust system of control for the CCG.

The Council of Members receives performance updates as to the progress of the CCG against its strategic objectives at each of its meetings. The Governing Body receives written assurance and opinion reports from each of its Committees throughout the year, as well as a wide range of updates through which it gauges performance against the key strategic objectives of the CCG.

The Council of Members has met on six occasions during 2013/14 and quoracy was achieved at each meeting, The Governing Body has responsibility for leading the development of the CCG's vision and strategy, as well as providing assurance to the Council of Members with regards to achievement of the CCG objectives.

It also has overall responsibility for financial management, quality improvement and monitoring performance against the Annual Commissioning Plan.

The CCG's Governing Body membership is set out on the CCG website, along with the Terms of Reference and membership of its Committees (http://www.hullccg.nhs.uk/pages/nhs-hull-clinical-commissioning-group-constitution). The 2013 / 14 Annual Report provides details of the remuneration paid to senior managers, via the Remuneration Report, as well as committees attended by Board Members and any declared interests.

The CCG Constitution establishes and delegates responsibility for certain CCG functions to the committees of the Governing Body. Minutes and opinion reports of committees are received by the Governing Body, with the Integrated Audit & Governance Committee also providing an assurance report to the Governing Body. Significant matters are escalated through the risk and control framework. Governing Body members sit on the committees so as to ensure that the Governing Body remains sighted on all key risks and activities across the CCG.

A summary of the committees' operation for 2013/14 is provided in the table below:

Committee	Key Functions	How the committee has fulfilled its duties to the Governing Body during 2013/14
Integrated Audit & Governance (Met 8 times and quorate on 6 occasions)	Providing assurance on the processes operating within the organisation for risk, control and governance. It assesses the adequacy of assurances that are available with respect to financial, corporate, clinical and information governance.	Received and reviewed the Board Assurance Framework and Risk Register on a regular basis throughout the year. Considered reports and opinions from a variety of internal and external sources including external audit, Counter Fraud Services, internal audit and the other committees of the Governing Body. Received and scrutinised reports on tender waivers, declarations of interest and gifts and hospitality. Reviews the annual accounts and annual governance statements and recommends these for approval by the Governing Body. Through these processes it is able to provide assurance to the Governing Body that the system of internal control is being implemented effectively.
Planning & Commissioning (Met 11 times and quorate on each occasion)	Ensuring that the planning, commissioning and procurement of commissioning-related business is in line with the CCG organisational objectives.	Prepare and recommend a Commissioning Plan to the Governing Body, together with the establishment of and reporting on effective key performance indicators with specifications which will deliver planned Quality, Innovation, Productivity and Prevention (QIPP) benefits. An opinion report is produced by the committee after each meeting for consideration by the Governing Body as to the sources of assurance available in relation to the areas of responsibility of the committee.

Committee	Key Functions	How the committee has fulfilled its duties to the Governing Body during 2013/14
Quality & Performance (Met 11 times and quorate on 10 occasions)	The continuing development, monitoring and reporting of performance outcome metrics in relation to the quality improvement, financial performance and management plans. Provision of assurances regarding the quality (safety, effectiveness and patient experience), Value for Money and performance of all commissioned / contracted services, That all contracted services comply with the required external regulation standards, required performance targets, activity, financial targets and local quality and patient safety standards. Ensuring that there are mechanisms and reporting systems in place to assure the CCG Board of quality and performance management for contracted providers.	A business intelligence report is provided to each meeting of the Governing Body, providing assurance on the delivery of statutory financial duties and key performance indicators. Areas of exception or concern are escalated a specific items for consideration of the Governing Body. An opinion report is produced by the committee after each meeting for consideration by the Governing Body as to the sources of assurance available in relation to the areas of responsibility of the committee.
Remuneration (Met 3 times and quorate on each occasion)	Advise and assist the Governing Body in meeting its responsibilities 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.	Drawing upon specialist expertise and benchmarking data, advised the Governing Body on the remuneration and other contractual arrangements of Very Senior Managers, Governing Body members and others within the CCG not secured on Agenda for Change terms and conditions. An opinion report is produced by the committee after each meeting for consideration by the Governing Body as to the sources of assurance available in relation to the areas of responsibility of the committee.

Effectiveness of the Governing Body

The Governing Body has continued to evaluate its effectiveness throughout the year and initiate changes which build and strengthen its functioning. This includes changes to the structure in which reports are submitted to the Governing Body to enhance the rigour with which a range of key considerations are consistently addressed.

It has held full day development sessions on a bi-monthly basis where key aspects of Governing Body effectiveness have been considered. These include externally facilitated consideration of the legal duties of CCGs, conflicts of interest examination and gifts and hospitality duties.

The Governing Body has approved an organisational development strategy which includes a comprehensive programme of Governing Body development at both an individual member and collective basis.

The Clinical Commissioning Group Risk Management Framework

The CCG has established and maintains a Risk Management Framework. This has been in place since the CCG was in shadow form and provides a systematic and consistent means through which all risks to the achievement of strategic and general objectives are identified, rated and eliminated or mitigated.

The Risk Management Strategy was reviewed and updated in November 2013. Changes to the strategy reaffirmed the CCG appetite for risk and further embedded the risk identification and evaluation processes to reflect the specific circumstances of the CCG.

This included changes to the definitions of the risk scoring matrix, which is based on the National Patient Safety Agency's 5 x 5 matrix, to better reflect the context of a CCG.

The strategy establishes the accountability arrangements, as follows:

Governing Body

The Governing Body on behalf of the Council of Members ensures that the organisation consistently adheres to the principles of good governance and maintains a risk management framework.

Integrated Audit and Governance Committee

The Integrated Audit and Governance Committee regularly reviews the CCG's risks at its meetings and provides assurance to the Governing Body on the maintenance of an appropriate framework.

Chief Officer

NHS Hull CCG's chief officer has overall responsibility for risk management. Through delegated responsibility the chief officer will have day to day management of the organisations risk management process.

The specific responsibilities of other committees, senior officers, lay members and all other staff within the CCG are clearly articulated.

The CCG Risk Register consolidates in one place the risks identified in relation to the achievement of the CCG objectives and facilitates the scrutiny of the controls in mitigating or eliminating the risk. The CCG has increased in-year the frequency of review of the risk register at directorate level to further embed the risk management framework within the CCG. The register is subject to monthly confirm and challenge at the Senior Leadership Team meeting and the Integrated Audit and Governance Committee.

The Board Assurance Framework (BAF) is an essential part of the CCG governance arrangements to ensure that the principal threats to achievement of the organisation's key objectives are clearly identified, mitigated and monitored. It has been subject to regular maintenance and review throughout 2013/14 enabling the Governing Body to gain assurance that the risks to the achievement of the principle objectives of the CCG have been identified, mitigated and controlled.

All formal papers, strategies or reports to the CCG explicitly identify and consider their impact against the CCG Assurance Framework as well equality and diversity impacts. The system has been in place in the CCG for the year ended 31 March 2014 and up to the date of approval of the Annual Report & Accounts. The process of review and strengthening of the risk and control framework of the CCG will continue throughout 2014/15.

The CCG has sought the assistance of its internal auditors on the development of its BAF and in April 2014 the Governing Body completed an internal audit facilitated comprehensive review of the risks within the Board Assurance Framework to ensure that these continue to reflect the evolving strategic objectives of the organisation as well as its updated strategic plan.

The CCG commissions a range of support services from North Yorkshire and Humber Commissioning Support Unit (CSU) including bespoke support to its risk management process and procedures. Key contacts have been established between the CSU and CCG and monthly client meetings are now held in relation to the risk support arrangements and performance.

The CCG has maintained throughout 2013/14 a wide range of means through which the public and other key stakeholders can influence and shape the work of the CCG and therefore contribute to the management of the associated risks. This includes:

- Holding of public meetings of the Governing Body attended by members of the public and other interested parties;
- Implementation of a comprehensive public and patient engagement programme linked to the CCG commissioning priorities.

The CCG was cited by NHS England as an example of good practice in its September 2013 publication, "Transforming Participation in Health and Care".

The CCG has established a comprehensive transformation programme for the delivery of its strategic objectives through to 2020.

The CCG Internal Control Framework

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

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

The Board Assurance Framework and Risk Register are regularly reviewed by the Integrated Audit & Governance Committee.

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.

Pension Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with.

This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Sustainable Development Obligations

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

We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives.

This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

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

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

Equality, Diversity & Human Rights

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

Risk Assessment in Relation to Governance, Risk Management & Internal Control

All risks to the CCG are assessed for their impact and likelihood and are profiled against the NHS England balanced scorecard for CCGs. The CCG's Governance, Risk Management and internal control frameworks have been subject to review in-year to ensure that they remain fit for purpose.

Further training will be provided to all staff to ensure their continued familiarity with the systems and processes.

The CCG Governing Body and it's Quality & Performance Committee have continued to maintain rigorous oversight of the performance of the CCG and the integrated Audit & Governance Committee has assessed the adequacy of the assurances available in relation to performance.

At the start of 2013/14 the CCG had no extreme (red) rated risks and 13 high (amber) rated risks within its Corporate Risk Register.

By the end of 2013/14 the CCG had 1 extreme risk and 8 high risks within its Corporate Risk Register.

The extreme rated risk was as follows:

Risk	Controls	Assurance
The NHS Constitution pledge in relation to A&E 4-hour wait performance is not delivered at an individual provider level.	Monitored through monthly contractual management board meetings with the relevant provider and remedial action plan reviewed via Senior Leadership Team and Quality & Performance Committee of the CCG.	The CCG Board receives bi-monthly assessment of progress via its Business Intelligence Report.

The CCG has developed a comprehensive transformation programme to support the achievement of its 6-year Commissioning Strategy. The programme has established formal programme management arrangements to deliver sustainable transformational change to health and public sector services in Hull and, in so doing, address the current risks identified within the Board Assurance Framework and Corporate Risk Register.

Review of Economy, Efficiency & Effectiveness of the Use of Resources

The Chief Finance Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control.

The Integrated Audit & Governance Committee receives a regular opinion from the Quality & Performance Committee as to the economic, efficient and effective use of resources by the clinical commissioning group.

The Integrated Audit & Governance Committee advises the CCG Governing Body (Board) on the assurances available with regards to the economic, efficient and effective use of resources.

An internal audit programme of activity is agreed and established to assess the adequacy of assurances available to the CCG in relation to the economic, efficient and effective use of resources.

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.

I am advised by the integrated audit & governance committee as to the adequacy of sources of assurance available to the clinical commissioning group in relation to governance; financial, information, corporate and clinical governance.

They have advised that they are assured that there is a generally sound system of control within the clinical commissioning group.

Work has been undertaken during the year to develop the sources of assurance available with respect to clinical governance and this work will continue during 2014/15.

Capacity to Handle Risk

The Accountable Officer leads the executive team and has overall responsibility for governance, statutory functions, quality and performance. This includes ensuring the implementation of an effective risk management system, development of the corporate governance framework, meeting all statutory requirements and ensuring that appropriate accountability statements for risk management and governance are in each Director's job profiles, as well as ensuring that all Directors have appropriate arrangements in place to address any shortfalls identified from the risk profile. The Accountable Officer chairs the Senior Leadership Team, which includes Directors who carry specific risk management responsibilities.

The clinical commissioning group Governing Body membership also includes independent Lay Members who bring a diverse range of skill and experience to the organisation and ensure that the best interests of local residents are reflected in the work of the clinical commissioning group.

The Chief Finance Officer has had responsibility for maintaining all internal controls on behalf of the Accountable Officer. The Chief Finance Officer is also the Senior Information Risk Owner and has ensured the delivery of statutory information governance and financial duties; including counter fraud. The Director of Quality and Clinical Governance has led on clinical governance, including infection control and decontamination, as well as acting as Caldicott Guardian. The Associate Director of Corporate Affairs has discharged the clinical commissioning group's obligations with regards to risk management and freedom of information. Taken together, the successful fulfilment of these functions has contributed to assuring the Governing Body on the achievement of the clinical commissioning group's statutory requirements.

All senior managers and other staff are required to bring to the attention of the Senior Leadership Team, via their line manager or Director, issues of major or significant risk, which have been identified and where the existing control measures are considered to be potentially inadequate. All managers are responsible for supporting and encouraging staff to report adverse incidents and near misses. All staff are responsible for the effective identification, reporting and management of risks within their area of responsibility. These specific responsibilities are identified in the CCG's incident reporting policy, which also includes detailed guidance and instructions for all staff.

The CCG works in collaboration with a wide range of local NHS partners and clinical networks to commission service improvement priorities from a range of potential NHS, voluntary, private and independent sector service providers. In addition, many other partnership arrangements are in place, including the clinical commissioning group's membership of the local Health & Wellbeing Board and specialised commissioning network.

External to the management structure, Internal Audit has an important role in the risk assessment of the CCG by advising in the achievement of corporate governance requirements, providing independent assessment and opinion to the Integrated Audit & Governance Committee, Governing Body (Board) and individual Directors. An annual work plan is agreed between the Head of Internal Audit and the Chief Finance Officer based on identified risks. A Service Level Agreement is in place with the East Coast Audit Consortium. Progress reports are presented to each meeting of the Integrated Audit & Governance Committee, including monitoring of all recommendations.

Review of Effectiveness

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

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body (Board), the Audit Committee and risk/ clinical governance/ quality committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

In carrying out my revoiew I have drawn assurance from the following:

- The outcomes from the NHS England authorisation process which say the CCG established without any conditions, together with the assessment of the CCG via the quarterly checkpoint meetings with the North Yorkshire & Humber Area Team of NHS England;
- The CCG's governance, risk management and internal control arrangements;
- The work undertaken by the CCG's internal auditors which has not identified any significant weaknesses in internal control;
- Performance, equality, sustainability and other information incorporated into the CCG's Annual Report and other performance information available to me;
- The results of national staff and stakeholder surveys; and
- The statutory external audit undertaken by KPMG, who will provide an opinion on the financial statements and form a conclusion on the CCG's arrangements for ensuring economy, efficiency and effectiveness in its use of resources during 2013/14.

The Head of Internal Audit Opinion

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

Significant Assurance can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The CCG has reviewed the BAF during the year. There have been no significant financial issues reported during the year.

Opinion **My overall opinion is:**

Significant Assurance, can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Whilst significant assurance has been given for all audit assignments undertaken, it must be noted that in most cases recommendations for improvement have been made where weaknesses in the design or inconsistent application of controls may put the achievement of particular objectives at risk.

Introduction

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Integrated Audit and Governance Committee, which should provide a reasonable level of assurance subject to the inherent limitations described below. The purpose of this Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the organisation's own assessment of the effectiveness of its system of internal control. This Opinion will assist the CCG in the completion of its Annual Governance Statement.

Basis of Forming the Opinion

The basis for forming my opinion is as follows:

Assurance Framework

An Assurance Framework (AF) exists to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation. The CCG has actively developed its processes which were in place during its shadow period and this development process continues with engagement from the Integrated Audit and Governance Committee and Board.

The CCG is reviewing the structure and operation of the Assurance Framework alongside Executives and the Board to reflect experiences from the first year of operation and the further development of organisational objectives and associated risks and opportunities. An assurance mapping process has also been undertaken to set out the CCG's assurance landscape and will be further developed as systems, processes and partner relationships embed.

Assurance across the organisation's business areas:

Access to services

- Reviews of QIPP and budget management at the CCG and CSU contract management arrangements further to financial controls being effected through contract management processes of CSU services including receipt of third party assurances.

Transparency and Governance

- An assurance mapping exercise enabled key assurance sources to be identified and internal audit activity aligned. Integrated Audit & Governance Committee effectiveness was assessed through desktop and interactive exercises and a conflicts of interest review was undertaken to assess compliance with procedures.

Patient Participation and Customer Services

- A review of patient engagement has been undertaken which evaluated the mechanisms for promoting patient centred care and how this fed the commissioning of high levels of quality care patient expect to receive.

Informed Commissioning

- Contracting arrangements with healthcare providers have been reviewed along with arrangements for continuing healthcare management. Two reviews were undertaken of information governance to assess arrangements for CSU management and delivery of a populated toolkit.

Higher Standards

- A review of performance management at the CCG has been undertaken with an emphasis on national and local targets and KPIs. The organisational response to Francis 2 has also been reviewed.

Contribution to Governance, Risk Management and Internal Control enhancements:

- Specific audit review of CSU Contract Management and review of the audit readiness report providing third party assurances to the CCG.
- Insight into the overall Governance and Assurance processes gained from liaison throughout the year with Senior Managers and subsequent work to develop the Assurance Framework including assurance mapping.
- Review and advice on CCG policies, Committee effectiveness (Integrated Audit & Governance Committee) and corporate governance documentation in respect of conflicts of interest.
- Involvement and relationship with the organisation e.g. attendance at Integrated Audit & Governance Committee meetings, CSU meetings (for finance and IGT) and Executive Team members (as required).
- Ongoing discussion with lead officers and Lay Members throughout the year.
- Effective utilisation of Internal Audit including in year communication, and changes to the audit plan (e.g. to reflect third party assurance through the CSU).
- Follow up, demonstrating progress against recommendations to improve systems and controls.
- Provision of briefings and CCG involvement through the MIAA partnership.

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

Director of Audit Services
April 2014

During 2013/14 the reviews undertaken by the CCG's internal auditors reported no opinions of limited or no assurance.

As a result of using North Yorkshire and Humber Commissioning Support Unit (CSU) to deliver some the CCGs functions the reliance on third party assurance is reasonably significant and gaining assurance in relation to these services was highlighted as a priority within the internal audit plan which was delivered by East Coast Audit Consortium in year. Deloitte's have completed a process of review on the North Yorkshire and Humber CSU and reported that the control processes described were operating with significant effectiveness to provide reasonable assurance that the related control objectives were achieved during the specified period.

Where they have reported a number of control exceptions these have been reviewed and the CCG is satisfied that either:

i) the risks to the CCG are minimal given that a relevant control is in place however evidence has not been recorded to that effect, or

ii) the CCG has sufficient compensating controls to mitigate any potential risks.

The CCG has requested an action plan from the CSU in order to address the issues identified and this will be subject to review by the Integrated Audit & Governance Committee during 2014/15.

Performance

The clinical commissioning group achieved a high level of performance across the operating framework requirements. However in a few areas performance fell below the target level:

- **Healthcare Associated Infection: MRSA** (March data) - the clinical commissioning group had a target of 0 MRSA infections for 2013/14, however, 1 case was reported during the year.

A multi-disciplinary team with representation from commissioners and providers meets monthly to review all cases which include community acquired and acute patients.

- **62 day cancer referral to treatment time following urgent GP referral** (February data) - The 2013/14 clinical commissioning group target is 85%, the latest year-to-date position is 83.25%.

- **62 day cancer referral to treatment time following referral from NHS Cancer Screening Services*** (February data) - The 2013/14 clinical commissioning group target is 90%, the latest year-to-date position is 81.82%.

Regular scrutiny takes place of all cancer target breaches through both the Quality and Performance Committee and the provider Contract Management Board.

- **Specialty level 18 week referral to treatment time – Admitted Pathways** (March data) - Whilst the clinical commissioning group met the overall target of 90% of admitted patients treated within 18 weeks, this target was not met for 3 specialties as follows; ENT, Plastic Surgery and Urology.

- **Specialty level 18 week referral to treatment time – Non-Admitted Pathways** (March data) - Whilst the clinical commissioning group met the overall target of 95% of non-admitted patients treated within 18 weeks this target was not met for 8 specialties as follows; Cardiology, Cardiothoracic Surgery, Dermatology, Gastroenterology, General Surgery, Neurosurgery, Trauma & Orthopaedics and Urology.

- **Incomplete pathways** - (March data) - The clinical commissioning group did not meet the overall target of 92% of patients treated within 18 weeks on incomplete pathways, only achieving 90.66%.

Referral to treatment times are subject to significant review to understand the reasons for the deterioration in achievement of targets, both from within the provider and in respect of increased referral activity above planned levels.

- Maternal smoking at delivery (Q3 data) - The clinical commissioning group has a target of 21% which has marginally under-achieved with maternal smoking at delivery rates being recorded at 21.12%.

- Breast-feeding prevalence at 6-8 weeks (Q2 data) - The clinical commissioning group has a target of 34.1% which has under-achieved with breast-feeding prevalence at 6-8 week rates being recorded at 31.43%.

- Mixed Sex Accommodation (MSA) Breaches (March data) - The clinical commissioning group had a target of 0 Mixed Sex Accommodation breaches for 2013/14, however, 2 cases were reported in March. Root Cause Analysis is to be shared by Hull & East Yorkshire Hospital as soon as possible.

Data Quality

The CCG Governing Body (Board) is advised by its Quality & Performance Committee as to the maintenance of a satisfactory level of data quality available to the CCG and the CCG maintains a process of continuous data quality improvement.

Business Critical Models

An appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report.

All business critical models have been identified and that information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.

Data Security

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

Discharge of Statutory Functions

During establishment, the arrangements put in place by the clinical commissioning group and explained within the Corporate Governance Framework were developed with 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 clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

The CCG has established and maintained a range of information governance, human resources and other corporate policies in place to support the delivery of its statutory functions and underpin the requirements of the CCG Constitution. Whilst in shadow form the CCG adopted the policies of its PCT predecessor. A programme is in place to review these policies and adapt them, as necessary, to the specific needs of the CCG. This programme of work will continue through 2014/15.

Compliance with statutory functions is delivered through the CCG's management structure and monitored through its committee structure and work programmes. These arrangements have been subject to external scrutiny.

Conclusion

With the exception of the performance issues that I have outlined in this statement, my review confirms that the CCG overall has a sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues have been or are being addressed.

Emma Latimer
Accountable Officer
30th May 2014

Section B – NHS Hull Clinical Commissioning Group Annual Accounts 2013/14

SECTION B

FOREWORD TO THE ACCOUNTS

NHS HULL CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2014 have been prepared by the NHS Hull Clinical Commissioning Group under section 232 (schedule 15,3(1)) of the National Health Service Act 2006 in the form which the Secretary of State has, within the approval of the Treasury, directed.

* Please note that all page references stated in Section B relate to the relevant page in Section B

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF HULL CLINICAL COMMISSIONING GROUP

We have audited the financial statements of Hull CCG for the year ended 31 March 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes.

These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

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

Respective responsibilities of the Accountable Officer and auditor

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

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2014 and of its net operating costs for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

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

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England except that the CCG has not included all required disclosures in respect of the pensions entitlement of general practitioners employed by the CCG in a senior management capacity as it considers that the data it has been provided with is incorrect. The reasons for this judgement are disclosed in the Remuneration Report below the Salaries and Allowances table and the Pensions Benefits table; and
- the information given in the Strategic Report and Members' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- in our opinion, the Governance Statement does not reflect compliance with NHS England's Guidance;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

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

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

matters that prevent us from being satisfied that the audited body has put in place such arrangements.

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

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

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

Certificate

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

5 June 2014

Clare Partridge for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 The Embankment
Neville Street
Leeds
LS1 4DW

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2014

	Note	2013-14 £'000
Commissioning		
Other Operating Revenue	2	**(852)**
Gross Employee Benefits	4	**2,122**
Other Costs	5	**365,739**
Net Operating Costs before Financing		367,009
Financing		
Investment Revenue		**0**
Other Gains & Losses		**0**
Finance Costs		**0**
Net Operating Costs for the Financial Year		367,009
Net Gain (Loss) on Transfer by Absorption		**0**
Retained Net Operating Costs for the Financial Year		**367,009**
Of which:		
Administration Costs		
Other operating revenue	2	**(11)**
Gross employee benefits	4	**1,997**
Other costs	5	**4,834**
Net administration costs before interest		**6,820**
Programme Expenditure		
Other operating revenue	2	**(841)**
Gross employee benefits	4	**125**
Other costs	5	**360,905**
Net programme expenditure before interest		**360,189**
Other Comprehensive Net Expenditure		
Impairments & reversals		**0**
Net gain (loss) on revaluation of property, plant & equipment		**0**
Net gain (loss) on revaluation of intangibles		**0**
Net gain (loss) on revaluation of financial assets		**0**
Movements in other reserves		**0**
Net gain (loss) on available for sale financial assets		**0**
Net gain (loss) on assets held for sale		**0**
Re-measurement of the defined benefit liability		**0**
Reclassification Adjustments:		
On disposal of available for sale financial assets		**0**
Total Comprehensive Net Expenditure for the Financial Year		**367,009**

The notes on pages 9 to 33 form part of this statement.

Statement of Financial Position as at 31 March 2014

	Note	2013-14 £'000
Non-current Assets		
Property, Plant & Equipment	8	0
Intangible Assets		0
Investment Property		0
Trade & Other Receivables	9	0
Other Financial Assets		0
Total Non-current Assets		0
Current Assets		
Inventories		0
Trade & Other Receivables	9	928
Other Financial Assets		0
Other Current Assets		0
Cash & Cash Equivalents	10	5
		933
Non-current Assets held for Sale		0
Total Current Assets		933
Total Assets		933
Current Liabilities		
Trade & Other Payables	11	(19,105)
Other Financial Liabilities		0
Other Liabilities		0
Borrowings		0
Provisions	12	(8)
Total Current Liabilities		(19,113)
Total Assets less Current Liabilities		(18,180)
Non-current Liabilities		
Trade & Other Payables	11	0
Other Financial Liabilities		0
Other Liabilities		0
Borrowings		0
Provisions	12	0
Total Non-current Liabilities		0
Total Assets Employed		(18,180)
Financed by Taxpayers' Equity		
General Fund		(18,180)
Revaluation Reserve		0
Other Reserves		0
Charitable Reserves		
Total Taxpayers' Equity		(18,180)

The notes on pages 9 to 33 form part of this statement.
The financial statements on pages 5 to 8 were approved by the Governing Body on 30 May 2014 and signed on its behalf by:

Emma Latimer
Accountable Officer

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2014

	General Fund £'000	Revaluation Reserve £'000	Other Reserves £'000	Total £'000
Balance at 1 April 2013	0	0	0	0
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	(1)	5	0	4
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	0
Adjusted Balance at 1 April 2013	(1)	5	0	4
Changes in Taxpayers' Equity for 2013-14				
Net operating costs for the financial year	(367,009)	0	0	(367,009)
Net gain (loss) on revaluation of property, plant & equipment	0	0	0	0
Net gain (loss) on revaluation of intangible assets	0	0	0	0
Net gain (loss) on revaluation of 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
Movements in other reserves	0	0	0	0
Transfers between reserves	5	(5)	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
Transfer between reserves in respect of assets transferred under absorption	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Re-measurement of the defined benefit liability	0	0	0	0
Net Recognised Expenditure for the Financial Year	(367,005)	0	0	(367,005)
Net funding	348,825			348,825
Balance at 31 March 2014	(18,180)	0	0	(18,180)

Statement of Cash Flows for the Year Ended 31 March 2014

	Note	2013-14 £'000
Cash Flows from Operating Activities		
Net operating costs for the financial year		(367,009)
Depreciation and amortisation		4
Impairments and reversals		0
Other gains (losses) on foreign exchange		0
Donated assets received credited to revenue but non-cash		0
Government granted assets received credited to revenue but non-cash		0
Interest paid		0
Release of PFI deferred credit		0
(Increase) decrease in inventories		0
(Increase) decrease in trade & other receivables		(928)
(Increase) decrease in other current assets		0
Increase (decrease) in trade & other payables		19,105
Increase (decrease) in other current liabilities		0
Provisions utilised		0
Increase (decrease) in provisions		8
Net Cash Inflow (Outflow) from Operating Activities		(348,820)
Cash Flows from Investing Activities		
Interest received		0
(Payments) for property, plant and equipment		0
(Payments) for intangible assets		0
(Payments) for investments with the Department of Health		0
(Payments) for other financial assets		0
(Payments) for financial assets (LIFT)		0
Proceeds from disposal of assets held for sale: property, plant and equipment		0
Proceeds from disposal of assets held for sale: intangible assets		0
Proceeds from disposal of investments with the Department of Health		0
Proceeds from disposal of other financial assets		0
Proceeds from disposal of financial assets (LIFT)		0
Loans made in respect of LIFT		0
Loans repaid in respect of LIFT		0
Rental revenue		0
Net Cash Inflow (Outflow) from Investing Activities		0
Net Cash Inflow (Outflow) before Financing		(348,820)
Cash Flows from Financing Activities		
Net parliamentary funding received		348,825
Other loans received		0
Other loans repaid		0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0
Capital grants and other capital receipts		0
Capital receipts surrendered		0
Net Cash Inflow (Outflow) from Financing Activities		348,825
Net Increase (Decrease) in Cash & Cash Equivalents		5
Cash & Cash Equivalents at the Beginning of the Financial Year		0
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	10	5

Notes to the Financial Statements

1. Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2013-14* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.5 Charitable Funds

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

1.6 Pooled Budgets

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

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

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

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

- The clinical commissioning group's share of 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:

Secondary Care Activity

Counting and coding of secondary care is not finalised until after the completion of the audited annual accounts process in June. Assumptions have been made around the liabilities of this for the Clinical Commissioning Group with a range of secondary care providers based on a number of factors including historical activity performance and known changes in activity, as well as block contract arrangements. The actual cost of activity will be different to the carrying amounts held in the Statement of Financial Performance and any variance will need to be managed in the Statement of Comprehensive Net Expenditure in the subsequent year. There is unlikely to be a significant change to the carrying value of assets and liabilities once activity is validated based on previous years outturn verses actual.

Accruals

There are a number of estimated figures within the accounts. The main areas where estimates are included are:

- Prescribing - The full year figure is estimated on the spend for the first 10 months of the year,
- Purchase of Healthcare - The full year figure is estimated on the month 11 actual information as agreed between the provider and commissioner.
- Continuing Care - This is based upon the client data base of occupancy at the financial year end.

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 cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.11.2 *Valuation*

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

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

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

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

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

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

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

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

1.11.3 *Subsequent Expenditure*

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

1.12 Intangible Assets

1.12.1 *Recognition*

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

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

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

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

1.12.2 *Measurement*

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

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

1.13 Depreciation, Amortisation & Impairments

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

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

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

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

1.14 Donated Assets

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

1.15 Government Grants

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

1.16 Non-current Assets Held For Sale

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

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

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

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

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

1.17 Leases

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

1.17.1 *The Clinical Commissioning Group as Lessee*

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

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

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

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

1.17.2 *The Clinical Commissioning Group as Lessor*

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

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

1.18 Private Finance Initiative Transactions

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

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

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

1.18.1 Services Received

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

1.18.2 PFI Asset

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

1.18.3 PFI Liability

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

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

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

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

1.18.4 Lifecycle Replacement

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

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

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

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

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

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

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

1.19 Inventories

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

1.20 Cash & Cash Equivalents

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

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

1.21 Provisions

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

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

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

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

1.22 Clinical Negligence Costs

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

1.23 Non-clinical Risk Pooling

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

1.24 Carbon Reduction Commitment Scheme

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

1.25 Contingencies

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

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

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

1.26 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.26.1 *Financial Assets at Fair Value Through Profit & Loss*

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

1.26.2 *Held to Maturity Assets*

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

1.26.3 *Available For Sale Financial Assets*

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

1.26.4 *Loans & Receivables*

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

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

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

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

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

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

1.27 Financial Liabilities

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

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

1.27.1 *Financial Guarantee Contract Liabilities*

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

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

1.27.2 *Financial Liabilities at Fair Value Through Profit & Loss*

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

1.27.3 *Other Financial Liabilities*

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

1.28 Value Added Tax

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

1.29 Foreign Currencies

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

1.30 Third Party Assets

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

The Clinical Commissioning Group does not hold any third party assets

1.31 Losses & Special Payments

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

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

1.32 Subsidiaries

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

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

The Clinical Commissioning Group does not have any subsidiaries

1.33 Associates

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

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

The Clinical Commissioning Group does not have any associates.

1.34 Joint Ventures

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

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

The Clinical Commissioning Group does not have any joint ventures

1.35 Joint Operations

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

The Clinical Commissioning Group does not have any joint operations.

1.36 Research & Development

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

1.37 Accounting Standards that have been Issued but have not yet been Adopted

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

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

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

2. Other Operating Revenue

	2013-14		
	Total	Admin	Programme
	£'000	£'000	£'000
Recoveries in respect of employee benefits	0	0	0
Patient transport services	0	0	0
Prescription fees and charges *1	696	0	696
Dental fees and charges	0	0	0
Education, training and research	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0
Non-patient care services to other bodies *2	156	11	145
Income generation	0	0	0
Rental revenue from finance leases	0	0	0
Rental revenue from operating leases	0	0	0
Other revenue	0	0	0
Total	852	11	841

3. Revenue

	2013-14		
	£'000	£'000	£'000
From rendering of services	841	0	841
From sale of goods	11	11	0
Total	852	11	841

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

*1 - This includes a rebate of £333k from a pharmaceutical company and prescription recharges to other organisations of £363k

*2 - This includes income of £115k from NHS England in relation to an Extensivist Project, the Mental Capacity Act and reimbursement of enhanced service charges. There is also £24k of income in relation to a post jointly funded with East Riding of Yorkshire CCG. The £11k from the sale of 'Admin' income relates to the sale of furniture from the former headquarters building.

4. Employee Benefits & Staff Numbers

4.1 Employee benefits expenditure

	2013-14				2012-13			
	Admin Permanent Employees	Admin Other	Admin Total	Permanent Programme Employees	Total Permanent Employees	Programme Other	Programme Total	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	1,601	33	1,634	101	1,702	1	102	1,736
Social security costs	151	0	151	9	160	0	9	160
Employer contributions to the NHS Pension Scheme	212	0	212	14	226	0	14	226
Other pension costs	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	1,964	33	1,997	124	2,088	1	125	2,122
Less: Recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0
Net employee benefits expenditure including capitalised costs	1,964	33	1,997	124	2,088	1	125	2,122
Less: Employee costs capitalised	0	0	0	0	0	0	0	0
Net employee benefits expenditure excluding capitalised costs	1,964	33	1,997	124	2,088	1	125	2,122

4.2 Average number of people employed

	2013-14		
	Permanent Employees	Other	Total
	Number	Number	Number
Total	38	1	39
Of the above:			
Number of whole time equivalent people engaged on capital projects	0	0	0

4.3 Staff sickness absence and ill health retirements

2013-14
Number
Total days lost 184
Total staff years 40
Average working days lost 5

4.4 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:

4.4.1 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 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015

4.4.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

4.4.3 Scheme provisions

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

- The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;
- With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as "pension commutation";
- Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;
- Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

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

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

5. Operating Expenses

	2013-14		
	Total	Admin	Programme
	£'000	£'000	£'000
Gross Employee Benefits			
Employee benefits excluding governing body members	**1,592**	**1,467**	**125**
Executive governing body members	**530**	**530**	**0**
Total gross employee benefits	**2,122**	**1,997**	**125**
Other Costs			
Services from other CCGs and NHS England *1	**5,090**	**3,258**	**1,832**
Services from foundation trusts *2	**38,753**	**0**	**38,753**
Services from other NHS trusts *3	**190,290**	**0**	**190,290**
Services from other NHS bodies *4	**404**	**0**	**404**
Purchase of healthcare from non-NHS bodies *5	**75,210**	**13**	**75,197**
Chair and Lay Membership Body and Governing Body Members	**412**	**412**	**0**
Supplies and services – clinical	**726**	**0**	**726**
Supplies and services – general	**764**	**91**	**673**
Consultancy services	**0**	**0**	**0**
Establishment	**570**	**257**	**313**
Transport	**9**	**8**	**1**
Premises *6	**4,533**	**494**	**4,039**
Impairments and reversals of receivables	**0**	**0**	**0**
Inventories written down	**0**	**0**	**0**
Depreciation	**4**	**0**	**4**
Amortisation	**0**	**0**	**0**
Impairments and reversals of property, plant and equipment	**0**	**0**	**0**
Impairments and reversals of intangible assets	**0**	**0**	**0**
Impairments and reversals of financial assets	**0**	**0**	**0**
• Assets carried at amortised cost	**0**	**0**	**0**
• Assets carried at cost	**0**	**0**	**0**
• Available for sale financial assets	**0**	**0**	**0**
Impairments and reversals of non-current assets held for sale	**0**	**0**	**0**
Impairments and reversals of investment properties	**0**	**0**	**0**
Audit fees	**98**	**98**	**0**
Other auditor's remuneration			
• Internal audit services	**84**	**84**	**0**
• Other services	**0**	**0**	**0**
General dental services and personal dental services	**0**	**0**	**0**
Prescribing costs	**47,029**	**0**	**47,029**
Pharmaceutical costs	**0**	**0**	**0**
General ophthalmic costs	**80**	**0**	**80**
GPMS/APMS *7	**1,204**	**0**	**1,204**
Other professional fees (excluding audit)	**139**	**69**	**70**
Grants to other public bodies	**0**	**0**	**0**
Clinical negligence	**0**	**0**	**0**
Research and development (excluding staff costs)	**138**	**0**	**138**
Education and training	**89**	**50**	**39**
Change in discount rate	**0**	**0**	**0**
Other expenditure *8	**113**	**-**	**113**
Total other costs	**365,739**	**4,834**	**360,905**
Total operating expenses	**367,861**	**6,831**	**361,030**

*1 - This includes £4.5M for the contract with North Yorkshire and Humber Commissioning Support Unit.

*2 - This includes £37.1M for the mental health and community services contracts with Humber NHS Foundation Trust.

*3 - This includes £177.1M for services from Hull & East Yorkshire Hospitals NHS Trust, £1M for Leeds Teaching Hospitals NHS Trust and £11.5M For Yorkshire Ambulance Services.

*4 - This relates to Community Pharmacy Minor Ailments.

*5 - This includes contracts with CHCP £26.7M, £24.8M of continuing healthcare cost, the contract with Spire Healthcare of £5.6M, £4.1M with Kingston Upon Hull City Council, £4M mental health and learning disabilities costs for out of area treatment and £1.9M of community equipment costs with NRS Healthcare.

*6 - This includes recharges from Community Health Partnerships and NHS Property Services as well as the cost of fitting out the CCG headquarters.

*7 - This includes payments to GP practices for providing local enhances services and the contract with Virgin Healthcare for providing the 'walk in' service.

*8 - This includes £73k for Catzero, £27k for a social prescribing pilot, £6.5k for the Smile Foundation and £3.5k for Building Health Partnerships.

6. Better Payment Practice Code

6.1 Measure of compliance

	2013-14 Number	£'000
Non-NHS Payables:		
Total Non-NHS trade invoices paid in the year	**9,375**	**76,806**
Total Non-NHS trade invoices paid within target	**8,800**	**73,638**
Percentage of non-NHS trade invoices paid within target	**93.87%**	**95.88%**
NHS Payables: CCG		
Total NHS trade invoices paid in the year	**1,626**	**233,103**
Total NHS trade invoices paid within target	**1,579**	**232,278**
Percentage of NHS trade invoices paid within target	**97.11%**	**99.65%**

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

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an expense

	2013-14 Land £'000	Buildings £'000	Other £'000	Total £'000
Minimum lease payments	**0**	**4,170**	**7**	**4,177**
Contingent rents	**0**	**0**	**0**	**0**
Sub-lease payments	**0**	**0**	**0**	**0**
Total CCG	**0**	**4,170**	**7**	**4,177**

7.1.2 Future Minimum Lease Payments

	2013-14 Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:				
• Not later than one year	**0**	**0**	**18**	**18**
• Between one and five years	**0**	**0**	**18**	**18**
• After five years	**0**	**0**	**0**	**0**
Total CCG	**0**	**0**	**36**	**36**

NHS Hull Clinical Commissioning Group occupies property owned and managed by Community Health Partnerships Ltd and NHS Property Services Ltd. For 2013-14, a transitional occupancy rent based on annual property cost allocations was agreed. This is reflected in Note 7.1.1.

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

8. Property, Plant & Equipment

	Land £'000	Buildings excluding Dwellings £'000	Dwellings £'000	Assets under Construction & Payments on Account £'000	Plant & Machinery £'000	Transport Equipment £'000	Information Technology £'000	Furniture & Fittings £'000	Total £'000
Cost or Valuation at 1 April 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**	**4**	**0**	**0**	**0**	**4**
Adjusted Cost or Valuation at 1 April 2013	**0**	**0**	**0**	**0**	**4**	**0**	**0**	**0**	**4**
Addition of Assets under Construction & Payments on Account				**0**					**0**
Additions purchased	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions leased	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale and reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Upward revaluation gains	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to revaluation reserve	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments charged to revaluation reserve	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfer (to) from other public sector body	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cumulative depreciation adjustment following revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cost or Valuation at 31 March 2014	**0**	**0**	**0**	**0**	**4**	**0**	**0**	**0**	**4**
Depreciation at 1 April 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale and reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Upward revaluation gains	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Charged during the year	**0**	**0**	**0**	**0**	**4**	**0**	**0**	**0**	**4**
Transfer (to) from other public sector body	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cumulative depreciation adjustment following revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Depreciation at 31 March 2014	**0**	**0**	**0**	**0**	**4**	**0**	**0**	**0**	**4**
Net Book Value at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Purchased	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Asset Financing									
Owned	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Held on finance lease	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
On-Statement of Financial Position private finance initiative & LIFT contracts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Private finance initiative residual interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation Reserve Balance for Property, Plant & Equipment									
Balance at 1 April 2013	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**	**5**	**0**	**0**	**0**	**5**
Adjusted Balance at 1 April 2013	**0**	**0**	**0**	**0**	**5**	**0**	**0**	**0**	**5**
Revaluation gains	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Release to general fund	**0**	**0**	**0**	**0**	**(5)**	**0**	**0**	**0**	**(5)**
Balance at 31 March 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

8.1 Economic lives

	CCG Minimum Life Years	Maximum Life Years
Buildings excluding dwellings	**0**	**0**
Dwellings	**0**	**0**
Plant & machinery	**0**	**0**
Transport equipment	**0**	**0**
Information technology	**0**	**0**
Furniture & fittings	**0**	**0**

9. Trade & Other Receivables

	Current 2013-14 £'000	Non-current 2013-14 £'000
NHS receivables: Revenue *1	199	0
NHS receivables: Capital	0	0
NHS prepayments and accrued income	0	0
Non-NHS receivables: Revenue *2	310	0
Non-NHS receivables: Capital	0	0
Non-NHS prepayments and accrued income *3	341	0
Provision for the impairment of receivables	0	0
VAT	77	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0
Interest receivables	0	0
Finance lease receivables	0	0
Operating lease receivables	0	0
Other receivables *4	1	0
Total	928	0

Total Current and Non-current	928
Included in NHS receivables are pre-paid pension contributions	0

*1 - This includes £119k credit note NHS Leeds Teaching Hospitals for under performance against the contract, and £40k from NHS England for Mental Act Capcity Funding.

*2 - This includes £160k from J2R, £36k from CCJSMS and £62.7k from Kingston Upon Hull City Council for drug reimbursments and £42k Humber All Nations Alliance for recovery of duplicate payment.

*3 - This includes £102k for Catzero, and £175k for City Healthcare Partnership.

*4 - This is relates to the overpayment of an employee.

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

9.1 Receivables past their due date but not impaired

	2013-14 £'000
By up to three months *1	266
By three to six months	0
By more than six months	0
Total	266

*1 - This includes £107k from J2R, £62.7k from Kingston Upon Hull City Council, £42k from Humber All Nation Alliance and £36k from CCJSMS.

NHS Hull Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2014.

10. Cash & Cash Equivalents

	2013-14 £
Balance at 1 April 2013	0
Net change in year	4,640
Balance at 31 March 2014	4,640
Made up of:	
Cash with the Government Banking Service	4,350
Cash with Commercial banks	0
Cash in hand	290
Current investments	0
Cash and cash equivalents as in Statement of Financial Position	4,640
Bank overdraft: Government Banking Service	0
Bank overdraft: Commercial banks	0
Balance at 31 March 2014	4,640
Patients' money held by the clinical commissioning group, not included above	0

11. Trade & Other Payables

	Current 2013-14 £'000
Interest payable	0
NHS payables: Revenue *1	2,543
NHS payables: Capital	0
NHS accruals and deferred income *2	1,318
Non-NHS payables: Revenue *3	5,168
Non-NHS payables: Capital	0
Non-NHS accruals and deferred income *4	9,973
Social security costs	29
VAT	0
Tax	33
Payments received on account	0
Other payables	41
Total	19,105

Total Current and Non-current	19,105
Included in Other payables are outstanding pension contributions	41

Included above are liabilities of Nil, for 0 people, due in future years under arrangements to buy out the liability for early retirement over 5 years.

*1 - This includes £1.1M Hull & East Yorkshire. £0.14M Humber NHS Foundation Trust, £0.6M for non contract activity with NHS organisations and £0.2M NHS England

*2 - This includes £1.2M for partially completed spells at Hull & East Yorkshire Hospitals NHS Trust.

*3 - This includes £0.5M for Dove House Hospice, £0.3M for East Riding of Yorkshire Council, £0.2M for Barchester Healthcare, £0.9M for CHCP, £0.7M for Kingston Upon Hull City Council.

*4 - This includes £7.2M of prescribing accruals.

12. Provisions

	Current	Non-current
	2013-14	2013-14
	£'000	£'000
Pensions relating to former directors	0	0
Pensions relating to other staff	0	0
Restructuring	0	0
Redundancy	0	0
Agenda for change	0	0
Equal pay	0	0
Legal claims	8	0
Continuing care	0	0
Other	0	0
Total	8	0

Total Current and Non-current	**8**

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them. £8k is included in the provisions of the NHS Litigation Authority as at 31 March 2014 in respect of clinical negligence liabilities of the clinical commissioning group.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £4,411k.

	Pensions Relating to Former Directors	Pensions Relating to Other Staff	Restructuring	Redundancy	Agenda for Change	Equal Pay	Legal Claims	Continuing Care	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 1 April 2013	0	0	0	0	0	0	0	0	0	0
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0	0	0	0	0	0	0
Adjusted Balance at 1 April 2013	0	0	0	0	0	0	0	0	0	0
Arising during the year	0	0	0	0	0	0	8	0	0	8
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 2014	0	0	0	0	0	0	8	0	0	8
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	8	0	0	8
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

13. Contingencies

	2013-14
	£'000
Contingent Liabilities	
Equal Pay	0
Other [NHS Litigation]	2
Amounts recoverable against contingent liabilities	0
Net Value of Contingent Liabilities	2
Contingent Assets	
Other	0
Amounts payable against contingent assets	0
Net Value of Contingent Assets	0

14. Financial Instruments

14.1 Financial risk management

International Financial Reporting Standard 7: *Financial Instrument: Disclosure* requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the clinical commissioning group's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group's internal auditors.

33.1.1 Currency risk

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

33.1.2 Interest rate risk

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

33.1.3 Credit risk

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

33.1.4 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament.

The clinical commissioning group draws down cash to cover expenditure, from NHS England, as the need arises, unrelated to its performance against resource limits. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

14.2 Financial assets

	At 'fair value through profit and loss' £'000	Loans and Receivables £'000	Available for Sale £'000	Total £'000
Embedded derivatives	0	0	0	0
Receivables:				
• NHS	0	199	0	199
• Non-NHS	0	310	0	310
Cash at bank and in hand	0	5	0	5
Other financial assets	0	1	0	1
Total at 31 March 2014	0	515	0	515

14.3 Financial liabilities

	At 'fair value through profit and loss' £'000	Other £'000	Total £'000
Embedded derivatives	0	0	0
Payables:			
• NHS	0	3,861	3,861
• Non-NHS	0	15,142	15,142
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2014	0	19,003	19,003

15. Operating Segments

NHS Hull Clinical Commissioning Group only have one segment: commissioning of healthcare services.

The perfomance of that single segment is outlined in the table below:

	Admin £'000	Programme £'000	Total £'000
Revenue Reource Limit	7,020	369,060	376,080
Income - External	11	841	852
			0
Expenditure - External	(6,831)	(361,030)	(367,861)
Total Surplus / (Deficit)	200	8,871	9,071

Expenditure relating to significant external suppliers (i.e. those who account for 10% or more of the CCG's total expenditure) includes £177.1m with Hull & East Yorkshire Hospitals NHS Trust and £37.3m with Humber NHS Foundation Trust.

16. Intra-Government & Other Balances

	Current Receivables £'000	Non-current Receivables £'000	Current Payables £'000	Non-current Payables £'000
Balances with:				
• Other Central Government bodies	0	0	103	0
• Local Authorities	67	0	0	0
• NHS bodies outside the Departmental Group	73	0	441	0
• NHS Trusts and Foundation Trusts	126	0	3,420	0
• Public Corporations and Trading Funds	0	0	0	0
• Bodies external to Government	662	0	15,141	0
Total at 31 March 2014	928	0	19,105	0

17. Related Party Transactions

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department.

- NHS England (including NHS North Yorkshire and Humber CSU)
- NHS Greater Huddersfield CCG
- NHS Foundation Trusts;
  - Humber NHS Foundation Trust
  - Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
  - Sheffield Teaching Hospitals NHS Foundation Trust
  - York Teaching Hospital NHS Foundation Trust
- NHS Trusts;
  - Hull and East Yorkshire Hospitals NHS Trust
  - Leeds Teaching Hospitals NHS Trust
  - Yorkshire Ambulance Service NHS Trust
- NHS Litigation Authority; and,
- NHS Business Services Authority.
- NHS Property Services Limited

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with :

Kingston Upon Hull City Council
East Riding of Yorkshire Council
HM Revenue and Customs

17. Related Party Transactions 2013-14 - Continued

The compensation paid to CCG Representatives is disclosed in Note 4, "Employee Benefits" within the Annual Accounts and within the Remuneration Report which is published as part of the Annual Report.

The transactions noted below are between NHS Hull CCG and the stated organisation and have been conducted during the normal cause of trading, no guarantees or provisions for irrecoverable balances have been made.

	Payments to Related Parties £000's	Receipts from Related Party £000's	Amounts owed to Related Party £000's	Amounts due from Related Party £000's
Dr Dan Roper - GP Member of the Clinical Commissioning Group Board (to Aug 13) Chair of Clinical Commissioning Group Board (from Aug 2013)				
GP Partner at Springhead Medical Centre	47	-	-	-
Dr James Moult - GP Member of the Clinical Commissioning Group Board				
Faith House Surgery – Partner (GP)	24	-	-	-
Leen Witvliet - GP Member of the Clinical Commissioning Group Board				
Dr Witvliet is a GP in Hull	7	-	-	-
Raghu Raghunath - GP Member of the Clinical Commissioning Group Board				
A partner at Dr Raghunath and Partners	7	-	-	-
A partner at Dr Ghosh, Raghunath and Partners	12	-	-	-
A partner at Dr Macphie, Raghunath and Partners	13	-	-	-
Membership of a Partnership at St Andrews Group Practices (Elliott Chapel, Newington Health Centre and Northpoint)	27	-	-	-
St Andrews have become partners with Dr Venugopal at Bransholme from 3rd February 2014	5	-	-	-
Dr Vince Rawcliffe - GP Member of the Clinical Commissioning Group Board				
Partner of New Hall Surgery	30	-	-	-
Dr Tony Banerjee - Chair of Clinical Commissioning Group Board (to Aug 2013)				
Partner of Dr Weir and Partners	28	-	-	-
Emma Latimer - Chief Officer				
Trustee of CatZero with the Charities Commission	175	-	-	-
Jason Stamp - Lay member of the Clinical Commissioning Group Board				
Employed as a Project Manager within North Bank Forum which is a voluntary and community sector infrastructure organisation.	81	-	-	-
Joy Dodson - Head of Business Intelligence				
Honorary treasurer (to 30th November 13) of Cruse Bereavement Care Hull and East Riding Area and Father is the Chair of the same organisatior	12	-	-	-

18. Events After the Reporting Period

There are no post balance sheet events which will have a material effect on the financial statements of NHS Hull Clinical Commissioning Group.

19. Losses & Special Payments

NHS Hull Clinical Commissioning Group had no losses and special payments cases during 2013-14.

20. Financial Performance Duties

Clinical commissioning groups have a number of financial duties under the National Health Service Act 2006 (as amended).

NHS Hull Clinical Commissioning Group's performance against those duties was as follows:

National Health Service Act Section	Duty	2013-14 Maximum £'000	2013-14 Performance £'000	Duty Achieved ?
223H(1)	Expenditure not to exceed income	**376,932**	**367,861**	**Yes**
223I(2)	Capital resource use does not exceed the amount specified in Directions	**0**	**0**	**Yes**
223I(3)	Revenue resource use does not exceed the amount specified in Directions	**376,080**	**367,009**	**Yes**
223J(1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	**Yes**
223J(2)	Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	**Yes**
223J(3)	Revenue administration resource use does not exceed the amount specified in Directions	**7,020**	**6,820**	**Yes**

Note: For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

21. Impact of IFRS

Accounting under IFRS had no impact on the results of NHS Hull Clinical Commissioning Group during the 2013-14 financial year.

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