annual report

creating a healthier

Annual Report and Accounts **2014-15**

Creating a healthier Hull

Hull Clinical Commissioning Group

Foreword

from the CCG Chair & Chief Officer

Welcome to the Annual Report and financial accounts of NHS Hull Clinical Commissioning Group (CCG) for 2014-15.

Our report presents an overview of our performance and work programmes over the past year, and the wider environment that shapes our work and priorities as an organisation.

We know that there continues to be a significant challenge ahead to deliver our vision of creating a healthier Hull. Poor health is often closely linked to poverty, housing, educational attainment, employment and social isolation, and these factors must also be addressed if we hope to achieve a better future for people in the city.

There are, however, real opportunities for health to have a major role in the city's regeneration. The excitement of being the UK City of Culture in 2017 is bringing communities together, providing a once in a generation opportunity to change the city's future and help people live more healthy and fulfilled lives. We very much want to play an integral part in this.

The publication of the NHS Five Year Forward View has been well received. With no national blueprint set out for CCGs, it presents an opportunity to be truly transformational and to work differently. This reaffirms the Hull 2020 programme vision for services that meet the needs of the individual.

Our passion for improving health and wellbeing in the city has been recognised through our shortlisting for a number of national and regional awards this year. We were a finalist in for Health Service Journal's CCG of the Year, and were delighted to be named NHS Board/Governing Body of the Year in the Yorkshire and Humber NHS Leadership awards.

Whilst the Board provides the leadership and sets the direction, this award was a tribute to the dedication of staff, clinicians and our Hull 2020 partners to improving health services for people in this city.

The Healthcare Financial Management Association (HFMA) Efficiency and Innovation Award for 2014-15 was presented to the CCG team behind the procurement of the new psychological therapy service for Hull, for its unique approach to developing the service specification.

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 would like to extend our sincere thanks to our members, staff and partners across the city, which have helped us deliver another productive, challenging and very rewarding year in health care.

Dr Dan Roper
CCG Chair

Emma Latimer
CCG Chief Officer

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NHS Hull CCG Annual Accounts 89

1. Foreword
from the Chair of NHS Hull CCG Council of Members

NHS Hull CCG's membership of 57 local GP practices has continued to work collaboratively and effectively during the last twelve months. We realise we have a strong role to play in helping to overcome challenges in the national and local healthcare system by our continuing involvement in the development and delivery of the CCG's strategic and operational plans.

The CCG's Council of Members has continued to meet bi-monthly over the year. The number of practices represented varies and there are a number of regular attendees covering more than one practice, reflecting practice mergers.

The CCG's Constitution has undergone a process of revision during 2014-15 to ensure that the CCG's governance arrangements align with the organisation, and that it remains fit for purpose.

Newly commissioned and re-commissioned services have been contributed to and approved by the Council of Members.

As a Council we have worked hard to be inclusive of our partners who deliver elements of healthcare in Hull. To this end many commissioned and non-commissioned service providers have presented at our meetings.

We have ensured that a good proportion of time at the Council of Members meetings is allocated to active discussion around a range of issues of interest to our member practices.

The co-commissioning of primary care has been considered by the Council of Members on more than one occasion. The members are cognisant of the importance of conflicts of interest. This is high on our agenda at all meetings and at the forefront of our minds in decision-making.

Dr. Vince Rawcliffe
Chair, NHS Hull CCG Council of Members

2. strategic report 2014-15

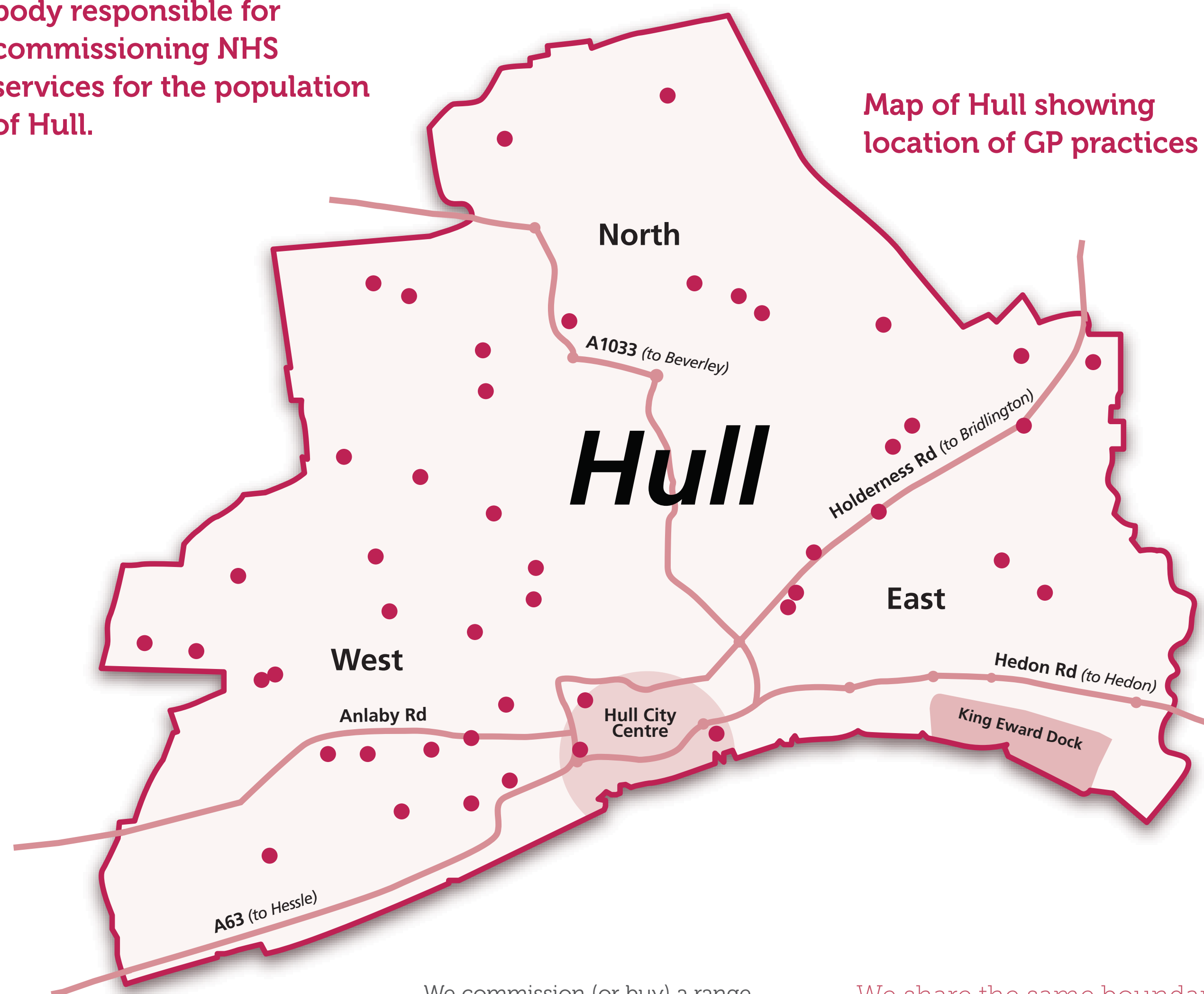
creating a healthier Hull

Get to know
your local CCG

NHS Hull Clinical Commissioning Group (CCG) was established under the Health and Social Care Act 2012. It is the statutory NHS body responsible for commissioning NHS services for the population of Hull.

NHS Hull CCG is 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 290,442 across 23 wards. We had an allocated budget of £380 million for 2014-15, 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.

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.

NHS Hull CCG Board 2014-15

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

We also work with Healthwatch Hull, the independent champion for local people who use health and social care services. Healthwatch Hull has powers to strengthen the patient and public voice in local services and they also provide information and signposting about local services. A representative of Healthwatch Hull 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 via the details below or visit our website: **www.hullccg.nhs.uk**

You can contact 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**

Facebook: Search **'NHS Hull CCG'**

The accounts for the year ended 31 March 2015 have been prepared by the NHS Hull CCG 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.

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

Our **plans, priorities** and **progress**

The CCG's Operational Plan for 2015-16 highlights specific programmes of work and how these are being implemented in line with the recommendations within the NHS Five Year Forward View.

The comprehensive refresh of the CCG's Strategic Plan 2014 - 2020 responds to and has been informed by more recent national NHS policy and guidance. In particular:

- the Five Year Forward View
- the NHS Constitution
- the implementation of the Better Care Plan for Hull
- the 'Commissioning for Value' data pack;
- the Health and Wellbeing Strategy 2013-2016; and
- the introduction of new models for primary care (co-commissioning)

The Operational Plan 2015-16 outlines the organisation's commitment to continue to improve health outcomes and the quality of health and care services for our population within the resources available to us. The associated programmes include Hull 2020, Hull's Better Care Plan and preparation for primary care co commissioning.

Themes within the NHS Five Year Forward View include:

- establishing a new relationship with patients and public: prevention and self- management;
- an outline of seven models for service provision - NHS England will work with local areas to work out what is right for them
- setting out what the NHS needs to do to be fit for the future; and
- a £30bn national funding gap which cannot be closed without more funding, alongside further action on demand and efficiency.

The CCG's Strategic Plan 2014-2020 and Operational Plan 2015-16 are available at **www.hullccg.nhs.uk.** The Five Year Forward View can be found at **www.england.nhs.uk.**

The Operational Plan 2015-16 outlines the organisation's **commitment** to continue to **improve health outcomes** and the **quality of health** and care services

Our strategic **health priorities**:

- **Developing 21st century primary (GP) care**
- **Integration**
- **Next generation healthcare**

Developing 21st century primary care

Primary care co-commissioning

Primary care co-commissioning, which commenced from 1 April 2015, is one of a series of key changes set out in the NHS Five Year Forward View.

In response to the NHS England invitation for expressions of interest, NHS Hull CCG submitted a proposal to work with them to jointly commission and ultimately take delegated responsibility for the commissioning of GP primary care services. This is seen as vital to enabling the CCG to realise its ambitions for the development of new models of primary care, and ensuring the future sustainability of primary care services in Hull in the context of rising demand and needs. The CCG's proposal has been approved and a new Primary Care Joint Commissioning Committee has been established and has started to meet.

Integration

Better Care in Hull and Hull Integrated Care Centre

The vision for Better Care in Hull is *"People in Hull will expect better care and better care will be organised around them."*

Better Care in Hull's aspiration is that local health and social care services will change significantly over the next five years. Health and social care organisational boundaries will be broken down to ensure that care is coordinated across different care settings. (Find out more about Better Care in Hull on page 37)

The CCG is working with Hull City Council and other partners to develop a new Integrated Care Centre, which will deliver specialist care, better management of long term health conditions and services for frail, elderly patients across Hull. (Find out more about this on page 23)

Next generation

The Children and Young People's Mental Health and Wellbeing Strategy is supported by an action plan that will ensure that the required changes are implemented. You can read the strategy at **www.hullccg.nhs.uk**

Promoting health and emotional wellbeing

As part of the Strategy, a new model has been launched this year for Child and Adolescent Mental Health Services (CAMHS). The model identifies how all statutory agencies are required to work together to ensure that the holistic mental health and wellbeing needs of children and young people are met.

Visit **www.humber.nhs.uk** for more information.

The CCG in collaboration with Hull City Council and voluntary sector partners is also delivering HeadStart Hull. This is a Big Lottery funded project to improve resilience and emotional wellbeing in children and young people aged 10-14 (Find out more about this on page 28)

Continued engagement with young people is vital so that we understand their needs and can respond appropriately.

CCG progress against the Strategic Plan during 2014-15

Unplanned care

The CCG, through the Hull and East Riding System Resilience Group (SRG), continues to concentrate efforts on supporting and seeking assurance from Hull and East Yorkshire Hospitals NHS Trust to achieve and sustain delivery of the A&E 4 hour wait standard. A number of initiatives have been developed that will be taken forward for completion in 2015-16:

- provision of an Ambulatory Care Unit and Frailty Unit with community services on the Hull Royal Infirmary (HRI) site;
- development of respiratory and circulatory pathways across primary, community and acute care;
- an integrated model for GP led primary care in the Emergency Department.

Improving patient experience for frail and elderly patients

A new medical admission unit opened in December 2014 on the HRI site with the aim to reduce the waiting times for patients, avoid inappropriate attendances to the Emergency Department and improve patient experience.

The purpose-built facility can accommodate 35 patients in a comfortable environment where they have tests and are kept under observation by the hospital's clinical team. Patients admitted to the unit are expected to be managed on a day case basis and only admitted to an inpatient ward if it is clinically appropriate. The new unit appears to be working well, seeing and treating an average of 30 patients per weekday and between 10 and 15 on Saturdays and Sundays. These are patients who would otherwise have been admitted to hospital, and the average length of stay is four hours against a usual length of six hours.

The Elderly Assessment Unit (EAU) opened in April 2015, fast-tracking frail and elderly patients for assessment by a multi-disciplinary team including community and social care teams, therapies and pharmacy. Patients access the unit through direct GP referral or via nurse triage in the Emergency Department.

(pictured above)

Planned care

Hull's strategic ambition is to reduce planned activity on the HRI and Castle Hill sites by 25% by 2020. The purpose of the planned interventions programme is to achieve transformation and service redesign across elective care that will deliver improvement in choice and access, higher quality and more cost effective care.

The CCG is working jointly with East Riding of Yorkshire CCG to deliver a planned care programme. The main objective is to ensure that these services are provided in settings that are as local to patients as possible and outside of a hospital whenever clinically appropriate and safe.

PSA monitoring closer to home

Six GP practices in Hull are part of a new scheme to offer patients with locally advanced prostate cancer who are stable on treatment, a Prostate Specific Antigen (PSA) monitoring service closer to home.

New computer software installed in practices enables these patients to be managed and followed up by their own GP rather than a hospital based consultant. The software works in conjunction with the GP's existing clinical systems and monitors PSA levels, symptoms and side effects of treatment - giving the GP and practice nurse clear advice and guidance on the patient management pathway.

Vulnerable people

The CCG has an on-going programme of initiatives to develop and support local mental health and learning disability services which include:

Let's Talk

In 2014 the CCG procured a new psychological therapy service, this has now been mobilised across the city and will be monitored and evaluated for the expected outcomes in 2015-16. Known as "Let's Talk", the new service is designed to significantly improve access times and choice of location and therapist.

The innovative approach taken towards developing the new service was successful in winning an Efficiency and Innovation Award, and early patient feedback is indicating that access to the new service is much improved.

Autism

The development of a city wide strategy and care pathway for Children, Young People and Adults with Autistic Spectrum Disorders (ASD) is underway. The strategy will cover the period 2015 to 2020.

The CCG acknowledges that waiting times for autism for assessment and diagnosis are too long and it is working with providers to reduce this. Significant progress has been made even as demand for the service has rapidly increased, rising from 114 referrals in 2013 to 301 in 2014. Local health and children's services are giving children access to some specialised services to support families that have previously only been available after diagnosis. These improvements must continue so that children in Hull receive an assessment and diagnosis within the 20 week target.

Learning disabilities

The ambitions for better outcomes for mental health care are extended to learning disability services. The CCG will continue to work closely with the local authority to implement the recommendations of the learning disability review which commenced in 2014, and ensure a range of services are available across the city for people with complex care needs. The CCG undertakes robust contract management with all of its commissioned services. This includes holding providers to account for their response to the Recommendations of the Winterbourne View – Time for Change report (2014) relating to patients with learning disabilities who currently reside in out of area placements. We will continue to develop community alternatives closer to home in order to support the return of the majority of people with a learning disability to local service provision based on their individual assessed need.

Dementia

There are many groups across Hull working to make Hull a **"dementia-friendly city"** including the Dementia Academy, the Dementia Action Alliance, and the Dementia Programme Board at Hull and East Yorkshire Hospitals. One of the key challenges is to avoid duplication and ensure actions are prioritised to provide the best service improvement for people with dementia and their carers.

A new dementia partnership group established in March 2015 brought together the key dementia decision-makers from across the city, with the aim of supporting partners to integrate with the Better Care in Hull and the Hull 2020 transformation programme.

New primary care lead for dementia

Dr Angharad 'Hari' Symes has been appointed as Primary Care Lead for Dementia in Hull. Her particular focus is on improving links between primary and secondary care and how they can work in a much more integrated way. This includes promoting increased use of the Dementia Audit Toolkit that has been developed to support the implementation of NICE guidelines for the treatment and care of people with dementia.

"I love working with older people. It can be overwhelming and frightening to receive a diagnosis of dementia and there is a lot more that can be done within the health community to improve patient experiences in dementia health care. We are looking at different models around the country and we want to find out what works best for Hull. We want to listen to the experiences of GPs and other clinicians in Hull and use this insight towards improving timely diagnosis of dementia."

Dr Angharad 'Hari' Symes

Commissioning safe, high quality care

NHS Hull CCG has strong systems in place to encourage open and transparent reporting of incidents and concerns. A number of mechanisms have been and will continue to be used to hold providers of health services to account for incidents of harm within their organisation.

The CCG regularly monitors information and data on:

- incident rates (locally and nationally);
- serious incidents; and
- patient complaints, concerns and patient experience (such as the Friends and Family Test).

All of NHS Hull CCG's main providers are required to report against their analysis of key reports, including the Winterbourne Report, the second Francis Report and the Berwick Report, and provide action plans/ strategies to address them. This work is being taken forward in 2015-16 as part of regular and robust contract management.

Putting Patients First

The Putting Patients First Board was launched in 2014 from the local stakeholder group established following the publication of the second Francis Report in 2013. During 2014-15 NHS Hull CCG and NHS East Riding of Yorkshire CCG have worked collaboratively with local health care providers to help ensure that improved quality of care and patient experience is embedded across all services.

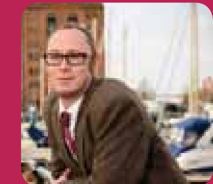
The **Putting Patients First** event in July 2014 was attended by 89 members of the public representing a cross section of the local population of Hull and the East Riding of Yorkshire. The event was designed to share the principles and good practices gathered by the three Putting Patients First working groups:

- The **Duty of Candour Group** looked at how local health organisations could ensure that they are open and honest with patients and carers, the public and with each other when things go wrong. This included a Duty of Candour Protocol being developed and adopted by all organisations.
- The **Complaints Group** reviewed the way each organisation handles their complaints internally and how the process works when a complaint involved more than one health organisation. It agreed best practice principles for investigating and learning from complaints.
- The final group explored how to strengthen the **Role of Staff in Patient Experience.** This included how to ensure that staff recruitment is based around the values of the NHS, how to share and learn from best practice and how to make it easier for all patients, including children, to provide feedback on their experiences.

"Events like Putting Patients First are very important. It is a good way of communicating between patients and the NHS. There is a big need for change and I hope that reform will take place. The reform should come from the peoples' experience." **Hull patient**

"All partners have shared a commitment to continuing and developing this approach because it is the right thing to do, and not just as a result of the Francis Report and its recommendations."
Sarah Smyth, Director of Quality and Clinical Governance, NHS Hull CCG

The Putting Patients First Board will continue to monitor full implementation of the recommendations and hold each organisation to account for the delivery of the outcomes.



"A large part of my role is to speak on behalf of patients and the public around the health issues in Hull which matter to them. This includes encouraging people to make complaints and speak openly around their experiences of the NHS.

All patients have a right to be treated with dignity and respect. When people are in great need, attending our services or receiving emergency care, we want them to feel that they have been involved in the decisions made about their care and that the health professionals have been open and honest with them.

"I actively encourage anyone who feels they have not received this type of treatment to make a complaint; this way we can ensure services are improved for patients"
Jason Stamp, CCG Board lead for Patient and Public Involvement

CCG Signs up to Safety

NHS Hull CCG has demonstrated its full commitment to patient safety by backing the national Sign up to Safety campaign. The campaign aims to make the NHS the safest healthcare system in the world. The ambition is to halve avoidable harm in the NHS over the next three years and save 6,000 lives as a result.

By signing up to the campaign organisations commit to listening to patients, carers and staff, learning from what they say when things go wrong and taking action to improve patient safety by helping to ensure patients get harm free care every time, everywhere. For further information please visit **www.hullccg.nhs.uk**

Quarterly patient experience monitoring

A quarterly patient experience report monitors performance using the friends and family test. This is then compared alongside other experience information, both local and national, to help inform the work of the CCG.

In 2014-15 there was a refinement of the patient experience report ensuring that all sources of information, data and other forms of intelligence are considered including the development of an 'at a glance' dashboard to support the interpretation of reports. This will be evaluated in 2015.

Safeguarding

The CCG has a robust Safeguarding Strategy and action plan and a Safeguarding Policy which includes key performance indicators (KPIs) included in provider contracts for 2015-16. The CCG will continually review its safeguarding arrangements.

The national counter-terrorism **prevent** programme features as a KPI within provider contracts which the CCG currently monitors, and there are plans to implement an internal training programme during 2015-16.

All **mental health and learning disability** patient placements and packages of care are reviewed to ensure the patient is supported in the least restrictive environment. The Mental Health Act is applied only when people with a 'mental disorder' are clinically assessed as needing to be admitted to hospital, detained and treated without their consent – either for their own health and safety or for the protection of other people.

The CCG supports **Not in Our Community,** the campaign to raise awareness about the sexual exploitation of young people. See page 30 for more.

Hull in numbers

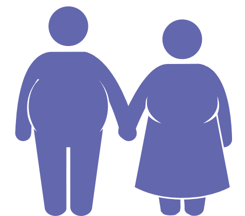
57 GP practices

£380m Budget

Almost 1 in 5 mothers remain smokers at the time of their baby's delivery

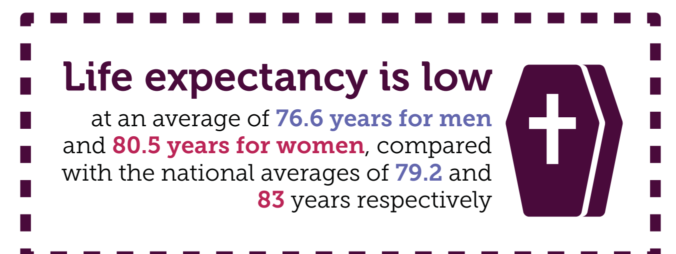
290,000 Patient population

One third of adults across the city smoke



70% men and 61% women are overweight or obese

More than 2000 alcohol related admissions to hospital each year



Life expectancy is low at an average of **76.6 years for men** and **80.5 years for women**, compared with the national averages of **79.2** and **83** years respectively

Working to address health inequalities

The health challenges in Hull are well known and long standing. Hull is ranked as the 10th most deprived local authority out of 326. Hull's Black and Minority Ethnic (BME) population is estimated to have risen fast, from 8,500 in the 2001 census to 28,700 by 2009. Hull is an area with marked health inequalities. For example:

- one third of adults across the city smoke. Almost 1 in 5 mothers remain smokers at the time of their baby's delivery;
- 70% men and 61% women are overweight or obese;
- 1 in 10 children in reception year are obese;
- there are more than 2000 alcohol related admissions to hospital each year; and
- life expectancy is low, at an average of 76.6 years for men and 80.5 years for women, compared with the national averages of 79.2 and 83 years respectively

We are very aware that despite significant efforts to tackle lifestyle and health outcome disparities, there remains a ten year life expectancy gap between two of our wards (St Andrews and Beverley) . Groups who have a higher risk of a worse outcome are people who are homeless, people who live in poverty, people who are long-term unemployed, people in stigmatised occupations (such as women and men involved in prostitution) and people who misuse drugs.

The CCG will continue to work closely with Hull City Council through the Health and Wellbeing Board Public Health team to address health inequalities and plan for improved health outcomes through the Hull Health and Wellbeing Board strategy, Hull 2020 and the Better Care Fund. Public Health and CCG colleagues work in collaboration to ensure the need to address health inequalities is embedded within local strategies.

The introduction of Community Hubs is focused on ensuring that those with the worst health outcomes have equitable access to a broad range of health and wellbeing services.

We will be working with partners in public health, police and other public sector services to ensure that more is done to tackle the social challenges that form the wider determinants of health problems. (see page 35 for more information)

Public Health England (PHE) data is regularly shared to provide an evidence base for the development of local health services. Smoking cessation, substance and alcohol abuse, obesity and violent crime are amongst other issues that are far more prevalent in some parts of the city than others and we are committed to working with our partners to better understand the root cause of these embedded life choices and behaviours, and to tackle them. A particular focus will be on building a sense of aspiration in children and young people that will equip them to avoid these unhealthy behaviours, be emotionally resilient and make better health choices in the future.

Inspiring a smokefree generation - Hull CCG pledges NHS support to Local Government Declaration on Tobacco Control

Early 2016 will see the first pilot Community Hub in place in the Riverside Ward of the City and a full evaluation completed to inform the rollout of the Community Hub model across the City.

Hull - Healthier Together

Joint Health and Wellbeing Strategy 2014-2020

Hull – Healthier Together seeks to tackle health inequalities and improve health and wellbeing. It has been developed by taking account of our assets, our challenges, The City Plan, Hull 2020 and the Joint Strategic Needs Assessment (JSNA).

The strategy cannot be delivered without the commitment of everyone who lives or works in Hull and cares about its future. The strategy sets out how we can work together to reduce health inequalities and improve people's health. It describes where we want to get to and how we will do it. The Health and Wellbeing Strategy for 2014- 2020 is available at **www.hullccg.nhs.uk**

"Working together we can succeed in making Hull a better place to live for longer"

How our money is spent

Hospitals
£183.1m
49.5% of budget

Prescribing / Drugs
£49.1m
13.3% of budget

Community Services
£47.6m
12.9% of budget

Mental Health
£35.5m
9.6% of budget

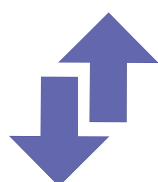
Continuing Healthcare
£29.4m
7.9% of budget

Ambulances
£11.6m
3.1% of budget

Running Costs
£7.0m
1.9% of budget

Primary Care
£2.8m
0.8% of budget

Property Charges
£2.1m
0.6% of budget


Other
£1.9m
0.5% of budget

Surplus
£9.9m
2.7% of budget

Grand total: £380.00m

Image courtesy of Hull Daily Mail

Involving local people and partners

NHS Hull CCG is committed to involving people in decision making, and seeks to engage people in honest on-going conversations. This means we can really understand their problems and the issues they face in their day to day lives and how, working in partnership with others, we can support them to be the best they can be.

The CCG needs to ensure that:

- the public, staff and stakeholders receive understandable, timely information in a manner appropriate for them;
- we listen to, act upon and respond to patient and carer feedback at all times;
- we engage with patients, carers and the public through our commissioning processes and demonstrate how this has informed our decisions;
- we work with people, either on an individual or collective basis, to find solutions to problems; and
- we publish annual evidence of what 'patient and public voice' activity has been conducted and how this has helped shape our plans.

Our Communications and Engagement Strategy provides a framework for all our communication and engagement activities over the next three years. You can read more about our aims, key objectives for communications and engagement and our approach to delivery at **www.hullccg.nhs.uk**

Here are some examples of the way we involved our stakeholders and communities to enhance the delivery of CCG programmes and projects in 2014-15:

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 from around 5,000 people on issues that affect the health and wellbeing of the city. The panel provides a real opportunity for local residents to comment and contribute to the development of public services in Hull.

Throughout the year People's Panel members have responded to quarterly questionnaires that focused on their general experiences of health services, their experiences of raising concerns and complaints and their views about out of hours and emergency care. The results of panel surveys have been used to inform more in depth engagement work such as the Integrated Care Centre public consultation, the re-procurement of Community Services and plans to commission a central 'one stop shop' for health and social care complaints.

The outcome of the surveys are published on our website www.hullccg.nhs.uk
You can join the panel:
Call: 01482 300300
Text: 'panel' to 07795 563000
Email: panel@hullcc.gov.uk

Supporting **older people**

Celebrating older people - The CCG is an active member of the Older People's Partnership, and for the second consecutive year has supported the Older People's Celebration Event in October 2014. This week-long series of activities and events celebrates and showcases the contributions that older people are making to our local community and the positive impact that cultural activities can have on health and wellbeing.

During the week, the CCG's engagement team spoke to over 100 older people to gain their views on options for providing care and support for people with long term conditions and those requiring rehabilitation or extra support following a period of ill health. This work formed part of the pre engagement work for the Integrated Care Centre consultation and built upon feedback previously gained in other engagement activity earlier in the year.

Dementia awareness training - the CCG is a partner in the Hull Dementia Academy and, as such, is committed to raising dementia awareness across all sections of communities. As part of this commitment the engagement team has supported the training of 74 people in dementia awareness; including CCG staff, Ambassadors and members of GP Practices' Patient Participation Groups. In addition, one of the CCG's Ambassadors has now joined the Dementia Academy and is being trained to deliver dementia awareness sessions to local businesses, service providers and community groups.

Dementia awareness training

Youth **engagement**

Rock Challenge

Humberside Police's Rock Challenge provides the CCG with a unique opportunity to engage with a number of primary and secondary school children across Hull as part of their experience. In 2014, we attended three Rock Challenge events in the city and were able to engage with around 2000 children and young people through our CCG led Health Fair. This allowed us to reach a captive audience and deliver appropriate health messages; such as information around oral health, the importance of exercise and the dangers of smoking.

Participation in this event has had some really positive impacts on the health of the young people involved. Of the respondents:

- 10% reported they smoked before becoming involved in the event, 75% of those have since stopped smoking or reduced the amount they smoke;
- 15% reported they drank alcohol before becoming involved in the event. Of those, 70% have stopped or reduced their alcohol intake since;
- 96% felt their self-esteem had improved and 91% felt the same of their teamwork skills;
- 19% said they had played truant from school before, of those 66% have stopped playing truant due to their involvement in the Rock Challenge;
- 83% reported they enjoy school more since becoming involved in the event; and
- 74% also reported they have better relationships with their teachers following their involvement.

(source: Humberside Police)

During 2015 the CCG will build upon its involvement in Humberside Police's Youth Engagement activity and will also be supporting Night Challenge and the Lifestyle programme, as well as continuing its support for Rock Challenge.

Listening to children with continuing and complex health needs
The CCG and Hull City Council are undertaking a review of services for children and young people with continuing care and complex needs in the city. As part of the review the local charity KIDS Yorkshire and the Humber was asked to undertake a targeted engagement exercise with children with continuing and complex health needs, their parents and carers and the health and care professionals working with them.

Questionnaires, one to one interviews and focus groups sought the views of past, current and potential future users of short break facilities and those who fit the criteria for continuing care funding, accessing additional support and services within the home or short break settings. The findings of this engagement will be used by the CCG and the council to plan future service development and provision.

In addition to this specific engagement, KIDS Yorkshire and the Humber is the CCG's engagement partner for work with children with special educational needs and, as such, provides support with ongoing work.

Bridging primary and secondary care

In January 2015 NHS Hull and East Riding of Yorkshire CCGs jointly hosted 'Bridging Primary and Secondary Care' a learning event attended by more than 200 GPs, secondary care (hospital) doctors and consultants.

The event sought to encourage open and productive dialogue between primary and secondary care clinicians and focused specifically on radiology, ENT, orthopaedics, urology, upper and lower Gastro Intestinal pathways, supporting the CCG's 'Productive Elective Care' work stream. A further event presenting different clinical pathways is planned for October 2015.

Patient experience to help shape new Community Services contract

During 2015 the CCG will be undertaking its largest service re-procurement - the £100 million contract to deliver Community Services for Hull. Patient feedback and targeted engagement work have been fundamental in helping to develop new service specifications for the three defined care groups; Urgent Care, Integrated Sexual Health Services and Integrated Community Care Services. Over the past 12 months the CCG has used its existing engagement channels such as the People's Panel and our scheduled programme of listening events to seek out public views on elements of services in the scope of this procurement.

Based on these findings, service specific questionnaires were distributed to all users of current services over a four week period in February and March 2015. In addition two focus groups were held looking specifically at long term conditions management, how patients currently access these services and what people's expectations and priorities for these services were. All of the findings from the engagement work have been consolidated into a comprehensive Patient Information Data Pack, which has formed part of the tender documentation given to all potential providers. This will ensure that patient experience and public feedback is at the heart of any proposed service delivery models and that patient engagement will be an ongoing expectation of any new provider as they start to develop new models of care prior to the start of new services in April 2016.

Hull Integrated Care Centre Public Consultation

In January 2015 the CCG launched its first formal 12 week public consultation on its plans for a new Integrated Care Centre to be built in the east of the city. This full consultation was preceded by other engagement work which included People's Panel surveys, questionnaires undertaken at supermarkets, libraries etc. and some targeted discussion groups with potential users of the new facility.

As part of the full consultation, the team undertook more in-depth focus groups, public meetings, roadshows and meetings with residents living near to the proposed site. During the consultation period contact was made with over 1,700 people and over 700 completed the consultation questionnaire. Information shared via both traditional and social media reached approximately 320,000 people. Many people expressed an interest in continuing to be involved throughout the development period.

All the consultation findings will be collated into a full feedback report which will be made public in the summer of 2015 (available at **www.hullccg.nhs.uk** or on request by calling **01482 344700**)

> Patient feedback and targeted engagement work have been fundamental in helping to develop new service

Hull Ambassadors

NHS Hull CCG's Ambassadors are a group of trained volunteers who support the CCG in undertaking public engagement activity. The Ambassadors act as a liaison point for feeding information from the communities they represent into the CCG and out from the CCG to the local population.

The locally recruited Ambassador team is currently 28 strong, representing people from all walks of life; many are active community leaders and others provide a vital link with other voluntary and community groups with which they are involved. During the past year Ambassadors have undertaken a great deal of valuable work including:

- conducting patient surveys to support the planning of new services;
- contributing to the development of service specifications;
- evaluation of tenders when procuring new services; and
- supporting at the CCG's Annual General Meeting and other public events.

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

Enosh Siraj and Matt Leathwood joined our Hull Ambassador team in 2014

Enosh Siraj is applying to study medicine. ***"I have a biomedical science degree so I have quite a bit of clinical knowledge, but being an Ambassador has helped me understand what goes on 'behind the scenes' in terms of commissioning new health services. Recently I've been supporting the consultation for the new Integrated Care Centre in Hull, which has meant discussing the CCG's plans with a range of different groups across the city to make sure the new facility has the right services in place when it is built.***

"I'm very interested in encouraging more young people in Hull to go for a career in medicine or healthcare. I will be working with the CCG's Associate Medical Director to create programmes to help students get access to the right type of work experience on the path towards becoming clinicians."

Matt Leathwood said ***"I find the Ambassador role very rewarding as it represents a genuine opportunity to get involved in evaluating services and shaping future health care delivery. My main interest is in mental health and, in particular, social prescribing which is about linking people up to non-medical support in the community that they might benefit from. Being an ambassador has enhanced my knowledge and participation in all things NHS."***

Hull CCG Health Fair September 2014

Hull CCG Health Fair September 2014

Healthier Hull Community Fund update

Last year we launched the Healthier Hull Community Fund to help local groups find their own ways to improve health in their community. This year we revisited some of the groups to see how they were making a difference to people. We made a short video that highlights the work of just three of the 79 local community groups awarded funding - JC Ready4Work's Project CREAM (Calories Rule Everything Around Me) which offered an intensive fitness, health and confidence building programme within west Hull, Longhill Link Up Trust's Older Peoples' Lunch Club and Hull Scorpions Baseball Team.

79 projects - £360,000 awarded - reaching an estimated 22,500 people in Hull!

View the video by searching *'Healthier Hull Community Fund'* on Facebook.

Working with diverse communities

The CCG continues to work with Humber All Nations Alliance (HANA), Hull Refugee Council and other groups and organisations working to support Hull's diverse communities. The engagement team regularly attends meetings and events to ensure that views of BME and diverse communities are pro-actively sought. The CCG is also an active member of the Older People's Partnership Group and the Independent Advisory Group (formerly DIAG) facilitated via Humberside Police, which has representation from a wide range of diverse groups.

The recent public consultation included seven facilitated and translated discussions with BME groups and details of the consultation document and an online questionnaire were published on the HANA website, *www.hanaonline.co.uk*, which allows for automatic translation into 67 languages. Work was also undertaken with HERIB (Hull and East Riding Institute for the Blind) to capture the views of blind and partially sighted people and also with Age UK.

The CCG's main public facing leaflet "How to get the most from your local Health Services" is published in the five most needed languages. As well as all the traditional distribution outlets for this leaflet, the CCG has recently targeted supermarkets and retail outlets regularly used by immigrants to the UK and migrant workers, with initial feedback indicating that these were well received.

Building Health Partnerships

The CCG has developed a local Building Health Partnerships (BHP) forum which brings together local voluntary, community and social enterprise sector (VCSE) organisations and representatives from the CCG and Hull City Council's Public Health Team. The group acts as a reference group for new and existing services commissioned by Public Health and the CCG and utilises the community based knowledge of its partners to contribute towards the planning and shaping of health, prevention and wellbeing services for communities across Hull.

During the past year the group has delivered a pilot programme for social prescribing via GP surgeries. This will become a mainstream programme jointly commissioned by Hull City Council and the CCG.

In December 2014 the group was also successfully accepted onto the second phase of the national Building Health Partnerships programme funded by NHS England. The programme will provide extra support to strengthen the partnership and its work programme to maximise social impact and explore new co-designed models of commissioning.

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 355409
Email: **HULLCCG.PALS@nhs.net**

> We appreciate how responsive NHS Hull CCG has been to the VCSE sector, and the transparency and timeliness of your communications with us too. It is a great demonstration of proper partnership working and due respect being given to all parties involved.

Volcom, Hull

2014-15 - A year of **creating** a **healthier Hull**

April - June 2014

Be Clear on Cancer

The CCG backed **Be Clear on Cancer**, an NHS campaign to **raise awareness** of possible signs and symptoms of lung cancer.

Around 34,900 people are diagnosed with lung cancer in England every year and finding it early makes it more treatable. The campaign encouraged people with symptoms, like a cough that lasts for three weeks or more, to see their doctor as soon as possible.

Dr Dan Roper, local GP and Chair of the CCG Board said "Locally, we can all help to make a difference and reduce the number of people who die from lung cancer by encouraging early recognition of possible symptoms and seeking treatment as soon as possible."

Healthy impact at Humberside Rock challenge

Humberside Police's Rock Challenge events in April and May provided the CCG with an opportunity to engage with around 2,000 children and young people from schools, colleges and youth groups in Hull around health and lifestyle issues.

We' re part of a healthier Hull

Practising what they preach, 10 members of our staff donned their running shoes and successfully completed the local Jane Tomlinson 10K run, raising money for a number of charities and getting fitter in the process!

CCG and Humberside Police join forces to fund Passive Drug Detection Dogs

We provided funding for Humberside Police to support their drive to clear city centre pubs and clubs of drugs through the use of Passive Drug Detection Dogs. The Spaniel and Labrador, named Bobby and Mia, have been detecting the presence of drugs on the streets of Hull along with their specialist dog handlers since August. In addition the project is actively breaking down the barriers between disadvantaged young people and the police, with a focus on educational work.

Hull 2020 launch August 2014

July - September 2014

Healthshare Hull MSK service launches

As part of the CCG's on-going review and redesign of community services in Hull, the priority has been to commission services that will deliver better outcomes for our patients and a reduction in referrals to secondary (hospital-based) care. Healthshare Hull was awarded the new Community Musculoskeletal contract to deliver high quality, patient-centred care for Hull. A one-stop service for joint and muscle related problems now operates over extended hours in a number of clinics across the city, with the ability for patients to self-refer.

Hull 2020 officially launched

A new era of public sector partnership was launched in August with nine public service organisations pledging to work together better for the people of Hull. For more information on Hull 2020 see page 32.

QT at Hull CCG

September saw members of the public attend our health fair and a 'Question Time' style event. The health fair featured information and advice from services such as weight management and smoking cessation; the 'Question Time' event provided a lively forum for members of the public to question the city's health decision-makers on issues that matter to them. BBC Radio Humberside presenter David 'Burnsy' Burns chaired the event.

Hull children and young people get a HeadStart

Hull became one of only 12 areas in England to receive funding from the Big Lottery Fund to develop a local HeadStart project which aims to improve mental wellbeing and resilience. HeadStart Hull was awarded a £498,902 grant from the Big Lottery Fund in August 2014 with 13 schools taking part in the pilot. Each school has been delivering support and interventions aimed at improving the mental wellbeing and resilience of children and young people between 10 and 14 years old. Find out more at **www.hullccg.nhs.uk**

The CareMonkeys is an 'app' that has been created by five young people working with Cornerhouse as part of the Humberside Police Lifestyle project. Taken forward as part of HeadStart, and in conjunction with the Police and Crime Commissioner, the app is one of the most innovative and ambitious approaches towards educating children and young people around their personal safety. Most importantly, the app provides a safe and trusted environment for young people to get information around a number of issues, including bullying and sexual exploitation. Find out more, and download the app at:
www.caremonkeys.co.uk

October – December 2014

Let's Talk launches in Hull

'Let's Talk… Depression and Anxiety Services Hull' launched on 1 October 2014 to help people who are experiencing anxiety and depression to quickly receive a service that best meets their needs. The service, led by City Health Care Partnership CIC (CHCP CIC), allows people to access a range of emotional and wellbeing support, delivered in a variety of settings by specialist staff.

Feedback from service users shows 98% of respondents said they would recommend the service to their friends and family. Service users said:

"Very helpful staff and good knowledge, now know a lot more about problem and issues that I can now better resolve myself."

"The information I have gained at the Stress Control class has made me a happier person which has greatly improved my quality of life."

CANTAB Dementia diagnosis tool helps GPs spot the early signs of Dementia.

43 GP practices in Hull began using CANTAB Mobile the easy to use iPad based dementia assessment tool in October 2014. The medical software provides a quick and accurate assessment of a patient's memory and can differentiate between patients with memory loss due to Alzheimer's and normal age-related forgetfulness. The device can help GPs to spot the early signs of dementia, enabling patients to receive the most appropriate care at the earliest point possible.

Working together to manage winter

As winter gripped we focused on a number of ways to ease the pressure on Hull's Emergency Department (ED). Minor Injury Unit (MIU) opening hours were extended and a new medical admission unit opened at Hull Royal Infirmary, significantly shortening the wait time many patients were experiencing in the ED. CCG Lay Member, Jason Stamp, publically praised health staff working hard to treat people in need. In addition, the CCG led an 'Alternatives to A&E' campaign that helped to divert patients who did not necessarily need to be seen in ED to other healthcare services including Minor Injuries Units (MIU), Pharmacies and NHS 111.

Christmas comes early for Hull 2020 Champions

Hull 2020 Champion, Debbi Lee, used her 'Community Café' project to provide a hearty Christmas lunch for people who otherwise might not have had one this year. Thanks to the support of local businesses, individuals and volunteers, over 20 people from Debbi's community enjoyed turkey and all the trimmings as part of the Big Lunch event.

Not in our community

The CCG is a committed partner in the Not in our Community campaign launched in November across the Humberside Police area to help tackle the issue of child sexual exploitation. Not in our Community aims to raise awareness about the sexual exploitation of young people and the signs that someone might be at risk of being exploited.

www.notinourcommunity.org

Not in our Community aims to raise awareness about the sexual exploitation of young people

Materials used to attract trainee GPs to Yorkshire and Humber as part of the 'Fall in love' recruitment campaign

January – March 2015

Integrated Care Centre consultation launches

The public consultation for the Integrated Care Centre launched at the end of January, and consultation activity picked up steam across the city throughout February (see page 23 for more details) The consultation will be evaluated during 2015 and the CCG wants to thank everyone who participated.

Trainee GPs invited to fall in love with Yorkshire

A high profile campaign in February invited the next generation of GPs to "Fall in Love with Yorkshire and Humber", promising them an unforgettable three years if they choose to start their GP journey here. Led by the Hull York Medical School (HYMS) and NHS Hull CCG, with support from other local CCGs, the recruitment drive was inspired by Hull's successful campaign for UK City of Culture 2017.

Dr. Michael Holmes, Associate Medical Director of NHS Hull CCG said: "I chose to base myself in the Hull area, and have never looked back. It is a wonderful, vibrant place that offers a rich learning environment combined with fantastic training and career opportunities for young doctors. With the added excitement of Hull hosting the UK City of Culture celebrations in 2017, there has never been a better time to experience what Hull and the whole of Yorkshire and Humber has to offer." To view the campaign film visit **www.hullccg.nhs.uk**

The intergenerational choir performance

Bringing generations closer

Supporting the aims of the Hull 2020 frailty and isolation work stream, local community groups were invited in October 2014 to team up and form a number of 'intergenerational' choirs. The choirs rehearsed together for twelve weeks before performing at Hull City Hall in 'A Singing Journey' in March. 700 people attended the event and anecdotal feedback on the evening showed that choir members, volunteers and individual organisations had been uplifted by their involvement in the project. Significantly, some of the groups have formed a strong bond that has lasted beyond the 12 week project, with a local age related charity wishing to continue the project and extend it to more groups across the city.

United against prostate cancer

NHS Hull CCG and Humberside Fire and Rescue Service joined forces in early March, taking the message to the streets of Hull on the side of a unique blue fire engine. As part of the Hull 2020 partnership, the eye-catching fire engine, the first of its kind in the UK, supports Prostate Cancer UK's 'Men United' campaign highlighting the signs and symptoms men and their families should look out for. For more information please visit www.prostatecanceruk.org

Looking to the future - transformational change in healthcare

> "In 2020 we will work together better to enable the people of Hull to improve their own health, resilience, wellbeing and to achieve their aspirations for the future."

Hull 2020 - Making a better future together

Hull 2020 brings together nine organisations from across the city to work together better for the people of Hull. Hull 2020 partners have shown commitment to the vision of working in a way which will not only better enable the people in Hull to improve their own health, wellbeing and future, but also promises to engage and communicate with local communities in a way which has not been seen before in the city.

The Hull 2020 partners are NHS Hull Clinical Commissioning Group (CCG), Hull City Council, City Health Care Partnership CIC (CHCP CIC), Healthwatch Kingston upon Hull, Humber NHS Foundation Trust, Yorkshire Ambulance Service, Humberside Police, Humberside Fire and Rescue Service and Hull and East Yorkshire Hospitals NHS Trust.

Hull 2020 launch August 2014

The Hull 2020 programme

A number of individual work streams have been developed under the programme. Each work stream is progressing at an appropriate pace based on programme and organisational priorities to ensure sustainable high quality services are delivered by 2020.

Here is a selection of the work that has brought the Hull 2020 programme to life since its launch in August 2014:

Frailty and Isolation

This work stream brings together partners providing services that meet the needs of some of the most vulnerable in the city. This includes dementia patients, elderly people and people with mental health and learning disabilities. The work stream is tasked with co-ordinating services to meet the common needs. For example, Humberside Fire and Rescue has a community team assessing the homes of the vulnerable individuals for fire prevention and risk. These assessments could potentially be linked to the meals on wheels services, district nursing, housing and rapid response services.

For 2015-16 the work stream's objectives include establishing a loneliness sub-group, promoting the most effective use of telehealth and telecare and developing the frailty agenda for Hull.

This work stream brings together partners providing services that meet the needs of some of the most vulnerable in the city.

The intergenerational choir project

Tackling loneliness

As part of a week-long celebration of older people during September 2014 a CCG-led loneliness workshop brought together 50 healthcare professionals and stakeholders to discuss the impact of loneliness on people's health and wellbeing.

The focus of the workshop was to understand:

- the connection with ageing well and health and wellbeing;
- that local amenities indirectly play a part in tackling loneliness and how we map these services and identify gaps at a local level;
- the individual, social and economic costs of loneliness; and
- that loneliness is everyone's business and we need to involve the community through local campaigns and build on existing successful initiatives.

A social isolation sub group involving Age UK and other Hull 2020 partners will meet during 2015-16 to develop priorities and a plan of action to tackle loneliness effectively.

Tackling loneliness in the community

Developing a plan of action to tackle loneliness effectively across Hull.

Integrating services

Humberside Fire and Rescue Service is exploring the location of a small operational fire station on the Integrated Care Centre site, to better support and protect vulnerable members of the local community. A natural integration with health and social care services that support more vulnerable people could allow them to deliver enhanced fire safety and prevention measures for people who are most at risk of fire within their own homes. An evaluation of this option will take place during 2015.

Thriving Communities

'Community means something here, you have to get involved, do the best for yourself and the people around you.'

The Hull 2020 Thriving Communities work stream was established to deliver the following outcomes:

- People feel that they are valued in the community, that they can, and have, played their part in shaping services and what their community looks and feels like; and
- Hull 2020 partner organisations commit to and recognise communities as valuable resources and part of the solution.

Over its first year the work stream has developed the Hull 2020 Thriving Communities Strategy. Hull City Council has invested in resources to support the Strategy and the work stream has supported the successful local Building Health Partnership application to participate in the second phase of the programme.

Supporting grass roots projects

A £500,000 fund opened this year to the voluntary and community sector for projects that focus on improving mental wellbeing, maintaining independence and tackling social isolation.

Established by the Hull Health and Wellbeing Board, the fund was based on values and principles set by the Thriving Communities work stream - in the main supporting projects that were already successful in empowering people within their communities. Twenty groups already demonstrating that they are achieving real benefits were successful in gaining one-off funding for their projects.

Over the next year the work stream will develop the Thriving Communities action plan with the assistance of community and voluntary groups and will support the delivery of Hull 2020 Community Champions programme.

Children and Families

With a focus on the 'best start in life', the Children and Families work stream has a continued focus on early help and intervention, children and young people's mental health and emotional wellbeing. The work stream is also working towards the integration of health and social care services for children.

Life Choices

The Life Choices work stream is at the forefront of the development of the new community hubs. It's objectives for 2015-16 include agreeing the blueprint for the city's community hubs using the Riverside Area as the prototype for future development and prioritising the remaining hubs for development across the city up to 2017. It will also lead on progressing a publicly accessible portal/service directory enabling people to access information easily.

What is a community hub?

The community hub is a 'model of care and support' that can either be based around an existing building or a grouping of services with a common purpose (for example council, health, police and fire).

We recognise that in different parts of the city there are likely to be different needs for the local population and community hubs may need to be modified to suit each local setting. All community hubs will have a single point of access for people in the local area.

Planned interventions and Urgent interventions

These work streams are mainly health focused and sit within Hull CCG's five year forward plan.

"We are all working hard to achieve the same aim: to help make our communities safer and healthier. The Hull 2020 programme gives us the best opportunity to share ideas, resources and networks to enable us to achieve this."

Dene Sanders Chief Fire Officer and Chief Executive Humberside Fire and Rescue Service

"We want make sure people get the quality services they deserve, from the right people, as quickly and efficiently as possible. By improving the way we work together, developing joined up systems and embracing new technology we can achieve this goal."

Justine Curran, Chief Constable, Humberside Police

"Hull 2020 is a fantastic opportunity for us to work alongside our people and communities to improve health and wellbeing and importantly tackle some of the underlying causes of ill health in the city."

Julia Weldon, Director of Public Health, Hull City Council

Simon's story:

"I live in an area that has seen its share of problems. The simple idea for my street was to plant lavender bushes in every front garden to help transform the area and get neighbours talking to each other. It's a small project that has begun to make a big difference. It shows that you don't need to move to a better area - working together we can make our area better."

Hull 2020 Champions

The Hull 2020 Champions are people who live or work in Hull who have an interest in improving their own lives and the lives of the people around them. The Hull 2020 Champions programme supports these people to make a plan and work out the steps needed to take an idea forward.

33 Hull 2020 Champions have come forward with great projects they want help to get off the ground - from community cafes, festivals and amateur sporting clubs to improving children's understanding of disability. All have a common goal in that they want to see their community unite and overcome its challenges.

You can find out more about becoming a Hull 2020 Champion, register a project or pledge support for any of the 25 projects showcased on the Hull 2020 website at **www.hull2020champions.org**

"Nobody knows the issues in their street better than the people who live in it. They know what needs to be done and often want to be part of the solution."

Emma Latimer, Hull 2020 Programme Sponsor

Emma joins Green Watch

In order to better understand the day to day workings of one of Hull 2020's key partners CCG Chief Officer Emma Latimer donned boots and uniform and spent a whole shift at East Hull Fire Station which involved attending two incidents!

"I had the chance to discuss some of the things we are planning to do in health and asked for their views on how they thought we could work better together. Green Watch really is a brilliant team and I can't thank them enough."

Better Care in Hull

Better Care in Hull (BCH) is Hull CCG and Hull City Council's shared vision of integrated services across the city's providers of health and social care, which include hospitals, community health services and social care services.

Better Care in Hull is underpinned by the national 'Better Care Fund', which sees £5.3bn allocated specifically for the transformation and integration of health and social care services across the UK. It is important to stress that the Better Care Fund is not new money, but rather is money already being spent on health and social care services in Hull. A single pooled budget supports the NHS and local authorities to work more closely together around people, placing their well-being as the focus of health and care services.

The Better Care in Hull single pooled budget was around £11.3m for 2014-2015 and will be £30.8m for 2015-2016. Our Better Care in Hull programme plan, which outlines how we will deliver eight identified schemes (below) to transform local health and social care, was submitted in 2014.

Our final plan was approved as an 'exemplar' and Better Care in Hull will focus on services for older people in the first instance. You can find out more about progress on BCH and read our newsletters at **www.hullccg.nhs.uk**

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

1	Prevention and community hubs	Our community hubs will provide more integrated services across health and social care and could also include services provided by the voluntary sector and community groups. The services offered in each location will be tailored to best meet the needs of the local population and to make best use of the existing resources.
2	Primary care and self care	We will support much more proactive management for patients with long term conditions in primary care with a named single point of contact.
3	Falls	We will develop early support and intervention services across health and social care to reduce the projected level of falls and support people to continue to be active and independent.
4	Reablement	We will provide short term support to help people after a period in hospital to learn or re-learn the activities they need to support everyday life.
5	Ambulatory care	A range of services will work together in hospital to enable patients to have their condition rapidly assessed, investigated and treated without the need to be admitted to the hospital ward.
6	Residential and home care	We will provide appropriate alternatives to residential care by expanding home care and extra care services and support.
7	Long term conditions & dementia	We will create a more integrated network of care and support for patients with long term health conditions and their carers.
8	Mental health	There will be better integration of mental health services between health and social care.

Our **development** and **performance** in 2014-15

The CCG's accounts have been prepared under a direction issued by the NHS Commissioning Board (NHS England) 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 by 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 the funding awarded to the CCG by around £19m in 2015-16. This challenge falls to both the CCG and the providers of services who are planned to contribute circa £13m and £6m 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 very 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 and 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 CCG ceases to exist, its functions will continue to be provided (using the same assets, by another public sector entity).

One of our aims is to ensure that we receive value for money for every pound spent.

Monitoring performance and improving health outcomes

The CCG monitors performance against the NHS frameworks and performance is considered through many other forums with the aim of providing assurance in line with the Board Assurance Framework.

Initiatives are aligned to the CCG strategy and work streams to ensure any corrective actions are implemented to address any deteriorating indicators.

Please see the following section for performance against health outcomes areas and the seven 'sentinel' indicators (page 40) which will be refreshed and reviewed in line with the NHS Five Year Forward View to ensure a sustained level of improvement in 2015-16.

Information on our annual performance is published at **www.hullccg.nhs.uk**

Performance against health outcomes areas 2014-15:

Indicator	2014-15 Targets	Latest Position	Status
Local Priority:			
Unplanned hospitalisation for chronic ambulatory care sensitive conditions	Reduce admissions for an ambulatory care sensitive condition by 1% from 2012-13 baseline (1206.4)	National data (Oct 13 – Sep 14) 1046.5	Achieved (Local data indicates Achieved)
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 (updated figure 2291.3) Target for 2014-15 is 2203.7	National data (2013-14) 2565.4	Not achieved
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 13 – Sep 14) 1046.5	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 13 – Sep 14) 429.8	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 13 – Sep 14) 1542.0	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 13 – Sep 14) 433.2	Achieved (Local data indicates achieved)
Positive experience of care	Assurance that local providers have taken action in response to Friends and Family Test feedback. Support has been provided by the CCG with the roll out of FFT, with an improved average score achieved between 2013-14 and 2014-15 for overall experience of GP out of hours services.	National data (Jan-Mar & Jul-Sep 2014) – 74.73% against 77.76% for same period previous year	Unknown (local data indicates partly achieved)
Incidence of MRSA bacteraemia	There should be no incidences of MRSA in the year	To February 2015 - 2	Not achieved
Incidence of C. Difficile	The number of incidences of C. Difficile in the year should be 68 or less	To February 2015 - 89	Not achieved
Dementia diagnosis rate	Target for 2014-15: Diagnosis rate of 67%	As at February 2015 – 62%	Not achieved
Improving Access to Psychological Therapies – numbers entering treatment	Target for 2014-15: 15% of those with depression/ anxiety by Q4	As at 2014-15 Q3, actual 13.96% against trajectory 11.84%	Achieved
Improving Access to Psychological Therapies – recovery rate for patients completing treatment	Target for 2014-15: 50% of those completing treatment	As at 2014-15 Q3 YTD – 35.7%	Not achieved

The following seven indicators will be refreshed and reviewed in line with the NHS Five Year Forward View (FYFV) to ensure a sustained level of improvement in 2015-16. For more information on the FYFV please visit www.england.nhs.uk.

Ambition area	Metric	Proposed attainment in 2018-19
Securing additional years of life from conditions considered amenable to healthcare	Potential years of life lost (Rate per 100,000 population)	2276.6(2012) - 2116.9(2018)
Improving the health-related quality of life for people with long-term conditions	Average EQ-5D score for people reporting having one or more long-term condition	70.40(2012) - 76.58(2018)
Reducing emergency admissions	Emergency admissions composite indicator	2900.7(2012) - 2241.5(2018)
Increasing the proportion of people having a positive experience of hospital care	Proportion of people reporting poor patient experience of inpatient care	139.7(2012) - 131.0(2018)
Increasing the proportion of people having a positive experience of care outside of hospital, in general practice and the community	Proportion of people reporting poor patient experience of general practice and Out of Hours Services	5.1(2012) - 4.8(2018)
Dementia Diagnosis Rate	Prevalence/Diagnosis	70.2% (2016)
IAPT Recovery Rate	Percentage of people who have completed treatment, having received 2 or more treatment contacts and are moving to recovery	50% in 2014-15 and 51% in 2015-16

Managing our resources 2015-16 and beyond

NHS Hull CCG will receive approximately £387m of resources in 2015-16. Of this £6m is allocated for the running of the CCG and £10m is the return of the 2014-15 surplus.

In order to manage these resources and deliver the £8m required surplus for 2015-16 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 2015-16 will be the first year in which the 'Better Care Fund' initiative will formally be in place. 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 £9,896k against its revenue resource limit of £380,084 as planned.

The CCG spent £6,963k on the administration of the organisation in 2014-15. This represented an underspend of £558k against a maximum target of £7,521k.

The CCG contracts with Yorkshire and Humber Commissioning Support (YHCS) for a range of commissioning support functions. Future commissioning support arrangements are subject to the NHS England lead provider framework. YHCS was not approved on to the framework and so the CCG is an active member of the Yorkshire and Humber Commissioning Support Transition Group which is determining the commissioning support arrangements during 2015 and beyond.

We are pleased to report that the CCG managed to operate within its revenue resource limits

Sustainability report

Sustainability has become increasingly important as the impact of people's 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.

We have worked together with NHS Property Services over the past year, (the organisation which the CCG leases the property where we house our headquarters) and due to the nature of their lease, through a private landlord, are unable to provide this information. We pay a service charge for the building and all the costs for water, waste and energy are part of this.

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.

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 health services that respect and respond to the diversity of our local population.

We aim to provide equality and fairness for all in our employment and care, and not to discriminate on grounds of gender, race, ethnic origin, colour, nationality, national origin, disability, sexual orientation, gender identity, marital status, religion or age. 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.

We oppose all forms of unlawful and unfair discrimination. Our patients, their carers and our staff deserve the very best we can give them in an environment in which all feel respected, valued and empowered.

Social, community and human rights obligations

Control measures are in place to ensure that the CCG complies with the requirements of:

- The Equality Act 2010, and in particular our public sector equality duty
- The Human Rights Act 1998
- The Equality Delivery System (EDS2)

We recognise our duties under the Equality Act 2010, including the Public Sector Equality Duty to pay due regard to:

- eliminating unlawful discrimination, harassment and victimisation;
- advancing equality of opportunity between people who share a protected characteristic and people who do not share it; and
- fostering good relations between people who share a protected characteristic and people who do not share it.

We also recognise our specific duty to publish equality objectives every four years and information regarding those that are affected by our organisation.

You can read more about our Equality Plan and Objectives, review of our performance, the implementation of NHS England Equality Standards and the information we publish in our Equality and Diversity section at **www.hullccg.nhs.uk**

For more details on how the CCG works with diverse communities in Hull please see page 25.

We aim to provide equality and fairness for all in our employment and care

View our organisational policies at **www.hullccg.nhs.uk**

Gender analysis

At the end of 31 March 2015 the following breakdowns for NHS Hull CCG in terms of gender of CCG Board, employees and Council of Members were as follows:

	Female	Male
The number of persons of each gender who were members of the CCG Board	8	9
The number of persons of each gender who were employees of the clinical commissioning group.	35	11
The number of persons of each gender who made up the membership (Council of Members)	10	47

3. members' report 2014 -15

creating a healthier Hull

Our CCG Membership

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 290,442 across 23 wards.

During 2014-15, the following practices comprised the membership of NHS Hull CCG:

Practice Name	Address
The Avenues Medical Centre	The Avenues Medical Centre, 149 – 153 Chanterlands Avenue, Hull HU5 3TJ
Dr Awan & Partners	Orchard 2000 Medical Centre, 480 Hall Road, Hull HU6 9BS
Bridge Group Practice	The Orchard Centre, 210 Orchard Park Road, Hull HU6 9EX
Burnbrae Medical Practice	445 Holderness Road, Hull HU8 8JS
The Calvert Practice	110a Calvert Lane, Hull HU4 6BH
Dr Chauhan & Partners	Clifton House Medical Centre, 263 - 265 Beverley Road, Hull HU5 2ST
Chestnut Farm Surgery	174 Dunvegan Road, Hull HU8 9LF
Dr AK Choudhary and Dr SR Danda	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Dr GM Chowdhury	Park Health Centre, 700 Holderness Road, Hull HU9 3JR
Dr BF Cook	Field View Surgery, 840 Beverley Road, Hull HU6 7HP
Dr AK Datta	Sutton Park Medical Practice, Littondale, Sutton Park, Hull HU7 4BJ
Dr G Dave	Laurbel Surgery, 14 Main Road, Bilton, Hull HU11 4AR
Diadem Medical Practice	Diadem Medical Practice, 2 Diadem Grove, Bilton Grange, Hull HU9 4AL
East Park Practice	Park Health Centre, 700 Holderness Road, Hull HU9 3JR
Dr Galea and Partners	The Oaks Medical Centre, Council Avenue, Hull HU4 6RT
Dr Ghosh, Raghunath & Partners	St Andrew's Group Practice, Goodhart Road, Hull HU7 4DW

Practice Name	Address
Haxby Group Orchard Park	The Orchard Centre, 210 Orchard Park Road, Hull HU6 9BX
Dr KV Gopal Surgery	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Dr GT Hendow	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Dr SG Hussain & Partners	Wilberforce Surgery, Wilberforce Health Centre, 6 – 10 Story Street, Hull HU1 3SA
Dr JC Joseph	Longhill Health Care Centre, 162 – 164 Shannon Road, Hull HU8 9RW
Kingston Health Hull	Kingston Health, Wheeler Street, Hull HU3 5QE
Kingston Medical Centre	151 Beverley Road, Hull HU3 1TY
Haxby Group Kingswood Surgery	Kingswood Health Centre, 10 School Lane, Hull HU7 3JQ
Dr Macphie, Raghunath & Partners	Newington Health Centre, 2 Plane Street, Hull HU3 6BX
Dr GS Malczewski	Longhill Health Care Centre, 162 – 164 Shannon Road, Hull HU8 9RW
Dr MK Mallik	919 Spring Bank West, Hull HU5 5BE
Dr J Musil	Princes Medical Centre, 2 Princes Avenue, Hull HU5 3QA
Dr JK Nayar	Newland Health Centre, 187 Cottingham Road, Hull HU5 2EG
New Green Surgery	Morrill Street Health Centre, Morrill Street, Hull, HU9 2LJ
Newland Group Practice	Alexandra Health Centre, 61 Alexandra Road, Hull HU5 2NT
Northpoint Medical Practice	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Dr 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
Dr Percival & Partners	Alexandra Health Centre, 61 Alexandra Road, Hull HU5 2NT
Dr NA Poulose, Awan & Basheer	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Haxby Group Priory Surgery	Priory Surgery, Priory Primary School, Priory Road, Hull HU5 5RU
Quays Medical Centre	Wilberforce Health Centre, 6 – 10 Story Street, Hull HU1 3SA
Dr Raghunath & Partners	St Andrew's Group Practice, Elliott Chappell Health Centre, 215 Hessle Rd Hull HU3 4BB
Dr R Raut & Partnership	Highlands Health Centre, Lothian Way, Hull HU7 5DD
Dr Rawcliffe & Partners	New Hall Surgery, Oakfield Court, Cottingham Road, Hull HU6 8QF
Dr AK Rej	Southcoates Medical Centre, 255 Newbridge Road, Hull HU9 2LR
Riverside Medical Centre	Riverside Medical Centre, The Octagon, Walker Street, Hull HU3 2RA
Dr D Roper & Partners	Springhead Medical Centre, 376 Willerby Road, Hull HU5 5JT
St Andrew's Group Practice (Newington)	Newington Health Centre, 2 Plane Street, Hull HU3 6BX
St Andrew's Group Practice (Northpoint)	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Dr M Shaikh	Longhill Health Care Centre, 162 – 164 Shannon Road, Hull HU8 9RW
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
Sydenham House Practice	215 Hessle Road, Hull, HU3 4BB
Dr AK Tak and Dr M Sadik	Newington Health Centre, 2 Plane Street, Hull HU3 6BX
Dr J Venugopal & Partners	Bransholme South Health Centre, Goodhart Road, Hull HU7 4DW
Dr Weir & Partners	Marfleet Group Practice, Preston Road, Hull HU9 5HH
Dr L Witvliet	358 Marfleet Lane, Hull HU9 5AD
Wolseley Medical Centre	Londesborough Street, Hull HU3 1DS
Dr Wong & Partners	Faith House Surgery, 723 Beverley Road, Hull HU6 7ER
Dr RD Yagnik	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 CCG Board Membership 2014-15 (All memberships run from 1 April 2014 to 31 March 2015 inclusive unless stated otherwise)

Chair
Dr Dan Roper

Chief Officer
Emma Latimer

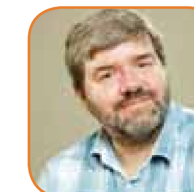
GP members

Dr Vince Rawcliffe

Dr Mark Follows
(1 April 2014 - 30 June 2014)

Dr John Parker

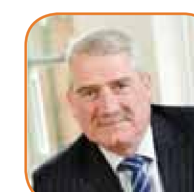
Dr Raghu Raghunath


Dr Leen Witvliet
(resigned 31 March 2015)

Dr James Moult

Dr Amy Oehring

Lay Members


Paul Jackson
(Strategic Change and Vice-Chair of the CCG Board)

Karen Marshall
(Audit, Remuneration and Conflict of Interest Matters)

Jason Stamp
(Patient and Public Involvement)

Our CCG Board

NHS Hull CCG Board Membership 2014-15 (All memberships run from 1 April 2014 to 31 March 2015 inclusive unless stated otherwise)

Chief Finance Officer
Emma Sayner

Director of Commissioning and Partnerships
Julia Mizon

Secondary Care Doctor
Dr Richard Grunewald

Practice Manager Representative
Carole Robinson

Registered Nurse
Angie Mason
(Commenced in post 1 September 2014)

Non-voting Members

Director of Quality & Clinical Governance/ Executive Nurse
Sarah Smyth

Director of Public Health, Hull City Council
Julia Weldon

NHS Hull CCG Integrated Audit & Governance Committee

(All memberships run from 1 April 2014 to 31 March 2015 inclusive unless stated otherwise)

Chair
Karen Marshall

Vice Chair/Lay Member
Paul Jackson

Lay Member
Jason Stamp

For membership of NHS Hull CCG's Remuneration Committee please see page 57. Please refer to the Membership Body & Governing Body Profiles section of the Remuneration Report on page 64 for details of conflicts of interest

Pension liabilities

For information on pension liabilities please see the accounting note 1.9.2 on page 12 of the Annual Accounts

Sickness absence 2014-15

The sickness absence data for NHS Hull CCG between 1 April 2014 and 31 March 2015 is below:

	2014-15	2013-14
Total FTE days lost	911	184
Total staff years	40	40
Average working days lost	22.72	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 2014 and 31 March 2015 is included in the Employee benefits note to the financial statements on page 23.

Audit costs

Our external auditor is KPMG LLP, 21 The Embankment, Neville Street, Leeds, LS1 4DW. Auditors' remuneration in relation to April 2014 to March 2015 totalled £96,000 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**

The CCG recognises the importance of maintaining data in a safe and secure environment. It uses the Serious Incidents Requiring Investigation (SIRI) tool to assess any matters involving potential data loss to the organisation. The tool requires the reporting of any data incident rated at level 2 or above via the Information Governance (IG) toolkit. NHS Hull CCG has had no such incidents during 2014-15. One minor incident (level 1) of data loss was recorded during 2014-15, however this fell short of the external reporting threshold.

The CCG recognises the importance of maintaining data in a safe and secure environment.

Access to **information**

During the period 1 April 2014 to 31 March 2015, the CCG processed the following requests for information under the Freedom of Information (FOI) Act 2000

	2014-15
Number of FOI requests processed	266
Percentage of requests responded to within 20 working days	99.6%
Average number of days taken to respond to an FOI request	13.8

Of the 266 requests processed during the year, 265 were within the statutory 20 working days. One took longer owing to a delay in its processing within the CCG. Appropriate action has been taken to prevent a re-occurrence.
In 7 cases no information was provided and in 17 cases only part of the information requested was provided. In each of these instances it was considered relevant to apply an exemption in accordance with the terms of the FOI Act. Exemptions applied included the information being accessible by other means, intended for future publication, the cost of providing the information exceeded the limits set by the FOI Act, the information requested was commercially sensitive or it was personal information.

Our publication scheme contains documents that are routinely published; this is available at **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.

Handling complaints
and principles for remedy

NHS Hull CCG is committed to a fair and transparent complaints process which aims to resolve all complaints and provide a full explanation to the complainant, improve services, patient care and staff awareness to enable the organisation to learn from the experience and make changes/improvements as necessary.

Complaints are handled in accordance with the CCG's complaints policy, which is currently being revised to reflect current guidance and reports including Francis 2 , The Hart Clwyd report, My Expectations for Raising Concerns and Complaints (November 2014) and The Care Quality Commission's "Complaints Matter" (December 2014).

NHS Hull CCG received six complaints during 2014-15. All of the complaints were related to the commissioning of services, with four relating specifically to decisions made under the Individual Funding Request process. None of the complaints were upheld.

Although this represents an increase in complaints recorded for the previous year from two to six, this is a healthy indicator for the organisation in that it enables us to identify areas where services need to improve for patients. To this end, during 2014-15 the CCG actively sought to raise public awareness to enable people whose experience of local health care has fallen below expected standards to raise complaints and concerns more easily. You can find out more at www.hullccg.nhs.uk

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

1. Getting it right
2. Being customer focused
3. Being open and accountable
4. Acting fairly and proportionately
5. Putting things right
6. Seeking continuous improvement

For more information see **www.ombudsman.org.uk**

Engaging our Staff

The CCG runs an annual engagement and climate survey, together with an interim half year survey to evaluate progress against the findings from the annual survey.

The 2013-14 survey was designed locally; the 2014-15 survey and ongoing surveys mirror the HSE health wellbeing and stress survey. The CCG has included the Opinion Research Corporation International metrics for engagement (Say Stay Strive) in the annual survey enabling the calculation of an annual Engagement Index score.

Supporting the survey is a current engagement strategy and operational plan which will migrate in 2015 into the health safety and wellbeing operational plan being implemented to achieve the recently ratified health safety and wellbeing strategy. CCG staff are involved in organisational objective setting as part of the annual staff meeting.

Staff consultation

Recognising the benefits of partnership working, 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; and
- promotes effective and meaningful communication between all parties that can be subsequently disseminated across the membership.

"There is a nice 'small team feel' about the organisation. I like the fact that we are encouraged to get out in the real world and see how it is for patients and staff. Makes for much better commissioning."

CCG staff member

Disabled employees

As an employer the CCG recognises and values people as individuals and accommodates 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

Policies are available at **www.hullccg.nhs.uk**

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.

Should circumstances change with an employee's disability status during their employment then the framework within the Absence Management Policy would be used. Occupational Health, Workforce and where applicable other specialist advice would be taken and reasonable adjustments would be made to support the employee to continue in employment as far as possible.

Health and safety performance

NHS Hull CCG continues to foster and encourage a positive health and safety culture within the organisation.

Following staff consultation six corporate health and safety policies were introduced. All risk assessments for the organisation such as COSHH, Manual Handling and Fire are up to date and all appropriate control measures are in place.

Training and induction processes were reviewed during the year in relation to health and safety, with a local induction process ensuring that CCG staff receive necessary information within their first week and complete all health and safety training within 12 weeks of commencement. A specific session on management responsibilities was also provided to members of the CCG Board. Current compliance for health and safety training overall is at 97.5%, against a target of 95%.

Current compliance for health and safety training overall is at 97.5%, against a target of 95%.

There were 3 minor health and safety incidents reported during the year. Thorough investigations were made in all cases and findings shared with staff, however none of the incidents met the external reporting threshold. A wellbeing strategy is in development for 2015-2017 in conjunction with the Human Resources team.

Countering **fraud**

The CCG implements anti-fraud prevention measures and counters fraud risks in compliance with NHS Protect Standards.

To ensure compliance with the national standards the CCG has a range of policies in place and contracts with the East Coast Audit Consortium, which supplies Local Counter Fraud Specialist (LCFS) services via an annual fraud plan. This includes initiatives to promote fraud awareness, deterrence and prevention, to investigate suspected cases of fraud and, if required, apply a range of potential sanctions including criminal, civil and disciplinary measures.

Progress against the Counter Fraud Plan is monitored at each meeting of the Integrated Audit and Governance Committee and at the end of the year the LCFS is required to submit an Annual Report.

Better payments practice code

The CCG has signed up to the Better Payments Practice Code and aims to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. During 2014-15 NHS Hull CCG paid 96.66% of non NHS trade invoices within target and 98.53% of NHS trade invoices within target.

Further details are on page 26 of the Annual Accounts.

Preparing for **emergencies**

The North Yorkshire and Humber area of NHS North of England has incident response plans in place, which are compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The CCG are members of the North Yorkshire and Humber Local Health Resilience Partnership and the Humber Health Sub Group.
The CCG is currently revising its Business Continuity Plan in line with the national Emergency Preparedness Resilience and Response (EPRR) core standards. The 2014-15 EPRR standards are designed to ensure that NHS England and associated commissioning and provider organisations in NHS in England are prepared to respond to an emergency, and have resilience in relation to continuing to provide safe patient care.

Statement as to **disclosure to auditors**

Each individual who is a member of the CCG Board 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 CCG's external auditor is unaware;and, that the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the CCG's auditor is aware of that information. This Members Report has been prepared by the Integrated Audit and Governance Committee on behalf of the Council of Members and CCG Board.

Remuneration Report
Introduction

NHS Hull CCG follows national guidance in remuneration (pay awarded) to very senior managers (VSMs). Hull CCG Remuneration Committee comprises the lay members and the chairman of the CCG Board. 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 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 the other individuals who attend and the 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 2014-15 (not subject to audit)

Membership is comprised of the following:

(All memberships run from 1 April 2014 to 31 March 2015 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
Chair of Hull CCG Board

In attendance:

September 2014

Alison Dubbins
Associate Director of Human Resources and Organisational Development – NHS Hull CCG

Emma Latimer
Chief Officer – NHS Hull CCG

Donna Robinson
PA to Director of Commissioning and Partnerships – NHS Hull CCG

Stephen Dean
Interim Workforce Manager – Yorkshire and Humber Commissioning Support

Emma Kirkwood
HR Business Partner - Yorkshire and Humber Commissioning Support

March 2015

Alison Dubbins
Associate Director of Human Resources and Organisational Development – NHS Hull CCG

Emma Latimer
Chief Officer – NHS Hull CCG

Donna Robinson
PA to Director of Commissioning and Partnerships – NHS Hull CCG

Emma Kirkwood
HR Business Partner Yorkshire and Humber Commissioning Support

The Remuneration Committee met on two occasions between 1 April 2014 and 31 March 2015. Attendance was as follows:

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

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 CCG. This means those who influence the decisions of the CCG as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.

During the year both the Chief Officer and the Chief Finance Officer received a performance related payment of 2.5%. This was approved by the Remuneration Committee.

The CCG can confirm:

- there were no senior managers service contracts awarded during 2014-15;
- there were no payments to past senior managers during 2014-15;
- there were no payments for loss of office during 2014-15; and
- there were no off-payroll engagements during 2014-15.
- there were no payments made to third parties for services of a senior manager

Salaries and allowances of CCG senior managers
2014-15 (subject to audit)

Name	Title	Period In Office	Salary & Fees (bands of £5000) £000's	Taxable Expense payments (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 £2500) £000's	Total (bands of £5000) £000's
Dr Daniel Roper	Chair of Clinical Commissioning Group Governing Body	1 April 2014 - 31 March 2015	75-80	0	0	0	110-112.5	185-190
Dr Raghu Raghunath	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	35-40	0	0	0	*	37.5-40
Dr Leen Witvliet	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	35-40	0	0	0	17.5-20	55-60
Dr James Moult	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	45-50	0	0	0	20-22.5	65-70
Dr John Parker	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	35-40	0	0	0	0	35-40
Dr Mark Follows	Clinical Commissioning Group Governing Body Member	1 April 2014 - 30 June 2014	5 - 10	0	0	0	15-17.5	25-30
Dr Vincent Rawcliffe	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	35-40	0	0	0	0	35-40
Dr Richard Grunewald	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	5-10	0	0	0	0	5-10
Dr Amy Oehring	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	35-40	0	0	0	225-230	240-245
Paul Jackson	Lay Member / Vice Chair	1 April 2014 - 31 March 2015	10-15	0	0	0	0	10-15
Karen Marshall	Lay Member	1 April 2014 - 31 March 2015	10-15	0	0	0	0	10-15
Jason Stamp	Lay Member	1 April 2014 - 31 March 2015	10-15	0	0	0	0	10-15
Emma Latimer	Chief Officer	1 April 2014 - 31 March 2015	110-115	54	0-5	0	0	120-125
Emma Sayner	Chief Finance Officer	1 April 2014 - 31 March 2015	60-65	48	0-5	0	15-17.5	85-90
Julia Mizon	Director of Commissioning and Partnerships	1 April 2014 - 31 March 2015	85-90	38	0	0	35-37.5	130-135
Sarah Smyth	Director of Quality and Clinical Governance/Executive Nurse	1 April 2014 - 31 March 2015	65-70	53	0	0	60-62.5	130-135
Angie Mason	Registered Nurse	1 September 2014 - 31 March 2015	5-10	0	0	0	0	5-10
Carole Robinson	Practice Manager	1 April 2014 - 31 March 2015	5-10	0	0	0	0	5-10

* Dr Raghu Raghunath began to draw his NHS pension from June 2014 therefore this figure is not applicable.

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

2014-15 (subject to audit)

Name	Title	Period In Office	Real increase in pension at age 60 (bands of £2500) £000's	Pension lump sum at age 60 related to real increase in pension (bands of £2500) £000's	Total accrued pension at age 60 at 31 March 2015 (bands of £5000) £000's	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5000) £000's	Cash Equivalent transfer value at 31 March 2015 £000's	Cash Equivalent transfer value at 31 March 2014 £000's	Real increase in Cash equivalent transfer value £000's	Employer's contribution to stakeholder pension £
Dr Daniel Roper	Chair of Clinical Commissioning Group Governing Body	1 April 2014 - 31 March 2015	2.5-5.0	12.5-15	20-25	60-65	426	308	110	0
Dr Raghu Raghunath	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	*	*	*	*	*	*	*	0
Dr Leen Witvliet	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	0-2.5	0-2.5	0-5	10-15	92	72	18	0
Dr James Moult	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	0-2.5	0-2.5	15-20	45-50	227	202	19	0
Dr John Parker	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	0	0	0	0	0	0	0	0
Dr Mark Follows	Clinical Commissioning Group Governing Body Member	1 April 2014 - 30 June 2014	0-2.5	0-2.5	30-35	90-95	480	444	23	0
Dr Vincent Rawcliffe	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	(2.5)-0	(7.5)-(5)	10-15	30-35	227	264	(44)	0
Dr Richard Grunewald	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	0	0	0	0	0	0	0	0
Dr Amy Oehring	Clinical Commissioning Group Governing Body Member	1 April 2014 - 31 March 2015	7.5-10	27.5-30	10-15	35-40	126	22	104	0
Paul Jackson	Lay Member / Vice Chair	1 April 2014 - 31 March 2015	0	0	0	0	0	0	0	0
Karen Marshall	Lay Member	1 April 2014 - 31 March 2015	0	0	0	0	0	0	0	0
Jason Stamp	Lay Member	1 April 2014 - 31 March 2015	0	0	0	0	0	0	0	0
Emma Latimer	Chief Officer	1 April 2014 - 31 March 2015	(2-5)-0	(2-5)-0	30-35	85-90	444	423	9	0
Emma Sayner	Chief Finance Officer	1 April 2014 - 31 March 2015	0-2.5	0-2.5	15-20	50-55	224	204	0	0
Julia Mizon	Director of Commissioning and Partnerships	1 April 2014 - 31 March 2015	0-2.5	2.5-5	30-35	95-100	590	531	45	0
Sarah Smyth	Director of Quality and Clinical Governance/Executive Nurse	1 April 2014 - 31 March 2015	2.5-5	7.5-10	15-20	45-50	206	162	39	0
Angie Mason	Registered Nurse	1 September 2014 - 31 March 2015	0	0	0	0	0	0	0	0
Carole Robinson	Practice Manager	1 April 2014 - 31 March 2015	0	0	0	0	0	0	0	0

* Dr Raghu Raghunath began to draw his NHS pension from June 2014 therefore this figure is not applicable.

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 total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

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 Hull CCG in the financial year 2014-15 was £120-£125k. This was 3.3 times the median remuneration of the workforce, which was £37.5K. All of these values were the same in 2013-14
- In 2014-15, two employees received remuneration which, when grossed up to a full time equivalent, is in excess of the highest-paid member of the Governing Body. Both of these are part time clinical advisory staff.
- 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.

Board profiles and declaration of interests and conflicts

Board Member	Declaration of Interests	Other information
Dr. Dan Roper Chair of Hull CCG		
Member of the Remuneration Committee. **Member of Primary Care Joint Commissioning Committee.** 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 over 25 years and is currently GP Principal at Springhead Medical Centre. Dan cares deeply 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. He has been involved in medical education for many years, particularly in the area of sports medicine.	• Partner at Springhead Medical Centre. • Provides minor surgery at present through the Direct Enhanced Service.	
Emma Latimer CCG Chief Officer		
Member of Primary Care Joint Commissioning Committee **Member of the CCG Board.** Emma Latimer is passionate about working closely with clinicians, partners and local people to tackle some of the biggest health challenges across the city of Hull. As part of a 25 year career in the NHS Emma has brought a wide range of experience from the ambulance service, hospital and community settings to health commissioning. As Chief Officer she is responsible for ensuring that the CCG functions effectively, ensuring improvement in the quality of services and health of local people whilst maintaining value for money. Emma is Programme Sponsor for the Hull 2020 programme. As a Trustee of Hull's acclaimed CatZero project, Emma has a particular interest in promoting health and wellbeing in children and young people, wanting to ensure that they access opportunities that help them realise their potential.	• Local public sector Director representing Community Health Partnerships on the Citycare Board on behalf of the CCG (not remunerated). • Trustee of CatZero with the Charities Commission (not remunerated). • Trustee of Team Teeth (not remunerated).	
Dr. Vince Rawcliffe GP member		
Chair of the NHS Hull CCG Council of Members **Member of Primary Care Joint Commissioning Committee** **Member of the CCG Board.** Vince Rawcliffe has been a GP (currently senior partner) at New Hall Surgery, Hull for 27 years. He has a special interest and additional qualifications in Palliative Care and Musculoskeletal medicine. He places a high value on medical education and has a strong involvement with Hull York Medical School. He is the Macmillan GP lead for early diagnosis of cancer in primary care settings.	• Member of New Hall Surgery. • GP Advisor to National Charity Target Ovarian (not remunerated).	

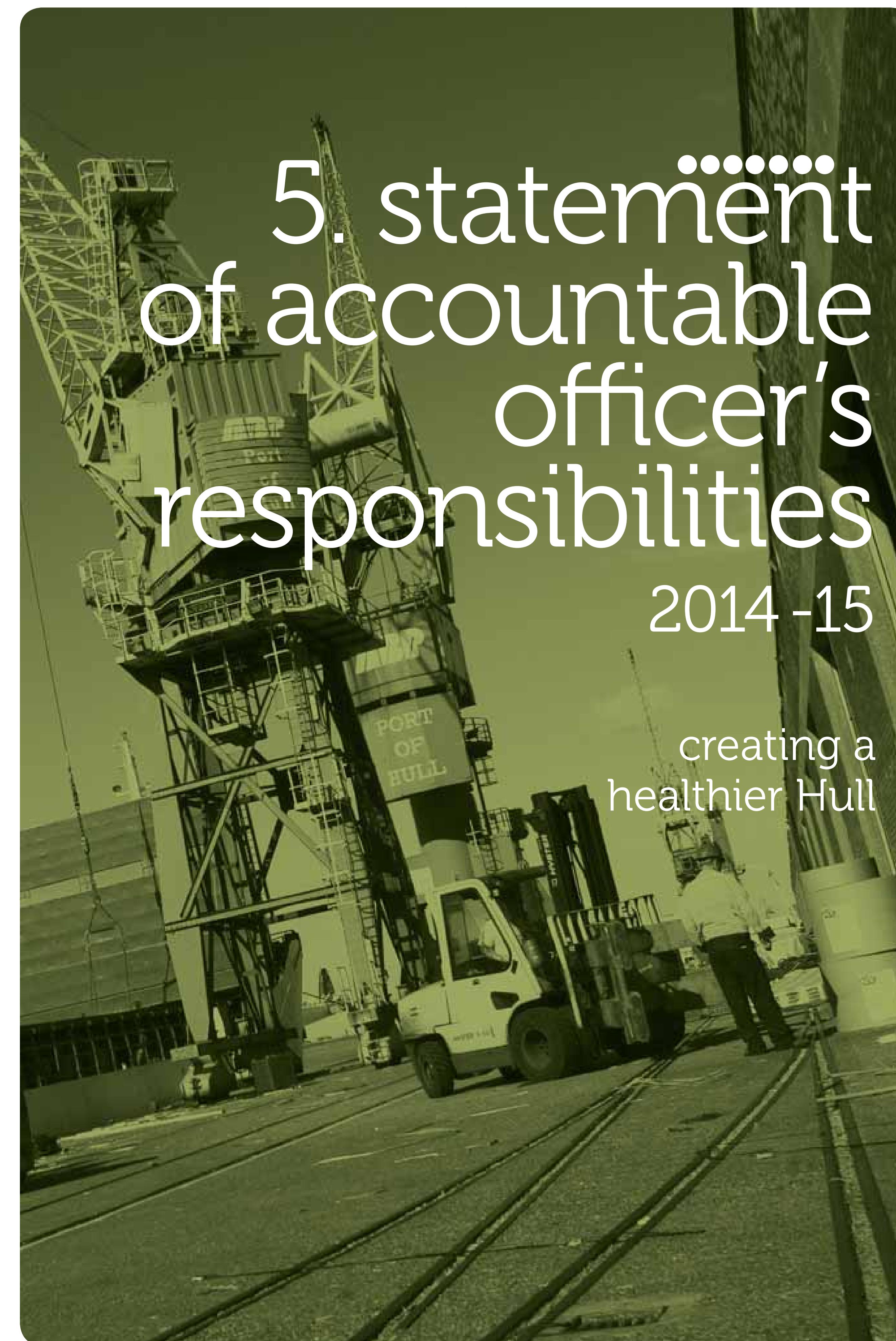
Board Member	Declaration of Interests	Other information
Dr. James Moult GP member		
Chair of CCG Quality and Performance Committee. **Member of Primary Care Joint Commissioning Committee.** **Member of the CCG Board.** **CCG GP lead for Primary Care Programme Board.** James Moult graduated from University College, London in 1997, going on to complete his GP training in Hull. He has been a Partner at Faith House Surgery for almost 6 years.	• NHS England GP Appraiser. • GP Partner at Faith House Surgery. • Dr Moult and his wife are Foster Carers employed by East Riding of Yorkshire Council.	
Dr. John Parker GP member		
Chair of CCG Quality and Performance Committee. **Member of Primary Care Joint Commissioning Committee.** **Member of the CCG Board.** John is a retired senior partner at Morrill Street Health Centre, and CCG GP lead for Urgent Care. John Parker worked as a GP in Hull for 30 years. He has a strong involvement with medical education, having previously been a tutor at Hull York Medical School. He is currently their Associate Director of Clinical Studies. He continues to work as a GP Registrar for out of hours supervision and as an out of hours GP. These roles enable him to maintain first-hand experience of current issues in urgent care.	• Associate Director of Clinical Studies, Hull York Medical School. • Out of hours GP in East Riding of Yorkshire for Humber NHS Foundation Trust.	
Dr. Mark Follows GP member		
Member of the Integrated Audit and Governance Committee **Locum GP and CCG GP Lead for Planned Care.** **Member of CCG Board (1 April 2014 – 30 June 2014)**	• 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 • Dr. Follows and his wife provide Gastroenterology Services for Fountain's Medical Diagnostics Services Limited (based in West Yorkshire).	Left position on 30 June 2014
Dr. Leen Witvliet GP member		
Member of CCG Quality and Performance Committee **Member of Primary Care Joint Commissioning Committee** **Member of the CCG Board.** **CCG GP Lead for Prescribing** Leen is a GP based on Marfleet Lane, East Hull.	• Self employed as NHS GP.	Left position on 31 March 2015

Board Member	Declaration of Interests	Other information
Dr. Raghu Raghunath GP member		
Member of CCG Planning and Commissioning Committee **Member of Primary Care Joint Commissioning Committee** **Member of the CCG Board.** **CCG GP lead for Unplanned Care, Organisational Development Workforce/ Recruitment/Training and Education and Research.** Raghu is a GP at St Andrew's Group Practice. He has strong academic, training and research interests and close links with the local Hull York Medical School as its Director of Clinical Studies. He is a GP trainer and he also delivers training to Foundation Year 2 doctors. He is the local clinical primary care lead for research.	• GP Partner at St Andrew's Group Practice. • St Andrew's has contract with CCG regarding Stroke units at Rossmore and St Mary's Nursing Homes. • Another partner at St Andrew's has a contract with the CCG (via City Health Care Partnership to run pain clinic services (APS): another partner at St Andrew's works for CHCP sexual health services. • Director, Industrial Audiometry consultancy services – providing ad hoc occupational health services. • GP Trainer, Foundation Year 2 Trainer Educational Supervisor, research interests via National Institute for Health Researcher projects. • Primary Care Director of Clinical Studies, Hull York Medical School.	
Dr. Amy Oehring GP member		
Chair of CCG Quality and Performance Committee. **Member of Primary Care Joint Commissioning Committee.** **Member of the CCG Board.** **Member of Hull Children, Young People and Families Board** Amy was born and brought up in Hull. She graduated from Leeds University but soon moved back to work in Hull. Amy is currently working as a GP partner at Sutton Manor Surgery. She has a special interest in skin complaints having gained a distinction in her diploma in dermatology from the University of Cardiff.	• GP Partner at Sutton Manor Surgery • Out of hours GP for City Health Care Partnership (occasionally).	
Emma Sayner Chief Finance Officer		
Member of Primary Care Joint Commissioning Committee. **Member of Integrated Audit and Governance Committee.** **Member of the CCG Board.** Emma has 15 years NHS experience with over 10 years senior management experience after graduating from the NHS Financial Management Training Scheme. During this time she has held a number of senior finance roles including that of Deputy Director of Finance for Hull Primary Care Trust (PCT), Head of Performance at Eastern Hull PCT and Senior Management Accountant at East Riding and Hull Health Authority. She is an Associate Member of the Chartered Institute of Management Accountants (ACMA) and holds a Bachelor of Arts Honours Degree.	• Partner at Burton Lodge Guest House – No direct business interest with the NHS.	

Board Member	Declaration of Interests	Other information
Julia Mizon Director of Commissioning and Partnerships		
Member of Primary Care Joint Commissioning Committee **Member of Planning and Commissioning Committee.** **Member of the CCG Board.** 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. She has experience of 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. Julia is committed to involving local people in decision-making with patient and public engagement embedded in the commissioning process.	• Nil Return	
Karen Marshall Lay Member for Audit, Governance and Conflict of Interest Matters		
Chair of CCG Integrated Audit & Governance Committee. **Chair of CCG Remuneration Committee.** **Member of Primary Care Joint Commissioning Committee.** **Member of the CCG Board.** Karen is a former advanced nurse practitioner and Non-Executive Director for NHS Hull who now works as an independent clinical skills trainer.	• Membership of Wax Lyrical Training • Trustee/Director and Chair of Hull Street Angels Trinity • Registered Nurse • Daughter-in-law is a Staff Nurse working for Hull & East Yorkshire Hospital Trust	
Jason Stamp Vice Chair of the Primary Care Joint Commissioning Centre		
Member of CCG Remuneration Committee. **Vice Chair of the CCG Quality and Performance Committee.** **Vice Chair of the Primary Care Joint Commissioning Committee.** **Member of CCG Integrated Audit & Governance Committee.** **Member of the CCG Board.** 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.	• Employed as a Project Manager within North Bank Forum, which is a voluntary and community sector infrastructure organisation working across Yorkshire and the Humber. • Appointed by NHS England as the Chair of the Patient and Public Voice Assurance Group for specialised Commissioning (Remunerated) • Appointed by NHS England as Co-Chair of the Stakeholder Communications and Engagement Group for the Collaborative Commissioning of specialised services • Appointed by NHS England as a Network Facilitator for Patient Public Involvement Lay Members (Remunerated)	

Board Member	Declaration of Interests	Other information
Paul Jackson Vice Chair of CCG Board and Lay Member for Strategic Change		
Vice Chair of CCG Remuneration Committee. **Vice Chair of CCG Integrated Audit and Governance Committee.** **Member of CCG Planning and Commissioning Committee.** **Chair of the Primary Care Joint Commissioning Committee.** **Vice Chair of the CCG Board.** **Member of the CCG Board.** 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.	• Nil Return	
Sarah Smyth Director of Quality & Clinical Governance /Executive Nurse		
Member of CCG Integrated Audit and Governance Committee. **Member of CCG Quality and Performance Committee.** **Member of Primary Care Joint Commissioning Committee.** **Member of the CCG Board.** Prior to her current appointment Sarah was the Associate Director of Clinical Quality and Patient Safety, Lead Nurse for NHS Hull PCT. 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. Sarah has significant leadership experience in driving the quality agenda forward within acute provision, community provision and commissioning.	• Nil Return	
Dr. Richard Grünewald Secondary Care Doctor		
Member of the CCG Board. 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.	• Nil Return	

Board Member	Declaration of Interests	Other information
Carole Robinson Practice Manager Representative		
Member of CCG Planning and Commissioning Committee. **Member of Primary Care Joint Commissioning Committee.** **Member of the CCG Board.** Carole has worked in the NHS for over 20 years including experience in GP Education, Fund holding and Practice Management. Carole has a BA honours in Business Studies achieved at the University of Lincolnshire and Humberside. Carole is a Practice Manager at Newland Group and Dr Chia and Westrop and has a special interest in holistic patient care.	• General Interest as a Practice Manager in a GP practice.	
Angie Mason Registered Nurse		
Member of Primary Care Joint Commissioning Committee **Member of the CCG Board.** Angie Mason is a registered Mental Health Nurse and has worked in nursing for over 25 years, with experience in both clinical and senior management roles, most recently with NHS Humber Foundation Trust.	• Trustee at SEED Eating Disorder Service (Charity) • Governor Archbishop Sentamu Academy • Specialist Advisor to the Care Quality Commission	Commenced in post on 1 September 2014



Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each CCG 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 CCG.

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 CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the CCG's assets (and hence for taking reasonable steps for the preventionand detection of fraud and other irregularities), are set out in the CCG Accountable Officer Appointment Letter.

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG 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 CCG 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 CCG Accountable Officer Appointment Letter.

Emma Latimer
NHS Hull CCG Chief Officer
Accountable Officer

22 May 2015

6. Annual governance statement 2014 -15

creating a healthier Hull

Annual Governance Statement 2014-15

Introduction & Context

The CCG (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.

As at 1 April 2014, the CCG was licensed without any conditions or directions. It is a membership organisation comprising the 57 general practitioner member practices within the boundary of Kingston upon Hull. It serves a population of approximately 270,000 local residents and in 2014-15 had a programme allocation of £372.5M.

Scope of Responsibility

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

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

Compliance with the UK Corporate Governance Code

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

In particular, we have described through the narrative within this annual governance statement and our annual report and accounts how we have implemented four of the five main principles of the Code; namely: leadership, effectiveness, accountability and remuneration.

The CCG is a statutory NHS organisation. It does not have shareholders and we do not therefore report on our compliance with the fifth main principle of the code; relations with shareholders. We do however set out via this annual governance statement and our annual report and accounts how we have discharged our responsibilities with respect to our members and the general public.

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 maintains 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 have previously been certified as compliant with the requirements of NHS England.

During 2014-15 the Constitution has been revised in the light of further NHS England guidance. In particular, it has been updated to enable the establishment of joint committee arrangements with NHS England with respect to the co-commissioning of primary care. The changes were approved by the Council of Members (membership body) and the Governing Body in January 2015. These amendments have been submitted to NHS North of England for approval.

Key Features of the CCG Constitution

The Constitution sets out the group's Standing Orders, Prime Financial Policies and Scheme of Delegation. Through these a robust system of control is maintained. The CCG remains accountable for all of its functions, including those that it has delegated.

The Scheme of Delegation defines those decisions that are reserved to the Council of Members and those that are the responsibility of its Governing Body (and its committees), the CCG committees, individual officers and other employees.

The Council of Members comprises representatives of the 57 member practices and has overall authority on the CCG's business. It receives performance updates at each of its meetings as to the progress of the CCG against its strategic objectives.

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's objectives. It has established five committees to assist it in the delivery of the statutory functions and key strategic objectives of the CCG . It receives regular opinion reports from each of its committees, as well as their minutes. These, together with a wide range of other updates, enable the Governing Body to assess performance against these objectives and direct further action where necessary.

The Integrated Audit and Governance Committee also provides the Governing Body with an evaluation of the sources of assurance available to the CCG . Significant matters are escalated through the risk and control framework and reviewed by the committee. The Governing Body is represented on all the committees so as to ensure that it remains sighted on all key risks and activities across the CCG

The CCG governance framework for 2014-15 is summarised in diagram 1 below:

The CCG Governance Framework Diagram 1

Integrated Audit and Governance Committee	Planning and Commissioning Committee	Quality and Performance Committee	Primary Care Co-commissioning Committee	Remuneration Committee
Areas of Responsibility • Independent Assurance • Governance, Systems and control including BAF and Risk Register • Internal Control and Audit • Declarations / Conflicts of Interest • Standards of business conduct • Legal Compliance • Health and Safety • Information Governance • Value for money	**Areas of Responsibility** • Service re-design • Procurement • Joint Commissioning • Engagement • CCG commissioning programmes • Financial Strategy • Strategic Planning • Partnership Development including Health and Wellbeing • Value for money	**Areas of Responsibility** • Financial Management • Contract Management • Performance Management • Value for Money (VFM) • Quality Improvement • Safeguarding • Serious Incidents / Incidents • Patient Experience • Equality and Diversity • Individual Funding Requests • CQUINS • Clinical Governance • Patient Experience • Research and Development • Infection Control • Value for money	**Areas of Responsibility** • GMS, PMS and APMS contracts • New enhanced services • Local incentive schemes • Establishment of new GP practices • Practice mergers • Discretionary payment • Extended PMS • New services to be commissioned from primary care. • Value for money	**Areas of Responsibility** • Remuneration and Terms of Service for VSM and Board Members • Remuneration for Clinical Leads • Make recommendations on pay and remuneration for employees of the CCG. Bonus-linked performance reviews for VSM • Performance review assessment for SLT • Make recommendations on Agenda for Change remuneration for all AfC pay bands; with regard to nationally agreed terms • Value for money
Policy Areas Approval • Governance • Risk management • Assurance • Conflicts of Interest	**Policy Areas Approval** • Commissioning • Engagement strategies / plans • Planning	**Policy Areas Approval** • Quality • Safeguarding • Performance • Clinical governance		**Policy Areas Approval** • VSM remuneration / Terms of Service • National terms and conditions • Performance management policy • Performance Related Pay • Workforce policies - remuneration

Further information regarding the CCG's Constitution, governance framework and activities can be found on the CCG website; **http://www.hullccg.nhs.uk/**

The **membership, attendance** and activity summary

The membership, attendance and activity summary of the Council of Members, Governing Body and its committees for 2014/15 are given below:

Key	
Did/Does not attend meeting at this time	■
Attended meeting	✓
Did not attend meeting	✗

Council of **Members**

Key Functions and 2014-15 summary

The Council of Members has final authority for all CCG business and established the vision, values and overall strategic direction for the organisation. It has reserved powers with respect to authorisation of the CCG Constitution, commissioning strategy and election / ratification of key appointments to the CCG Board.

During 2014-15 the Council met 6 times and was quorate on each occasion. It approved changes to the CCG Constitution, ratified the appointment to the vacancies for GP Members of the CCG Board and approved the Conflicts of Interest Policy, with particular reference to the newly established Primary Care Joint Commissioning Committee arrangements. In addition, the Council considered agenda items pertaining to its responsibilities including regular items relating to quality, performance and strategy.

Attendance Record	08/05/14	10/07/14	11/09/14	06/11/14	08/01/15	12/03/15
AH Tak & Dr M Sadik	✗	✓	✓	✓	✗	✓
Awan & Partners	✓	✓	✓	✓	✓	✓
Bridge Group Practice	✓	✗	✓	✓	✗	✓
Burnbrae Medical Practice (Practice of Haxby Group)	✗	✓	✓	✗	✓	✗
Chauhan & Partners	✗	✗	✗	✗	✓	✓
Chestnut Farm Surgery	✗	✗	✗	✓	✗	✗
Choudhary AK & Danda SR Practice	✗	✗	✗	✓	✗	✗
Chowdhury GM	✗	✗	✗	✗	✗	✗
Cook BF	✓	✓	✓	✓	✓	✓
Datta AK	✗	✗	✓	✓	✗	✗
Dave G	✓	✓	✓	✗	✗	✗
Diadem Medical Practice	✓	✓	✓	✗	✓	✓
East Park Practice	✗	✗	✗	✗	✓	✓
Foulds and Partners	✗	✓	✓	✗	✓	✓
Ghosh, Raghunath & Partners	✗	✓	✓	✗	✓	✓
Hendow GT	✗	✓	✓	✗	✓	✓
Hussain SG & Partners	✗	✗	✗	✗	✗	✗
Joseph JC	✓	✗	✗	✓	✗	✗
Kingston Health Hull	✓	✓	✓	✓	✓	✗
Kingston Medical Centre	✓	✓	✗	✓	✓	✓
Kingswood Surgery	✗	✓	✓	✗	✓	✗
KV Gopal Surgery	✗	✓	✗	✓	✗	✗
Machpie, Raghunath & Partners	✗	✓	✓	✗	✓	✓
Malczewski GS	✓	✗	✗	✗	✗	✗
Mallik MK	✓	✗	✓	✓	✓	✓
Miller and Partners	✗	✓	✓	✓	✗	✓
Morrill Street Group Practice	✓	✗	✓	✓	✗	✗
Musil J	✓	✓	✗	✓	✓	✓
Nayar JK	✗	✗	✗	✗	✗	✗
Newland Group Practice	✗	✗	✗	✗	✗	✗
New Green Surgery	✓	✓	✓	✓	✓	✓
Northpoint	✗	✗	✗	✗	✗	✗
Orchard Park Surgery	✗	✓	✓	✗	✓	✗
Palooran, George & Koshy	✓	✗	✓	✓	✗	✗
Percival & Partners	✗	✗	✗	✗	✗	✗
Poulose NA, Awan & Basheer	✓	✓	✓	✓	✓	✓
Priory Surgery Haxby Group	✗	✓	✓	✗	✓	✗
Quays Medical Centre	✓	✓	✓	✓	✓	✓
Raghunath & Partners	✗	✓	✓	✗	✓	
Raut Partnership	✓	✓	✓	✓	✓	✓
Rawcliffe & Partners	✓	✗	✗	✓	✓	✓
Rej AK	✓	✗	✗	✓	✗	✗
Riverside Medical Centre	✓	✓	✓	✓	✓	✗
Roper & Partners	✓	✗	✓	✓	✓	✓
Shaikh Partnership	✗	✗	✗	✗	✗	✗
St Andrews Group Practice Newington	✗	✓	✓	✗	✓	✓
St Andrews Northpoint	✗	✓	✓	✗	✓	✓
Story Street Practice & Walk in Centre	✗	✓	✗	✗	✓	✓
Sutton Manor Surgery	✓	✓	✓	✓	✓	✓
The Avenues Medical Centre	✓	✓	✗	✓	✓	✗
The Calvert Practice	✓	✗	✗	✗	✗	✗
Venugopal J & Partners	✗	✓	✓	✗	✓	✓
Weir & Partners	✗	✗	✗	✓	✓	✓
L Witvliet	✗	✗	✓	✓	✓	✓
Wolseley Medical Centre	✗	✓	✓	✓	✓	✓
Wong & Partners	✓	✓	✓	✓	✓	✓
Yagnik RD	✓	✗	✗	✗	✗	✗

* The representative may have changed during this period.

Clinical Commissioning Group **Governing Body**

Key Functions and 2014-15 summary

The governing body has its functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act. In particular, it has responsibility for:

a) ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance (its main function);

b) determining the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act; and

c) those matters delegated to it within the CCG's Constitution

The CCG governing body has met 9 times during the year and was quorate on each occasion. Its agendas have incorporated a comprehensive range of reports to support delivery of its key functions; including the 2015-16 Operational Plan, Business Intelligence Reports (incorporating contracts, finance and performance monitoring) and Hull 2020 transformation programme updates.

Attendance Record	25/04/14	30/05/14	25/07/14	26/09/14	28/11/14	30/01/15	27/02/15	27/03/15
Mark Follows	✗	✓	■	■	■	■	■	■
Richard Grunewald	✓	✓	✓	✗	✓	✓	✓	✓
Paul Jackson	✗	✓	✓	✓	✓	✓	✓	✗
Emma Latimer	✓	✓	✓	✓	✓	✓	✓	✓
Karen Marshall	✓	✓	✓	✓	✓	✓	✓	✓
Angie Mason	■	■	■	✗	✓	✓	✓	✓
Julia Mizon	✓	✓	✓	✓	✓	✓	✓	✓
James Moult	✗	✓	✓	✓	✓	✓	✓	✓
Amy Oehring	✓	✓	✗	✗	✓	✓	✓	✓
John Parker	✓	✗	✓	✓	✓	✓	✓	✓
Raghu Raghunath	✓	✗	✓	✓	✓	✗	✓	✓
Vince Rawcliffe	✓	✓	✗	✓	✓	✓	✓	✓
Carole Robinson	✓	✓	✓	✓	✓	✓	✓	✓
Dan Roper	✓	✓	✓	✓	✓	✓	✗	✓
Emma Sayner	✗	✓	✓	✓	✓	✓	✓	✓
Sarah Smyth	✓	✗	✓	✓	✓	✓	✓	✓
Jason Stamp	✓	✓	✓	✓	✓	✓	✓	✓
Leen Witvliet	✓	✓	✓	✓	✓	✓	✓	✓

Integrated Audit and Governance Committee

Key Functions and 2014-15 summary

The Integrated Audit and Governance Committee is responsible for providing assurance to the CCG governing body 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. The committee is able to direct further scrutiny, both internally and externally where appropriate, for those functions or areas where it believes insufficient assurance is being provided to the CCG governing body.

During 2014-15 the committee's met 8 times during the year and was quorate on each occasion. The committee's activities included:

- Receiving and reviewing the Board Assurance Framework and Risk Register on a regular basis throughout the year.
- Considering 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.
- Receiving and scrutinising reports on tender waivers, declarations of interest and gifts and hospitality.
- Reviewing the annual accounts and annual governance statement and made recommendations to the governing body.
- Through its work programme provided assurance to the governing body that the system of internal control is being implemented effectively.

Attendance Record	17/04/14	13/05/14	27/05/14	08/07/14	09/09/14	11/11/14	13/01/15	17/03/15
Karen Marshall	✓	✓	✓	✓	✓	✓	✓	✓
Paul Jackson	✓	✓	✓	✓	✓	✓	✓	✓
Mark Follows	✗	✓	✗	■	■	■	■	■
Jason Stamp	■	■	■	✓	✗	✓	✓	✗

Planning and Commissioning Committee

Key Functions and 2014-15 summary

The Planning and Commissioning Committee is responsible for ensuring that the planning, commissioning and procurement of commissioning-related business is in line with the CCG organisational objectives. In particular, the Committee is responsible for preparing and recommending 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 update report is produced by the committee after each meeting for consideration by the governing body as to the sources of confidence available in relation to the areas of responsibility of the committee.

The Committee met 12 times during the year and was quorate on 11 occasions. The committee's activities included:

- Development of the community services re-procurement specifications;
- Receiving and reviewing commissioning a wide range of clinical commissioning policies and prescribing rebates;
- The CCG procurement framework, and
- The IM&T strategy

Attendance Record	02/04/14	07/05/14	04/06/14	02/07/14	06/08/14	03/09/14	01/10/14	05/11/14	03/12/14	07/01/15	04/02/15	04/03/15
John Parker	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Raghu Raghunath	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓
Paul Jackson	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓
Julia Mizon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Penny Stephenson	✓	✗	✓	✓	✗	✓	✓	■	■	■	■	■
Karen Billany	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓
Philip Davis	✓	✓	✓	✓	✗	✓	✓	✗	✓	✓	✓	✓
Erica Daley	✓	✓	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓
Bernie Dawson	✓	✓	✗	✗	✗	✓	✓	✓	✓	✗	✓	✓
Joy Dodson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗	✓
Andrew Taylor / Vicky Harris	✗	✗	✓	✗	✗	✗	✓	✗	✓	✓	✗	✓
Sue Lee	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Smyth	✓	✓	✗	✓	✓	✓	✓	✗	✗	✗	✗	✗
Elaine Schofield	✓	✗	✗	✓	✗	✗	✗	✗	■	■	■	■
Danny Storr	✓	✗	✗	✓	✓	✓	✓	✗	✓	✗	✓	✓
Carole Robinson	■	■	✓	✗	✗	✓	✓	✓	✓	✓	✓	✓
Amy Oehring	■	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗	✓
Mike Holmes	■	■	✓	✗	✗	✓	■	■	■	■	■	■

Quality and Performance Committee

Key Functions and 2014-15 summary

The Quality and Performance Committee is responsible for the continuing development, monitoring and reporting of performance outcome metrics in relation to quality improvement, financial performance and management plans. It ensures the delivery of improved outcomes for patients in relation to the CCG's agreed strategic priorities.

The Committee met 11 times during the year and was quorate on all occasions. An update report is produced by the committee after each meeting for consideration by the governing body as to the sources of confidence available in relation to the areas of responsibility of the committee. The committee's activities included:

- Provider quality monitoring and performance escalation;
- The CCG's strategy response to the second report of Sir Robert Francis and Putting Patients First;
- Monitoring of CQUINS, incidents and serious untoward incidents, and
- Scrutiny of financial delivery

Attendance Record	24/04/14	22/05/14	26/06/14	24/07/14	25/09/14	23/10/14	20/11/14	17/12/14	22/01/15	26/02/15	26/03/15
James Moult	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Carla Ramsay	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓	
David Blain / Hayley Crawley	✗	✓	✓	✓	✓	✓	✗	✓	■	■	■
Leen Witvliet	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	✓
Emma Corbet / Esther Smith	✓	✓	✓	✓	✗	✓	✓	✓	✓	✓	✓
Jason Stamp	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Joy Dodson	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lorna Morris	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sarah Smyth	✓	✗	✓	✓	✓	✓	✗	✓	✓	✓	✓
Sue Lee	■	✗	✓	✓	✓	✗	✗	✓	✓	✓	✓

Primary Care Joint Commissioning Committee

Key Functions and 2014-15 summary

The Joint Committee carries out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England and such CCG functions under sections 3 and 3A of the NHS Act as have been delegated to the joint committee.

The Committee was established following the enactment of the relevant legislative arrangements and met on one occasion in shadow form during the year. The role of the Committee includes the following activities:

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

The Committee's first meeting agenda included consideration of its Terms of Reference and Conflict of Interest Policy.

Attendance Record	27/03/15
Paul Jackson	✓
Jason Stamp	✓
Emma Latimer	✓
Emma Sayner	✓
Julia Mizon	✓
Sarah Smyth	✓
Karen Marshall	✓
Geoff Day	✓
John Parker	✓
Julia Weldon	✓
Angie Mason	✓

Remuneration Committee

Key Functions and 2014-15 summary

The purpose of the Committee is to 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. In so doing the Committee will have proper regard to the organisation's circumstances and performance and to the provisions of any national agreements and NHS Commissioning Board guidance as necessary.

The Committee met twice during the year and was quorate on each occasion. Highlights of the Committee's activity included pay progression considerations, honorary contracts reviews and VSM and Agenda for Change performance frameworks.

Representative	10/09/14	07/01/15
Karen Marshall	✓	✓
Dan Roper	✓	✓
Jason Stamp	✓	✓
Paul Jackson	✗	✓

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 functionality.

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 board assurance framework and Good Governance Framework.

The Governing Body has committed to the previously approved organisational development strategy, which includes a comprehensive programme of Governing Body development as a team. Activities in the last financial year have included Governing Body facilitation focused on the characteristics of high performing boards, strengthened debate and decision making competence, improved Governing Body function, higher levels of engagement with core business from Governing Body members, the definition and approval of a set of corporate values and improved strategic thinking and planning, including the establishment of a set of strategic objectives for the 2015-16.

The Clinical Commissioning Group Risk Management Framework

The CCG maintains a Risk Management Strategy which sets out its appetite for risk, together with the practical means through which risk is identified, evaluated and the control mechanisms through which it is managed. It creates a framework to achieve a culture that encourages staff to:

- Avoid undue risk aversion but rather identify and control risks which may adversely affect the operational ability of the CCG,
- Compare and prioritise risks in a consistent manner using defined risk grading guidance, and
- Where possible eliminate or transfer risks or reduce them to an acceptable and cost effective level or otherwise ensure the organisation accepts the remaining risk.

The Risk Management Strategy was reviewed and updated in December 2014. 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 CCG's Chief Officer has overall responsibility for risk management. Through delegated responsibility the Associate Director of Corporate Affairs (currently the Director of Quality and Clinical Governance/Executive Nurse) has day to day management of the organisation's 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 maintains a Risk Register through an electronic reporting system which is accessible to all staff. Risks are systematically reviewed at the Corporate Operations Group, GP Senior Leadership Team Meeting and the Integrated Audit and Governance Committee as well as by directorates and senior managers. The Risk Register assesses the original and mitigated risks for their impact and likelihood and tracks the progress of individual risks over time through a standardised risk grading matrix. Risks that increase in rating are subject to additional scrutiny and review.

The Integrated Audit and Governance Committee maintains oversight of the risks to the CCG through review of the Risk Register at each of its meetings. It provides an opinion to the Governing Body as to the adequacy of assurances available with respect to the control mechanisms for risk.

All formal papers, strategies or policies to the Council of Members, Governing Body or its committees are assessed for their risks against the defined framework. All new or updated policies of the CCG are subject to equality impact assessments.

The Board Assurance Framework is an essential part of the CCG's governance arrangements. It provides the means through which threats to the achievement of the organisation's strategic objectives are clearly identified, assessed and mitigated. It has been subject to regular review throughout 2014-15 and is received at each meeting of the Integrated Audit and Governance Committee. The committee provides an opinion to the Governing Body as to the adequacy of the assurances available with

respect to management of the Board Assurance Framework. In doing so the committee draws upon the sources of assurance available to it, including the work of the CCG's external auditors, a comprehensive internal audit programme and the work of NHS Protect.

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 maintains an active programme of engagement with the public and other stakeholders on key strategic and service decisions and considers its plans in the light of any risks identified. This work includes engagement with the CCG's ambassadors, its People's Panel of five thousand local residents and a combination of formal and informal consultations on key aspects of its commissioning programme.

The system has been in place in the CCG for the year ended 31 March 2015 and up to the date of approval of the Annual Report and Accounts. The process of review and strengthening of the risk and control framework of the CCG will continue throughout 2015-16.

The Clinical Commissioning Group Internal Control Framework

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

The system of internal control allows 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 Governing Body, on behalf of the Council of Members, ensures that the organisation maintains a comprehensive system of internal control through the application of its standing orders, prime financial policies and scheme of delegation.

The Integrated Audit and Governance Committee routinely considers performance and other reports which enables it to assess the effectiveness of internal control mechanisms. It then provides an opinion to the Governing Body as to the adequacy of assurances available with respect to internal control.

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 CCG, 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.

In line with good data protection practice, the CCG has undertaken a process of identifying and risk assessing all Personal Confidential Data that it has responsibility for. This on-going work enables assurance to be provided that all such flows of data are fair, lawful and secure. It also ensures that adequate technical and operational measures are in place to secure any transfers of data.

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. 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 Governing Body and its Quality and Performance Committee have continued to maintain rigorous oversight of the performance of the CCG and the Integrated Audit and Governance Committee has assessed the adequacy of the assurances available in relation to performance.

At the start of 2014-15 the CCG had one extreme (red) rated risk and 7 high (amber) rated risks within its Corporate Risk Register. By the end of 2014-15 the CCG had 5 extreme risk and 6 high risks within its Corporate Risk Register. The extreme rated risks were 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. This risk was extreme (red) rated at the end of 2013-14	Monitored through monthly contractual management board meetings with the relevant provider and remedial action plan reviewed via Senior Leadership Team and Quality and Performance Committee of the CCG. Exception Notice in place.	The CCG Board receives bi-monthly assessment of progress via its Business Intelligence Report.
Everyone Counts Indicator Risk that the performance target for cancer 62-day wait for treatment will not be achieved in 2014-15	Monitored through monthly contractual management board meetings with the relevant provider. Contract Query Notice in place. Action plan reviewed via Senior Leadership Committee	The CCG Board receives bi-monthly assessment of progress via its Business Intelligence Report.
Everyone Counts Indicator Risk that the 18 week Referral To Treatment targets are not delivered in 2014-15	Monitored through monthly contractual management board meetings with the relevant provider. Weekly meetings between commissioners and provider. Patient Tracking Lists are received weekly by commissioner to monitor impact of the recovery plan	The CCG Board receives bi-monthly assessment of progress via its Business Intelligence Report
Waiting times for Childrens and Young Persons (CYP) Autism: Assessment and Diagnosis exceeds the commissioned target.	Monitored through contract monitoring meetings and through the CYP Autism Strategy Group.	External assurance process include the CYP Autism Strategy Group which reports to the CYP and Maternity Programme Board (CCG) and to the Children and Families Board (Partnership)
The requirements of the local SEND reforms as part of the Children and Families Act 2014, requires 1,200 children and young people SEN plans to be translated to the new Education, Health and Care Plans (EHCP). Risks occur in the capacity to translate existing statements within the 18 months the local authority requests.	Monitoring of Transition Plan	Assurance is provided through the Hull Childrens and Families Board, Hull CCG Children, Young People and Maternity Programme Board and Hull SEND Board. Partnership working with Hull City Council and local providers on capacity and resilience and is via workstreams from the above committee's and boards.

The Board Assurance Framework (BAF) is the key source of evidence that links the organisation's 'mission critical' strategic objectives to risks, controls and assurances, and is the main tool that the Governing Body uses in discharging its overall responsibility for internal control. The BAF is regularly reviewed and updated by each nominated risk owner and goes bi-monthly to the Integrated Audit and Governance Committee and biannually to the CCG Board to provide assurance on behalf of the organisation.

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 and Governance Committee receives a regular update from the Quality and Performance Committee as to the economic, efficient and effective use of resources by the CCG. The Integrated Audit and Governance Committee advise the Governing Body 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. The findings are reported to the Integrated Audit and Governance Committee.

Review of Effectiveness of Governance, Risk Management & Internal Control

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

I am advised by the Integrated Audit and Governance Committee as to the adequacy of sources of assurance available to the CCG in relation to financial, information, corporate and clinical governance. They have advised that they are assured that there is a generally sound system of control within the CCG. 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 2015-16.

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 of the 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 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 CCG.

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/Executive Nurse has led on clinical governance, including infection control and safeguarding, as well as acting as Caldicott Guardian. On behalf of the Associate Director of Corporate Affairs, the Director of Quality and Clinical Governance/ Executive Nurse has discharged the CCG's obligations with regards to risk management and the Director of Commissioning and Partnerships freedom of information. Taken together, the successful fulfilment of these functions has contributed to assuring the Governing Body on the achievement of the CCG'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 CCG's membership of the local Health and Wellbeing Board and specialised commissioning network.

Internal Audit has an important role in the risk assessment of the CCG by advising on the achievement of corporate governance requirements, providing independent assessment and opinion to the Integrated Audit and Governance Committee, Governing Body 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 and Governance Committee, including monitoring of all recommendations.

During 2014-15 several risk management development sessions were organised. The Corporate Services Manager attended one of the CCG's team brief sessions to raise awareness and provide a brief outline of the risk process. Following this, more detailed sessions were held with risk owners and senior managers via the Corporate Operations Groups. These sessions focused on the purpose of the risk register and board assurance framework and resulted in increased ownership and knowledge from the participants.

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 CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

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

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

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

- The assessment of the CCG through the quarterly checkpoint meetings with NHS North of 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;
- 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 2014-15.

The CCG currently contracts with a number of external organisations for the provision of support services and functions. This specifically includes the NHS Shared Business Service, NHS Business Services Authority and Victoria Payroll Services. Assurances on the effectiveness of the controls in place for these third parties are received in part from an annual Service Auditor Report from the relevant service and I have been advised that adequate assurances have been provided for 2014-15.

The CCG also contracts with Yorkshire and Humber Commissioning Support for a range of commissioning support functions. Future commissioning support arrangements are subject to the NHS England lead provider framework. Yorkshire and Humber Commissioning Support was not approved on to the framework and so the CCG is an active member of the Yorkshire and Humber Commissioning Support Transition Group which is determining the commissioning support arrangements for 2015-16 and beyond.

During the year the Internal Audit issued no audit reports with a conclusion of limited or no assurance.

Whilst significant assurance has been given for all audit assignments completed to date, 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. All recommendations have been agreed to appropriately mitigate such risks.

Following completion of the planned audit work for the financial year for the CCG the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG'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.

Performance

Hull CCG 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 CCG had a target of 0 MRSA infections for 2014-15, however, 2 cases were reported during the year.
- Healthcare Associated Infection: Clostridium difficile (March data) – the CCG had a target of 62 cases for 2014-15; however, 89 cases were 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 2014-15 CCG target is 85%; the latest year-to-date position is 79.41%.
- 62 day cancer referral to treatment time following referral from NHS Cancer Screening Services (February data) - The 2014-15 CCG target is 90%, the latest year-to-date position is 87.82%.

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) - The CCG did not meet the overall target of 90% of admitted patients treated within 18 weeks, only achieving 84.68%.
- Specialty level 18 week referral to treatment time – Non-Admitted Pathways (February data) - The CCG did not meet the overall target of 95% of non-admitted patients treated within 18 weeks, only achieving 89.98%.
- Incomplete pathways - (February data) - The CCG did not meet the overall target of 92% of patients treated within 18 weeks on incomplete pathways, only achieving 90.25%.

Referral to treatment times are subject to significant review and are being monitored against the Hull & East Yorkshire Hospital Trust (HEYHT) recovery plan and managed through contractual reviews and SRG group.

- Mixed Sex Accommodation (MSA) Breaches (March data) - The CCG had a target of 0 Mixed Sex Accommodation breaches for 2014-15; however, 23 cases were reported during the year. Root Cause Analysis is to be shared by HEYHT as soon as possible.
- Accident and Emergency – total time spent in department (March data) – The CCG did not meet the overall target for 95% of patients attending A&E to spend four hours or less in the department, only achieving 88.29%
- Ambulance response times (March data) – Yorkshire Ambulance Service did not meet the overall target for 75% 'Red' calls having an emergency response arriving at the scene of the incident within 8 minutes, only achieving 69%. However, performance for incidents within the CCG area was above target at 79.7%

Data Quality

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

Business Critical Models

The CCG recognises the principles reflected in the Macpherson report as a direction of travel for business modelling in respect of service analysis, planning and delivery. An appropriate framework and environment is in place to provide quality assurance of business critical models within the CCG. The CCG has adopted a range of quality assurance systems to mitigate business risks.

These include:

- Stakeholder experience including patient complaints and serious untoward incident management arrangements;
- Risk Assessment (including risk registers and a board assurance framework);
- Internal Audit Programme and External Audit review;
- Executive Leads with clear work portfolios;
- Policy control and review processes;
- Public and Patient Engagement, and
- Third Party Assurance mechanisms.

Data Security

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

The CCG recognises the importance of maintaining data in a safe and secure environment. It uses the Serious Incidents Requiring Investigation (SIRI) tool to assess any matters involving potential data loss to the organisation. The tool requires the reporting of any data incident rated at level 2 or above via the information governance toolkit. The CCG has had no such incidents during 2014-15. One minor incident (level 1) of data loss was recorded during 2014-15, however, this fell short of the external reporting threshold.

Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG 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 CCG has previously 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 CCG 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. A further review is scheduled into the CCG's 2015-16 internal audit plan.

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 CCG'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.

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 internal control 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
22 May 2015

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healthier Hull

SECTION B

FOREWORD TO THE ACCOUNTS

NHS HULL CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2015 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.

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS HULL CCG

We have audited the financial statements of NHS Hull CCG for the year ended 31 March 2015, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes. These financial statements have been prepared under applicable law and the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Members of NHS 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 2015 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

KPMG

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

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting polices directed by the NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the information given in the Strategic Report and Members' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

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

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

Respective responsibilities of the CCG and auditor

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

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

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

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

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

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

KPMG

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

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

Conclusion

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

Certificate

We certify that we have completed the audit of the accounts of NHS 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.

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

Chartered Accountants
1 The Embankment
Leeds
LS1 4DW

26 May 2015

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

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1	2,360	2,122
Operating Expenses	5	368,532	365,739
Other operating revenue	2	(704)	(852)
Net operating expenditure before interest		**370,188**	**367,009**
Investment Revenue		0	0
Other (gains)/losses		0	0
Net operating expenditure for the financial year		**370,188**	**367,009**
Net (gain)/loss on transfers by absorption		0	0
Retained Net Operating Cost for the Financial Year		**370,188**	**367,009**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1	2,186	1,997
Operating Expenses	5	4,857	4,834
Other operating revenue	2	(88)	(11)
Net administration costs before interest		**6,955**	**6,820**
Programme Income and Expenditure			
Employee benefits	4.1	174	125
Operating Expenses	5	363,675	360,905
Other operating revenue	2	(616)	(841)
Net Programme costs before interest		**363,233**	**360,189**

Other Comprehensive Net Expenditure	2014-15 £000	2013-14 £000
Impairments and reversals	0	0
Net gain/(loss) on revaluation of property, plant & equipment	0	0
Net gain/(loss) on revaluation of intangibles	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Movements in other reserves	0	0
Net gain/(loss) on available for sale financial assets	0	0
Net gain/(loss) on assets held for sale	0	0
Net actuarial gain/(loss) on pension schemes	0	0
Share of (profit)/loss of associates and joint ventures	0	0
Reclassification Adjustments	0	0
On disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year	**370,188**	**367,009**

The notes on pages 10 to 36 form part of this statement

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	8	0	0
Intangible assets		0	0
Investment property		0	0
Trade and other receivables	9	0	0
Other financial assets		0	0
Total non-current assets		**0**	0
Inventories		0	0
Trade and other receivables	9	2,190	928
Other financial assets		0	0
Cash and cash equivalents	10	4	5
Total current assets		**2,194**	933
Non-current assets held for sale		0	0
Total current assets		**2,194**	933
Total assets		**2,194**	933
Current liabilities			
Trade and other payables	11	(20,726)	(19,105)
Other financial liabilities		0	0
Other liabilities		0	0
Provisions	12	(8)	(8)
Total current liabilities		**(20,734)**	(19,113)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(18,540)**	(18,180)
Non-current liabilities			
Trade and other payables	11	0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	12	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(18,540)**	(18,180)
Financed by Taxpayers' Equity			
General fund		(18,540)	(18,180)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(18,540)**	(18,180)

The notes on pages 10 to 36 form part of this statement

The financial statements on pages 6 to 9 were approved by the Governing Body on 22 May 2015 and signed on its behalf by:

Emma Latimer
Accountable Officer

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(18,180)	0	0	**(18,180)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(18,180)**	**0**	**0**	**(18,180)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	(370,188)			(370,188)
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(370,188)**	**0**	**0**	**(388,368)**
Net funding	369,828	0	0	369,828
Balance at 31 March 2015	**(18,540)**	**0**	**0**	**(18,540)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	**0**	**0**	**0**	**0**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**(1)**	**5**	**0**	**4**
Adjusted NHS Commissioning Board balance at 1 April 2013	**(1)**	**5**	**0**	**4**
Changes in NHS Commissioning Board taxpayers' equity for 2013-14				
Net operating costs for the financial year	(367,009)			(367,009)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	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
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Commissioning Board Expenditure for the Financial Year	**(367,005)**	**0**	**0**	**(367,005)**
Net funding	348,825	0	0	348,825
Balance at 31 March 2014	**(18,180)**	**0**	**0**	**(18,180)**

The notes on pages 10 to 36 form part of this statement

Statement of Cash Flows for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(370,188)	(367,009)
Depreciation and amortisation	5	0	4
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in trade & other receivables	9	(1,262)	(928)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	11	1,621	19,105
Increase/(decrease) in other current liabilities		0	0
Provisions utilised		0	0
Increase/(decrease) in provisions	12	0	8
Net Cash Inflow (Outflow) from Operating Activities		**(369,829)**	(348,820)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(369,829)**	(348,820)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		369,828	348,825
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on SoFP PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**369,828**	348,825
Net Increase (Decrease) in Cash & Cash Equivalents	10	**(1)**	5
Cash & Cash Equivalents at the Beginning of the Financial Year		**5**	0
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**4**	5

The notes on pages 10 to 36 form part of this statement

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

1.5 Charitable Funds

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

1.6 Pooled Budgets

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

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

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

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

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

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

- None

1.7.2 Key Sources of Estimation Uncertainty

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

- **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 CCG 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

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

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

1.11.2 Valuation

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

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

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

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

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

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

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.

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.

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

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

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

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

1.22 Clinical Negligence Costs

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

1.23 Non-clinical Risk Pooling

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

1.24 Continuing healthcare risk pooling

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

1.25 Carbon Reduction Commitment Scheme

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

1.26 Contingencies

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

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

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

1.27 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.27.1 Financial Assets at Fair Value Through Profit and Loss

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

1.27.2 Held to Maturity Assets

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

1.27.3 Available For Sale Financial Assets

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

1.27.4 Loans & Receivables

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

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

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

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

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

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

1.28 Financial Liabilities

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

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

1.28.1 Financial Guarantee Contract Liabilities

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

· The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,

· The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.28.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.28.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the 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.

1.29 Value Added Tax

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

1.30 Foreign Currencies

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

1.31 Third Party Assets

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

1.32 Losses & Special Payments

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

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

1.33 Subsidiaries

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

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

1.34 Associates

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

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

1.35 Joint Ventures

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

1.36 Joint Operations

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

1.37 Research & Development

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

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

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

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

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

2 Other Operating Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges *1	0	0	0	696
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Non-patient care services to other bodies *2	666	86	580	156
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Other revenue *3	38	2	36	0
Total other operating revenue	**704**	**88**	**616**	**852**

*1 - The prior year value included items that have been classified in 2014/15 under *2 following further guidance as well as a pharmacy rebate that is now recorded as a reduction in prescribing expenditure.

*2 - This has increased due to £357k of recharges related to drugs costs being reclassified from *1 (£363k in 2013/14) as well as increases in recharges to other NHS organisations for staff on secondment.

*3 - This includes repayments from GP practices following overpayments of enhanced services in 2013/14 And a contribution from Hull City Council towards commissioning scheme.

3 Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
From rendering of services	704	88	616	841
From sale of goods	0	0	0	11
Total	**704**	**88**	**616**	**852**

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4. Employee benefits and staff numbers

4.1.1 Employee benefits 2014-15

	Total: Total £000	Total: Permanent Employees £000	Total: Other £000	Admin: Total £000	Admin: Permanent Employees £000	Admin: Other £000	Programme: Total £000	Programme: Permanent Employees £000	Programme: Other £000
Employee Benefits									
Salaries and wages	1,954	1,851	103	1,806	1,732	74	148	119	29
Social security costs	171	171	0	161	161	0	10	10	0
Employer Contributions to NHS Pension scheme	235	235	0	219	219	0	16	16	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,360**	**2,257**	**103**	**2,186**	**2,112**	**74**	**174**	**145**	**29**
Less recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Net employee benefits including capitalised costs	**2,360**	**2,257**	**103**	**2,186**	**2,112**	**74**	**174**	**145**	**29**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,360**	**2,257**	**103**	**2,186**	**2,112**	**74**	**174**	**145**	**29**

4.1.2 Employee benefits 2013-14

	Total: Total £000	Total: Permanent Employees £000	Total: Other £000	Admin: Total £000	Admin: Permanent Employees £000	Admin: Other £000	Programme: Total £000	Programme: Permanent Employees £000	Programme: Other £000
Employee Benefits									
Salaries and wages	1,736	1,702	34	1,634	1,601	33	102	101	1
Social security costs	160	160	0	151	151	0	9	9	0
Employer Contributions to NHS Pension scheme	226	226	0	212	212	0	14	14	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,122**	**2,088**	**34**	**1,997**	**1,964**	**33**	**125**	**124**	**1**
Less recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Net employee benefits including capitalised costs	**2,122**	**2,088**	**34**	**1,997**	**1,964**	**33**	**125**	**124**	**1**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,122**	**2,088**	**34**	**1,997**	**1,964**	**33**	**125**	**124**	**1**

4.2 Average number of people employed

	2014-15 Total Number	2014-15 Permanently employed Number	2014-15 Other Number	2013-14 Total Number
Total	**43**	**40**	**3**	39
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirement

	2014-15 Number	2013-14 Number
Total Days Lost	911	184
Average working days lost	**22.7**	**4.6**

It should be noted that the increase in working days lost is the result of a small number of staff being on long term sick for the majority of the year.

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

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

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

4.4.3 Scheme Provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

5. Operating expenses

	2014-15 Total £000	**2014-15 Admin £000**	**2014-15 Programme £000**	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	1,906	1,732	174	1,592
Executive governing body members	454	454	0	530
Total gross employee benefits	**2,360**	**2,186**	**174**	**2,122**
Other costs				
Services from other CCGs and NHS England	4,743	3,507	1,236	5,090
Services from foundation trusts *1	36,951	99	36,852	38,753
Services from other NHS trusts *2	186,902	0	186,902	190,290
Services from other NHS bodies	0	0	0	404
Purchase of healthcare from non-NHS bodies *3	84,260	0	84,260	75,210
Chair and Non Executive Members	447	447	0	412
Supplies and services – clinical	760	0	760	726
Supplies and services – general	442	24	418	764
Consultancy services	0	0	0	0
Establishment	757	326	431	570
Transport	12	10	2	9
Premises *4	2,313	179	2,134	4,533
Impairments and reversals of receivables	5	0	5	0
Inventories written down	0	0	0	0
Depreciation	0	0	0	4
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets	0	0	0	0
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	96	96	0	98
Other non statutory audit expenditure				
· Internal audit services *5	1	1	0	84
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	48,111	0	48,111	47,029
Pharmaceutical services	0	0	0	0
General ophthalmic services	41	0	41	80
GPMS/APMS and PCTMS	1,600	0	1,600	1,204
Other professional fees excl. audit	94	93	1	139
Grants to other public bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	190	0	190	138
Education and training	156	75	81	89
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
CHC Risk Pool contributions *6	529	0	529	0
Other expenditure *7	122	0	122	113
Total other costs	**368,532**	**4,857**	**363,675**	**365,739**
Total operating expenses	**370,892**	**7,043**	**363,849**	**367,861**

*1 - This decrease in costs relates to the retendering of the IAPT services that is now commissioned by a community interest company (under note 3)

*2 - The reduced cost relates to the retendering of the MSK service that is now commissioned by private sector organisation (under note 3) in addition to the tariff deflator

*3 - This increase includes the increased cost of continuing healthcare, an increase in activity delivered by private sector acute hospitals, the recommissioning of services described in notes 1 and 2 plus an increase in the cost of comminty equipment

*4 - In 2013/14 this included the non-recurrent cost of fitting out the CCG headquarters as well as the block payments, based on allocation, to the NHS property companies. This year the charges to the property companies has been more closely linked to occupancy of the premises with a greater volume of charges being levied to the provider and reimbursed by the CCG (increasing the CCG's costs in *3)

*5 - Following additional clarification £99k of Internal Audit costs are now included within Services from foundation trusts as Humber FT host the Internal Audit service.

*6 - This is the CCG's contribution to the national risk share related to the legacy continuing healthcare claims. This was not in place for 2013/14.

*7 - This includes funding provided to voluntary sector organisations

6 Better Payment Practice Code

Measure of compliance	2014-15 Number	2014-15 £000	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	11,037	89,238	9,375	76,806
Total Non-NHS Trade Invoices paid within target	10,668	86,987	8,800	73,638
Percentage of Non-NHS Trade invoices paid within target	**96.66%**	**97.48%**	**93.87%**	**95.88%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,382	232,122	1,626	233,103
Total NHS Trade Invoices Paid within target	2,347	228,521	1,579	232,278
Percentage of NHS Trade Invoices paid within target	**98.53%**	**98.45%**	**97.11%**	**99.65%**

7 Operating Leases

7.1 As lessee

[Where the NHS Clinical Commissioning Group is a lessee, include a general description of significant leasing arrangements, including:
(a) *basis on which contingent rent is determined*
(b) *terms of renewal, purchase options or escalation clauses and*
(c) *restrictions imposed by lease arrangements]*

7.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payments recognised as an expense					
Minimum lease payments	0	2,290	23	**2,313**	4177
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**2,290**	**23**	**2,313**	**4,177**

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

7.1.2 Future minimum lease payments

	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payable:					
No later than one year	0	0	20	**20**	18
Between one and five years	0	0	28	**28**	18
After five years	0	0	0	**0**	0
Total	**0**	**0**	**48**	**48**	**36**

8 Property, plant and equipment

2014-15	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2014	0	0	0	0	4	0	0	0	4
Addition of assets under construction and 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	(4)	0	0	0	(4)
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	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/Valuation At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Depreciation 1 April 2014	0	0	0	0	4	0	0	0	4
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	(4)	0	0	0	(4)
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	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
Depreciation at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value at 31 March 2015	**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 2015	**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-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 1 April 2014	0	0	0		0	0	0	0	0
Revaluation gains	0	0	0		0	0	0	0	0
Impairments	0	0	0		0	0	0	0	0
Release to general fund	0	0	0		0	0	0	0	0
Other movements	0	0	0		0	0	0	0	0
At 31 March 2015	**0**	**0**	**0**		**0**	**0**	**0**	**0**	**0**

9 Trade and other receivables

	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue *1	376	0	199	0
NHS receivables: Capital	0	0	0	0
NHS prepayments and accrued income *2	1,404	0	0	0
Non-NHS receivables: Revenue	239	0	310	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments and accrued income *3	88	0	341	0
Provision for the impairment of receivables	0	0	0	0
VAT	81	0	77	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables *4	2	0	1	0
Total Trade & other receivables	**2,190**	**0**	**928**	**0**
Total current and non current	**2,190**		**928**	
Included above:				
Prepaid pensions contributions	0		0	

*1 - The increase relates to a credit note from Leeds Teaching Hospitals NHS Trust for under trading against the contract.

*2 - This includes the pre-payment of the maternity pathway with Hull and East Yorkshire Hospitals. In 2013/14 £1,391k for this had been netted off against an accrual for incomplete spells therefore reducing the value stated in the Note 11 - Trade and Other Payables

*3 - The reduction relates to prepayments made in 2013/14 relating to commissioning schemes that have now ceased.

*4 - These debtors are employees that have been overpaid and are repaying this over a set period.

9.1 Receivables past their due date but not impaired

	2014-15 £000	2013-14 £000
By up to three months *1	32	266
By three to six months	0	0
By more than six months	0	0
Total	**32**	**266**

*1 - The majority of the overdue receivables outstanding in 2013/14 related to drugs recharged to other organisations. The issues around these charges following the dimise of the PCT have now been resolved resulting in a significantly lower value of outstanding transactions.

NHS Hull CCG did not hold any collateral against receivables outstanding at 31 March 2015.

10 Cash and cash equivalents

	2014-15 £	2013-14 £
Balance at 1 April 2014	4,640	0
Net change in year	(520)	4,640
Balance at 31 March 2015	**4,120**	**4,640**
Made up of:		
Cash with the Government Banking Service	3,990	4,350
Cash with Commercial banks	0	0
Cash in hand	130	290
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**4,120**	**4,640**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2015	**4,120**	**4,640**

11 Trade and other payables

	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	0	0	0	0
NHS payables: revenue *1	1,204	0	2,543	0
NHS payables: capital	0	0	0	0
NHS accruals and deferred income	1,540	0	1,318	0
Non-NHS payables: revenue	3,822	0	5,168	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals and deferred income *2	14,065	0	9,973	0
Social security costs	27	0	29	0
VAT	0	0	0	0
Tax	29	0	33	0
Payments received on account	0	0	0	0
Other payables *3	39	0	41	0
Total Trade & Other Payables	**20,726**	**0**	**19,105**	**0**
Total current and non-current	20,726		19,105	

Included above are liabilities of £0, for 0 people, due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2014: £0 for 0 people).

*1 - The reduction largely relates to 2013/14 including an outstanding balance with Hull and East Yorkshire Hospitals. There was no such balance at 31 March 2015.

*2 - This movement relates to an increase in accrued charges for continuing healthcare costs and expenditure with a private sector acute hospital due to over trading against the contract.

*3 - This is made up of outstanding pension contributions

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12 Provisions

	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	8	0	8	0
Continuing care	0	0	0	0
Other	0	0	0	0
Total	**8**	**0**	**8**	**0**
Total current and non-current	**8**		**8**	

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them. This has resulted in £8k being provided by the CCG as at 31 March 2015 in respect of the employers liability scheme.

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 2015 is £2,084k (201/14 - £4,411k).

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Agenda for Change £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2014	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**0**	**0**	**8**
Arising during the year	0	0	0	0	0	0	0	0	0	0
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 2015	**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
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**0**	**0**	**8**

13 Contingencies

	2014-15 £000	2013-14 £000
Contingent liabilities		
Equal Pay	0	0
NHS Litigation Authority Legal Claims	0	0
Employment Tribunal	0	0
Other employee related litigation	2	2
Redundancy	0	0
Amounts recoverable against contingent liabilities	0	0
Net value of contingent liabilities	**2**	**2**

14 Financial instruments

14.1 Financial risk management

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

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

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

14.1.1 Currency risk

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

14.1.2 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.

14.1.3 Credit risk

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

14.1.3 Liquidity risk

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

14 Financial instruments cont'd

14.2 Financial assets

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	376	0	376
· Non-NHS	0	239	0	239
Cash at bank and in hand	0	4	0	4
Other financial assets	0	2	0	2
Total at 31 March 2015	**0**	**621**	**0**	**621**

	At 'fair value through profit and loss' 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	199	0	199
· Non-NHS	0	311	0	311
Cash at bank and in hand	0	5	0	5
Other financial assets	0	1	0	1
Total at 31 March 2015	**0**	**516**	**0**	**516**

14.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,743	2,743
· Non-NHS	0	17,927	17,927
PFI, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**20,670**	**20,670**

	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,861	3,861
· Non-NHS	0	15,142	15,142
PFI, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**19,003**	**19,003**

15 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	370,892	(704)	370,188	2,194	(20,735)	**(18,540)**
Total	**370,892**	**(704)**	**370,188**	**2,194**	**(20,735)**	**(18,540)**

The only external supplier (i.e. that account for 10% or more of the CCG's total expenditure) is Hull and East Yorkshire Hospitals expenditure of £173.3m.

16 Intra-government and other balances

	Current Receivables 2014-15 £000	Non-current Receivables 2014-15 £000	Current Payables 2014-15 £000	Non-current Payables 2014-15 £000
Balances with:				
· Other Central Government bodies	84	0	96	0
· Local Authorities	154	0	3,498	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	86	0	87	0
· NHS Trusts and Foundation Trusts	1,694	0	2,657	0
Total of balances with NHS bodies:	**1,780**	**0**	**2,744**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	172	0	14,389	0
Total balances at 31 March 2015	**2,190**	**0**	**20,727**	**0**

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	0	0	103	0
· Local Authorities	67	0	0	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	73	0	441	0
· NHS Trusts and Foundation Trusts	126	0	3,420	0
Total of balances with NHS bodies:	**199**	**0**	**3,861**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	662	0	15,141	0
Total balances 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 Yorkshire and Humber Commissioning Support Units)
- NHS East Riding of Yorkshire CCG
- NHS Greater Huddfersfield CCG

- NHS Trusts:
  - Hull & East Yorkshire Hospitals NHS Trust
  - Leeds Teaching Hospitals NHS Trust
  - Yorkshire Ambulance Service NHS Trust

- NHS Foundation Trusts:
  - Northern Lincolnshire & Goole NHS Foundation Trust
  - Sheffield Teaching Hospitals NHS Foundation Trust
  - Sheffield Children's NHS Foundation Trust
  - York Teaching Hospital NHS Foundation Trust
  - Humber NHS Foundation Trust

- NHS Litigation Authority; and,
- NHS Business Services Authority.
- NHS Property Services

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
National Insurance Fund

17 Related party transactions cont'd

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 Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr Dan Roper - Chair of the Clinical Commissioning Group Board				
Partner in Springhead Medical Centre	26	-	-	-
Dr Amy Oehring - GP Member of the Clinical Commissioning Group Board				
GP Partner of Sutton Manor Surgery	15	1	-	-
Dr James Moult - GP Member of the Clinical Commissioning Group Board				
GP Partner at Faith House Surgery	14	-	-	-
Dr Leen Witvliet - GP Member of the Clincal Commissioning Group Board				
Self Employed as NHS GP. - Dr L Witvliet Practice	8	-	-	-
Dr Ragh Raghunath - GP Member of the Clincal Commissioning Group Board				
GP Partner at St Andrews Group Practice (Elliott Chapel)	77	2	-	-
A Partner at Dr Ghosh, Raghunath and Partners	4	-	-	-
A Partner at Dr Macphie, Raghunath and Partners (Newington Health Centre)	4	-	-	-
Membership of a Partnership at St Andrews Group Practice (Northpoint)	1	-	-	-
St Andrews have become partners with Dr Venugopal at Bransholme 3rd February 2014	6	-	-	-
Dr Vince Rawcliffe - GP Member of the Clincal Commissioning Group Board				
Partner of New Hall Surgery	17	-	-	-
Jason Stamp - Lay Member of the Clinical Commissioniing Group				
Employed as a Project Manager within North Bank Forum	8	-	2	-
Carole Robinson - GP Member of the Clinical Commissioning Group Board				
Practice Manager at Newland Group Practice	11	-	-	-
Holmes Mike - Associate Medical Director				
Partner Haxby Group	3	-	-	-
Dodson Joy - Head of Business Intelligence				
Father Chair of Cruse Bereavement Care Hull and East Riding	1	-	-	-

18 Events after the end of the reporting period

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1st April 2015. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View to deliver a new deal for primary care and another step towards plans set out by NHS England early last year to give patients, communities and clinicians more involvement in deciding local health services.

19 Losses and special payments

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

	Total Number of Cases 2014-15 Number	**Total Value of Cases 2014-15 £'000**	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Administrative write-offs	1	5	0	0
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**1**	**5**	**0**	**0**

20 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

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

	2014-15 Target	**2014-15 Performance**	2013-14 Target	2013-14 Performance
Expenditure not to exceed income	380,788	370,892	376,932	367,861
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	380,084	370,188	376,080	367,009
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	7,521	6,963	7,020	6,820

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