NHS

Hull Clinical Commissioning Group

Creating a healthier Hull

NHS Hull Clinical Commissioning Group

Annual Report and Accounts

2015-16

Welcome

From the CCG Chair & Chief Officer

Welcome to the 2015-16 Annual Report and Accounts for NHS Hull Clinical Commissioning Group (CCG). This report gives an overview of the CCG's activity to create a healthier Hull, with key performance measures, commentary, and highlights of a year of working with people and partners across our city.

Our third year as a CCG has seen us cement some of the partnerships we brought together for Hull 2020. Humberside Fire and Rescue Service has been fantastic partner to work with - from innovative falls response to the huge potential of the Hull Integrated Care Centre. We would like to think we're leading the way with this sort of partnership working and it's encouraging to know that others across the country are looking to us for inspiration.

Another highlight was the launch of the Hull Medical, Health and Social Care Academy which has involved all health partners in Hull joining forces with St Mary's College to help develop our future health workforce.

We have a frontline clinical workforce in our hospital and in the community that continues to serve our city with enthusiasm and dedication. As a CCG we are aware of the challenges facing the system and with that in mind, this year has seen the beginning of the development of new models of care with more focus on prevention, out of hospital care and providing care at scale . Our Blueprint for Primary Care has been a significant piece of work that has been developed hand-in-hand with Hull GPs – as commissioners of local health care – to support the ambitions of the NHS Five Year Forward View.

The NHS Five Year Forward View is quite clear in identifying a radical need for upgrade in prevention and public health. The new Sustainability and Transformation Plan (STP) for Humber, Coast and Vale puts our population's needs at the centre of service redesign, with a move towards 'place-based' health planning rather than traditional planning based around individual organisations. We are at the very beginning of the journey, setting our priorities for improving health and wellbeing, transforming the quality of care delivery and ensuring we have financially sustainable services for the 1.4 million people who live within the Humber, Coast and Vale area.

We know that we have a long-standing challenge to improve health, wellbeing and life expectancy in Hull. We have moved from 10th most deprived local authority area in the UK to the 3rd and it is clear we have an incredible amount of work to do. Relationships need to be strengthened to improve life outcomes for people in the city, and, using our knowledge, skills and our system leadership role, we are determined to work together across the health and social care landscape and with local politicians, in a way which will ensure that health will improve.

Knowing that small amounts of funding in the right hands can do so much to turn round the health of our communities, we were delighted to re-run the Healthier Hull Community Fund this year. We awarded 99 local groups more than £400,000 to get their health-inspired ideas off the ground. We're proud to say that we do things differently in Hull and want to continue supporting inspiring projects coming from smaller groups and individuals to improve health.

Citizen voice should be at the heart of everything we do as a CCG and we are both 'veterans' of the 'hot-seat', taking questions from the public on everything from mental health, GP appointments and NHS performance at our AGM and on radio phone-ins. We will continue to do this each year as we know it is well received. Local people should get the opportunity to quiz the people who make decisions about their health care, and we have to face their questions – no matter how difficult they may be.

Hull will soon be the UK City of Culture, and we are particularly excited about being a major sponsor and how we harness all the community involvement and enthusiasm of volunteers in 2017 to bring about lasting changes to peoples' health. Culture in the broadest sense is about how people live their lives –the rules they set for themselves in terms of their own personal beliefs and behaviours and how they interact with their environment.

We hope this document gives a flavour of the breadth and diversity of work the CCG engages in with its partners to create a healthier Hull. We positively welcome feedback on your experience of local health services and you can find out how to share your views within the report.

On behalf of the entire CCG Board we would like to extend our sincere thanks to our Council of Members, health, public sector and voluntary sector partners, our own staff and NHS staff across Hull – without you we could not have had such a fulfilling and positive year in health care!

Dr. Dan Roper
CCG Chair

Emma Latimer
CCG Chief Officer

The accounts for the year ended 31 March 2016 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.

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

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Part One: Performance Report 2015-16

We are Hull CCG

NHS Hull CCG is a clinically-led organisation, which brings together 55* 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 293,091 across 23 wards. We had an allocated budget of £389 million for 2015-16, with a required surplus of £7.8 million.

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. Where appropriate, we will jointly commission services with partners such as neighbouring East Riding of Yorkshire CCG or Hull City Council.

The main health provider organisations that we have contractual arrangements for services with are:

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

We also work with Healthwatch Hull, the independent champion for local people who use health and social care services.

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 on page 7 or visit our website: **www.hullccg.nhs.uk**

*at 31 March 2016

A snapshot of 2015-16

How our money is spent

HOSPITAL
£183.4M
47.1%

COMMUNITY SERVICES
£56.2M
14.4%

PRESCRIBING/ DRUGS
£51.0M
13.1%

MENTAL HEALTH
£39.0M
10.0%

CONTINUING HEALTHCARE
£26.3M
6.8%

AMBULANCE
£11.8M
3.0%

RUNNING COSTS
£6.2M
1.6%

OTHER
£3.6M
0.9%

PRIMARY CARE
£2.8M
0.7%

PROPERTY CHARGES
1.1M
0.3%

SURPLUS
£7.8M
2.0%

Grand Total
£389.2m

CCGTV
Did you know we have 12 films about the work of the CCG on YouTube? Search NHS Hull CCG to view

Public health indicators

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

67% of 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

Almost one-third (31%) of adults across the city smoke. 1 in 5 mothers remain smokers at the time of their baby's delivery

One in three children (16500) are living in poverty and 11% of households are experiencing fuel poverty

CCG Statistics

CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) COMMITTED TO **NO WAITING OVER 18 WEEKS** TO ACCESS TREATMENT **BY APRIL 2016**

FALLS
HULL FIRST FALLS RESPONSE RESPONDED TO 245 FALLS DURING SIX MONTH PILOT

A&E
NATIONAL TARGET **95% PATIENTS SEEN** IN FOUR HOURS **APRIL-2016 75.8%** (18 OUT OF 20) PATIENTS SEEN WITHIN 4 HOURS)

MUSCULO-SKELETAL SERVICE
1425 REFERRALS PER MONTH
98% SEEN WITHIN 21 DAYS OF REFERRAL
98% SATISFIED
1 IN 3 SELF-MANAGE THEIR CONDITION

AMBULATORY CARE 518 HULL PATIENTS ARE SEEN EACH MONTH **IN THE AMBULATORY CARE UNIT AT HULL** AND EAST YORKSHIRE HOSPITALS

WE HAVE INCREASED DEMENTIA DIAGNOSIS BY 4% WHICH IS AN EXTRA 101 PATIENTS DIAGNOSED

LET'S TALK SERVICE (APR 15–FEB 16) 6,663 ASSESSMENTS 65% MADE WITHIN **7 DAYS OF REFERRAL**

EMERGENCY ADMISSIONS 3.3% REDUCTION YEAR ON YEAR

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Overview of 2015 – 16 by Emma Latimer, CCG Chief Officer

Our Performance

This overview highlights our key programmes of work, service transformation and performance during 2015-16 and explains how we are working – with our partners and the people of Hull – to improve health in our city.

Key areas:

- Humber, Coast and Vale Sustainability and Transformation Plan
- Hull 2020 – making a better future together
- Hull's Blueprint for stronger primary care
- Better Care through integration
- Action to reduce inequalities
- Building relationships with communities
- Making mental health a priority
- Commissioning safe, high quality care
- Hull 2017 - creating a healthier Hull through arts and culture

More detailed performance analysis, commentary and tables to support this overview follow from page 30.

Humber, Coast and Vale Sustainability and Transformation Plan

Under NHS England planning guidance 2016 - 2021 every local health and care system must develop a five year Sustainability and Transformation Plan (STP). Local CCG's have been asked to collaborate to design and deliver the STP and NHS Hull CCG will be part of a new Humber, Coast and Vale STP 'footprint'.

Humber, Coast and Vale STP includes:

- **NHS Hull CCG**
- **NHS East Riding of Yorkshire CCG**
- **NHS North Lincolnshire CCG**
- **NHS North East Lincolnshire CCG**
- **NHS Vale of York CCG**
- **NHS Scarborough and Ryedale CCG**

Humber, Coast and Vale also includes all local authorities and health providers in these CCG areas - more than 20 organisations in total,- serving a patient population of 1.4 million. There are 44 STP footprint areas across the UK and I am privileged to be Interim Footprint Leader for Humber, Coast and Vale. The size of our STP 'footprint' will help to ensure health and care services are planned around places and where patients access services, rather than around individual organisations. In our case the footprint is centred around acute (hospital) care in York, North Lincolnshire and Goole, Hull and East Yorkshire and Scarborough.

The Sustainability and Transformation Plans (STPs), must show clearly how we respond to the triple aims set out in the NHS Five Year Forward View - improved health and wellbeing, transformed quality of care delivery, and sustainable finances.

Local plans will still be developed for place-based commissioning (including the Hull 2020 transformation programme) and services will still be commissioned across Hull and East Riding of Yorkshire. The STP, however, involves working together as a system, planning and commissioning for the next five years for major trauma services, emergency and urgent care, cancer, stroke, vascular, critical care and other specialist pathways.
We also need to make more use of public health intelligence in terms of getting a sense of the value we are getting from the services we commission and, of these services, which are having the greatest impact. There will also be a focus on building resilient 24/7 out-of-hospital care, which aligns with our new community care services contract and Primary Care Blueprint. See page 12.

We have just begun the process of setting our collective priorities for Humber, Coast and Vale for the next five years and there will be an opportunity for people to find out more during 2016.

Further information on Sustainability and Transformation Plans is also available on the NHS England website www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/stp/

Hull 2020 - Making a better future together

The Hull CCG-led Hull 2020 partnership has been going strong for nearly two years with a number of projects already making a difference to the lives of people living and working in Hull.

Hull 2020 is a partnership of public sector organisations working together to deliver public sector reform across the city. Collectively we all have an enormous amount of knowledge, skills and expertise and the Hull 2020 programme gives us the opportunity to work differently. Together we can work on plans and projects where, doing things together not only makes sense, but can also really make difference to the people we all serve.

The formal partners in the programme are:

- **NHS Hull Clinical Commissioning Group**
- **Humber NHS Foundation Trust**
- **Hull City Council**
- **Yorkshire Ambulance Service NHS Trust**
- **Hull and East Yorkshire Hospitals NHS Trust**
- **City Health Care Partnership CIC**
- **Humberside Police**
- **Humberside Fire and Rescue Service**
- **Healthwatch Kingston upon Hull**

Whilst improving people's health is a key goal of the programme, Hull 2020 is as much about supporting people to care for themselves as it is about providing services. Better physical and mental health have far ranging benefits including improved jobs prospects, better social cohesion, positive impact on crime figures and increased public safety.

Since the Hull 2020 programme started, local public sector leaders have looked at several areas of work and have now fine-tuned these into specific areas of focus. The programmes of work are also aligned to the priorities of the city's Health and Wellbeing Strategy.

Our key Hull 2020 work programmes are:

Safe and Independent Lives

This is now a formal sub-group of the Hull Health and Wellbeing Board with a focus on two broad areas of work; 'Frailty and Isolation' initiatives and 'Safe and Independent Lives'. Led by Humberside Fire and Rescue Service, the group contributes towards activities which help more people to be able to manage their own health and wellbeing and live safely and independently in the community. The initial focus of the Group is on vulnerable people, particularly (but not limited to) the frail elderly. Work during 2015-16 included:

- Better Care Fund: A report into a pilot using True Call software to stop nuisance callers to vulnerable people has shown that the software impacted successfully to provide additional protection from potential financial scams.
- The Hull FIRST Falls Service launched in November 2016 (see below)
- Age Friendly Cities – Dementia Action Alliance continues to support the development of an Age Friendly City.

Pioneering Falls Response Puts Patients First

The pioneering new Falls Response Service for patients in Hull involves NHS Hull CCG, Humberside Fire and Rescue Service, City Health Care Partnership CIC (CHCP CIC), Yorkshire Ambulance Service NHS Trust and Humber NHS Foundation Trust.

The holistic approach to care sees Humberside Fire and Rescue officers picking people up safely when they have fallen, quickly assessing their needs and, in partnership with the Hull Falls Prevention team, resolving any instant problems that might have caused the fall.

The initial clinical triage for calls is via 999 and NHS 111. Clinical advisors provide an assessment to ensure patients are provided with the most appropriate care for their needs; non-emergency patients are seen by the Hull FIRST Team within one hour.

At the end of the six month pilot the team had supported 245 patients who had fallen in their home or care home with an average response of 16 minutes. In addition the team has attended 1344 incidents to support emergency first responders.

Positive feedback from patients has been received and in view of the pilot's success the Hull FIRST Response will continue to support patients for an additional 12 months.

Thriving Communities

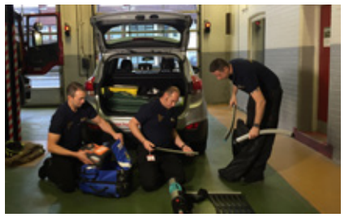
We want to ensure people feel that they are valued in their community, that they have played their part in shaping what the community looks like and that communities are recognised as a valuable resource for all. The Thriving Communities Group will refresh the role, purpose and membership of the group for 2016-17. Work in 2015-16 included:

- **Hull Pound**
  Assessment of the impact and economic value of voluntary and community sector in Hull is complete and has been considered by the working group. Key themes and recommendations will be identified and communicated across partners and stakeholders.
- **Social Prescribing**
  The CCG is to commission and procure a social prescribing service using information gathered collectively between voluntary organisations, Hull CCG and public health.

Other Hull 2020 workstreams:

- **Children, young people and families board**
- **Community hubs**
- **Clinical and professional reference group**
- **Information management and technology**
- **Finance**
- **Estates**
- **Communication**

Find out more at www.hull2020.org



Falls Response Team in action

Workforce and OD (Organisational Development)

This group is looking to address the major challenge in recruiting a highly skilled public sector workforce in Hull. It is developing plans for attracting, developing and retaining talent. This group has been instrumental in the launch of the Hull Medical, Health and Social Care Academy at St Mary's Sixth Form College.

Hull Medical, Health and Social Care Academy

Hull's new Medical, Health and Social Care Academy at St Mary's College is one of the most exciting projects to come from the Hull 2020 programme.

We want our next generation to lead healthier, more fulfilled lives with great long term career prospects. To do this we knew we needed to link in with colleges and academies to develop the skills we need within the city for our future workforce.
We were delighted to team up with such a forward-thinking college like St Mary's. The new Academy has been extremely well received by parents and students. It is able to offer a unique mix of specialist teaching, training and work experience for students interested in a medical, health or social care career path.

We know there are many different roles across the NHS and social care and all are needed and valued in the community. We need dedicated midwives, therapists, mental health professionals, health visitors, paramedics, theatre assistants, social workers, and health commissioners planning the services people in the city need now and in the future.

The Hull Medical, Health and Social Care Academy is nearing the end of its first academic year and already has 60 expressions of interest for September 2016.

Hull 2020 Champions

Hull 2020 Champions are people living or working in Hull who want to use their enthusiasm, skills or resources to help others. Champions are given advice, project support to develop their ideas and then using the principles of 'crowd sourcing' can gain the 'things' they need to turn their ideas into reality. At the end of 2015-16 nearly 100 people had stepped forward to become champions and projects have been wide ranging from pensioner's social clubs to Asthma awareness campaigns.

Bourne Different

Ian Bourne was one of the first Hull 2020 Champions with his project 'Bourne Different'. Ian has lived with Cerebral Palsy all his life and often faces bullying and harassment. Following a redundancy a few years ago Ian decided to start his own business with the aim of helping disabled people into employment, aiming to change hundreds of lives.
Ian's first step was to devise a lesson for schools to reduce discrimination and show that although he might look and sound different, inside he is the same. Ian was supported by the Champions Team in the development his plans and introduced to teachers at Sutton Park Primary School who worked with him to plan and deliver the sessions. The sessions were a huge success and he has since expanded into secondary schools and even community groups.

Ian is now embarking upon creating a disability and employment forum, alongside his 'Bourne Different' project.

Read more about the Hull 2020 Champions at **www.hull2020champions.org**

Hull's Blueprint for stronger primary care

The CCG has worked in partnership with general practices in Hull over the last 12 months to develop a 'Primary Care Blueprint' that supports local practices to address the challenges they face in continuing to deliver high quality and sustainable services. This has been one of the most significant programmes of work during 2015-16 to support the ambitions of the NHS Five Year Forward View, which includes 7 day working and shifting more of care from hospital to non-hospital settings.

Given the current landscape in Hull with 53 practices serving 290,000 patients, fewer GPs per 100,000 patient population than the national average and long-standing GP recruitment challenges, we need to establish a more sustainable way of delivering GP care.

The Blueprint proposes the creation of practice groupings (based around geographical areas of the city). The benefits of this full scale change could include:

- More resilient models of primary care through greater sharing of resources and the introduction of new models of delivery
- Greater financial sustainability through realising the economies of working at scale
- A GP premises strategy that ensures all patients are able to receive care in modern premises that meet current quality standards
- Improved recruitment and retention of the workforce through the development of flexible career opportunities supported by improved access to training
- Opportunities to improve access for patients through the introduction of new ways of working and interacting with practices. This will be delivered by the development and implementation of innovative approaches to care using new technology

Engagement has already taken place with GPs, practice staff and the Local Medical Committee (LMC) Executive to support the development of the Primary Care Blueprint. The CCG's Council of Members approved the Primary Care Blueprint in October 2015. During 2016 the CCG will be consulting with people in the city, including patient participation groups, around the Primary Care Blueprint, particularly on innovative approaches to delivering care using new technology.

NHS Hull CCG Chair Dr. Dan Roper commented:

"Family doctor services in Hull, like elsewhere in the country, are facing unprecedented pressures and challenges. There is a widespread recognition that smaller practices face particular difficulties in succession planning and recruitment. The development of the new 'Primary Care Blueprint' is an opportunity to explore how the CCG can support practices in the city to work together to sustain, and ultimately improve, primary care services for patients registered with Hull practices."

The implementation of the Primary Care Blueprint will commence in 2016-17 and you can read the full document in the publications section of our website at **www.hullccg.nhs.uk**

Pathway Information Portal Comes To Hull

July 2015 saw the launch of the Hull Pathway Information Portal (PIP), an online resource aimed at providing local GP practices with the latest news regarding treatment options in primary care, referral processes and patient leaflets. The PIP provides a "one stop shop" where practices can access required information during an appointment with a patient. This means the GP, nurse or health care professional is able to give the most accurate treatment advice to patients at the time of appointment and request guidance from 'provider services' if needed. To date, there are over 85 pathways displayed on the PIP, with incredibly positive feedback from clinical and non-clinical staff, and plans for more pathways and services to be added over the coming year.

A clinical workforce for the future

The Hull 2020 programme has conducted a survey of the public sector workforce across Hull, with an intention to establish the number of resources, their roles and their locations. This work will be taken forward in 2016-17 to establish how the workforce across different organisations and skill sets might work together. This will include opportunities for joint training, sharing of skilled individuals across multiple organisations as well as collaborative recruitment and retention schemes.

Staff at Springhead Medical Centre have been recognised for their Friends and Family Test initiative

Springhead Medical Centre Runner Up In NHS England Awards

2015 saw Springhead Medical Centre come runner up in the 'Best Friends and Family Test Initiative in Primary Care' category at the NHS England Friends and Family Test awards.

Nominated by the practice Patient Participation Group (PPG) for their ongoing engagement and refresh of the Friends and Family Test, the practice narrowly missed out on the title, to be named as runner up in the category. The nomination focused on how the Springhead team worked with the PPG to ensure the patient feedback received through the test was relevant, meaningful and genuinely reflected the views of people accessing practice services.

Dr Vince Rawcliffe, Chair of the Hull CCG Council of Members, said:

NHS Hull CCG's membership of 55 local GP practices continued to work collaboratively and effectively during 2015-16. The Council of Members committee meets bi-monthly and is well attended with the majority of practices represented regularly. The ability to give direction to the CCG Board on areas of commissioned service is working well and feedback is given by the GP representatives about those services in place. We know 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.
Our meetings are used for regular input from partner organisations in terms of both our providers and Health and Wellbeing Board partners. Our work is further assisted and enhanced by good attendance from CCG Board members including senior officers and GPs and the input of local Practice Managers.

Better Care in Hull - through integration

Better Care in Hull is NHS Hull CCG and Hull City Council's shared vision of integrated services across local providers of health and social care as part of the national Better Care Fund (BCF) programme. Our aspiration is that local health and social care services will look very different in the next five years.

Hull is the third most deprived city in the UK and is predicted to see a 17% increase in older people by 2030. Life expectancy in Hull is lower than the UK average (76.6 years for men and 80.5 years for women). Prevalence of long term conditions is high and people tend to seek support later in the progression of their condition resulting in an over-reliance on hospital services. There is a need to raise health expectations, support self-care and create a coordinated community response to health and social care needs.

In addition, a default to residential care has often been seen as the first resort when care needs increase at home or following a hospital admission. Overall communities have been very dependent on both health and social care statutory services and one of the local ambitions is to improve community resilience and increase use of third and voluntary sector support.

This demographic growth, low health expectations and disease linked to high levels of deprivation is the rational and local evidence base for our BCF plan having an initial focus on the needs of the elderly with schemes designed to improve primary care intervention, prevention, rehabilitation and rapid community response to prevent unnecessary hospital admissions and support rapid discharge following a hospital attendance.

Better Care conference 2015

Progress during 2015-16

From the launch of the Better Care Plan, local health and social care partners have built on existing joint working arrangements and developed new schemes in line with the views and engagement of people who use health and social care services.

A new service for falls in the home has been established forging a partnership between, health social care and the Humberside Fire and Rescue service (see page 10). This provides a rapid response and integrated follow up to non-urgent falls keeping people in their own home and preventing the risk of future falls.

Further successful outputs of some of the Better Care in Hull schemes to date include:

- 85% of the older people discharged into reablement* services in Hull were still living at home 91 days after discharge from hospital, this is higher than the England average and the average for our region.
- 9.6 % reduction in emergency admissions
- 9.5% reduction in the number of hospital admissions due to falls
- Delayed Transfer of Care (DTOC) for adults in Hull was delayed for 7.6 per 100,000 population, this is lower than the England average, the regional average and all but one comparator local authority.

In November 2015 the Better Care in Hull Conference brought together more than 120 health and social care professionals. A short video capturing some of the themes of the conference plus comments and reflections made by partner organisations and delegates on the first year of Better Care in Hull - from the new falls rapid response scheme to extra care housing – can be viewed via **www.hullccg.nhs.uk/bettercare**

In February 2016 the Better Care team gave an overview of some of the work programmes and challenges for Hull and the pioneering integration of fire and health services as part of the Hull FIRST falls response team at two conferences in Newcastle and Leeds which generated a great deal of interest amongst delegates.

2016-17 and beyond

Work in 2016-17 will address the new national conditions to maintain social care, and invest in out-of-hospital services, in addition to reducing delayed transfer of care. There will also be a specific work stream to progress information sharing and joint care planning across health and social care. In 2016-17 the CCG and Hull City Council will explore options for taking integration further under the newly formed Transformation Board.

A review of the 8 original schemes has resulted in 4 programmes that will capitalise on existing work and joint commissioning. The intention is to ensure that the progress to date is taken forward as business as usual across health and social care.

A high level representation of the four schemes is shown below:

Prevention (BCF 1)	• Community Hubs (See & Solve) • Ageing Well • Befriending • Extra Care housing • Home Care • Falls Prevention • Information Sharing/Systems Integration
Intervention (BCF 2)	• Care Coordination (Risk Profiling) • Social Prescribing • Multi-Disciplinary Team long term condition management • Single Point of Contact across Health & Social Care (trusted assessments) • Carers Service • Dementia Collaborative • End of Life • Mental Health
Rehabilitation (BCF 3)	• Reablement • Falls Recovery • Health & Social Care Discharge to Assess • Intermediate Level of Care (Thornton Court/ Highfield Resource Centre)
Rapid Community Response (BCF 4)	• Hull First – Falls Response • Integrated Care Centre • Ambulatory Care

*Reablement is services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living

A more detailed summary of the BCF performance indicators is on page 38. To find out more about the Better Care in Hull see www.hullccg.nhs.uk/bettercare

Hull Integrated Care Centre

From 2018 Hull's new Integrated Care Centre will deliver specialist out-of-hospital care, improving management of long term health conditions and services for frail, elderly patients in the city.

The new facility supports fully integrated working with social care, residential care homes, social housing, voluntary groups and charities, aiming to provide more alternatives to hospital admission if a patient's health condition exacerbates. Patients can be referred directly by their GP for assessment and treatment within the new Centre and discharged home, or back to their care home, the same day, with an on-going plan of care that would be shared with their GP and social care.

The new Centre is part of the Hull 2020 vision to bring public services together for a healthier future for Hull. One of the more innovative features is the location of a small Humberside Fire and Rescue Service (HFRS) station on the site, with potential to utilise fire service skills to support the rehabilitation and recovery of patients following a period in hospital. This is believed to be one of the first partnership projects of its kind in the UK - building on the success of HFRS and health-led Hull FIRST Falls Response Team. Read more about this on page 10.

Action to reduce health inequalities

When we talk about health inequalities in health we are describing the systematic differences in health between social groups that are avoidable by organised action and considered unfair and unjust (Due North)

We work closely with public health colleagues to effectively design and commission services and work with local communities and partners to best meet the needs of the population of Hull. Although health and wellbeing is improving overall, our local challenges remain significant. Hull is currently ranked the 3rd most deprived Local Authority in the UK, with a population set to grow by 2.5% by 2025 and an increase of 23.8% in the population of people over 65. A wide range of health and wellbeing issues provide an indication of the key challenges for the CCG. These include:

- **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**
- **Healthy Life Expectancy is 57.4 years for men and 56.9 years for women compared with 63.3 and 63.9 years respectively for men and women in England**
- **1:3 children (16500) are living in poverty and 11% of households are experiencing fuel poverty**
- **Almost one-third (31%) of adults across the city smoke. 1 in 5 mothers remain smokers at the time of their baby's delivery;**
- **67% of 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**

The CCG and Hull City Council assess the future health and care needs of Hull's population through the Hull Joint Strategic Needs Assessment (JSNA). The 2016 JSNA for Hull and links to a range of Public Health England Health Profiles for Hull can be found at

www.hullpublichealth.org

Hull Health and Wellbeing Board

The Hull Health and Wellbeing Board is a formal committee of Hull City Council established under the Health and Social Care Act 2012. The Health and Wellbeing Board has a number of core statutory responsibilities in relation to health, public health and social care to improve health and wellbeing and narrow the gap in health inequalities in Hull. Membership includes representatives from the CCG, elected members, senior officers of Hull City Council including the Director of Public Health, NHS England and Healthwatch Hull.

The Board meets in public bi-monthly.

The Health and Wellbeing Board has three outcome groups which are aligned to the Health and Wellbeing Strategy and to Hull 2020. These groups have membership from across the health and social care economy, including the voluntary and community sector and the Police and Fire and Rescue services. The Health and Wellbeing Board has a specific outcome group concerned with inequalities, but also has inequalities incorporated as a theme in the other two outcome groups.

These groups each produce a report twice annually which assesses the impact that the Health and Wellbeing Strategy is having on the health and wellbeing of the population, including the effect on inequalities. These documents are reported to the Health and Wellbeing Board, and to the Hull 2020 Board, both of which include the CCG as core members. The outcome group reports are published in public as part of the papers for the Health and Wellbeing Board meetings. As the CCG is working as a partner with others through both Hull 2020 and the Health and Wellbeing Board, it is able to assess the impact that strategies are having on inequalities.

The Health and Wellbeing Strategy Hull Healthier Together 2014-2020

was developed jointly by the CCG and Hull City Council taking account of the city's assets, challenges, the City Plan, Hull 2020 and the JSNA.

The CCG will continue to work with Hull City Council and with the Public Health team to address health inequalities and plan for improved health outcomes through the Hull Health and Wellbeing Board, Hull 2020, the Better Care Fund and the Adult and Children's Safeguarding Boards.

The Health and Wellbeing Board has a key role in the development of the Sustainability and Transformation Plan (STP) for Humber, Coast and Vale (see page 8). A joint Health and Wellbeing Board seminar was held in April 2016 with the East Riding of Yorkshire Health and Wellbeing Board to look at STP planning and delivering the NHS Five Year Forward View.

The CCG has been working with the Hull City Council Public Health team to manage the implications of the Public Health grant reduction of at least 20% by 2020, and will continue to work together to prioritise public health activity across the health and social care system, including the public health grant and will explore how prevention in the NHS will be radically upgraded.

The Annual Report and Accounts 2015-16 is formally considered by Hull Health and Wellbeing Board. You can find out more about Hull Health and Wellbeing Board at **www.hullcc.gov.uk** Hull 'Healthier Together', Hull's Health and Wellbeing Strategy 2014-2020 is available in the publications section of **www.hullccg.nhs.uk**

Joint working with Hull City Council's Public Health Team

A public health advisory service is delivered through an agreed memorandum of understanding between the CCG and Hull City Council Public Health. This includes a public health registrar based part-time within the CCG to provide public health input and guidance to CCG work programmes - most notably support for the diabetes and respiratory planned intervention and pathways; joint working with public health, the CCG and GPs to maintain the high uptake rate of vaccinations across the city; promoting the uptake of the adult screening programmes; and joint working with adult social care to develop a health protection assurance framework for residential and nursing homes in the city.

The Director of Public Health is a CCG Board and Primary Care Joint Commissioning Committee member. The DPH Annual Report 2015 'We Could be Heroes - inspire a smoke free generation' cites the signing of the Hull Tobacco Declaration as a highlight of the last 12 months and the Chair of the CCG contributed to the report. You can download the report from **www.hullpublichealth.org**

The City Health and Wellbeing Manager is a member of Planning and Commissioning Committee, one of the key CCG decision-making bodies. A Collaborative Working Action Group with membership from the CCG's commissioning, business intelligence and quality teams and public health colleagues has been established with a joint work programme for 2016-17.

The Public Health Consultant chairs the Hull 2020 Thriving Communities workstream.

Public Health Nursing Service for 0-19 Years

One key example of joint working with public health has been the engagement of the CCG in the commissioning of the integrated 0-19 public health nursing service that was jointly commissioned by Hull City Council and NHS England.

Hull 'Healthier Together' sets out the 'Best Start in Life' as one of its key outcomes. The CCG has worked closely with Hull City Council to tender for a new service model for 0-19 services, which includes working to tackle childhood obesity as a key element. The new contract to deliver public health nursing services aimed to promote healthy lifestyles and to positively impact upon public health outcomes. The new contract brings together Health visiting (0-11 years), School Nursing (11-19 years), Family Nurse Partnership (which delivers a preventative programme for vulnerable first time mothers aged 18 and under) and the Oral Health Promotion Service focusing on early years, primary school and community settings in Hull. Following a competitive tendering process City Health Care Partnership CIC commenced the new service from 1 May 2016.

Question Time

Held at the beginning of September 2015 the CCG's AGM features an open question and answer session, chaired by a local radio presenter, where members of the audience have the opportunity to question the senior management team on any aspect of the CCG's work.

Improving Communication in Primary Care

This year's AGM was attended by more than 100 local people. Members of the Black and Minority Ethnic (BME) community and Lesbian, Gay, Bisexual and Transgender (LGBT) community highlighted some communication-related issues experienced in local health care, particularly within local GP surgeries. This led to dedicated training event in November developed by people from those communities and attended by 75 clinical and non-clinical staff working in general practices in Hull to jointly overcome barriers in communication.

Building Relationships with Communities

"We will be brave in order to achieve a real difference to lives of the people who live here. We are not only committed to involving people in our decision making, we truly are attempting to engage them in honest on ongoing conversations to 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." NHS Hull CCG Engagement Strategy 2014-17

The CCG has a strong record of local engagement and partnership working and much of this work is acknowledged both regionally and nationally to be at the forefront of public participation. Our CCG Constitution confirms the key role of the Lay Member with a lead role in championing patient and public involvement, making particular reference to ensuring the public voice of the local population is heard and that opportunities are created and protected for patient and public empowerment.

There are a number of mechanisms that support pro-active engagement and consultation with people and partners in Hull.

People's Panel

The People's Panel is a joint programme with Hull City Council with an active membership of about 3600 people. It is used to gather public insight and feedback on a range of themes, via a detailed quarterly questionnaire. The Panel membership is kept informed on how their views are having an impact on the work of the Council and CCG through a regular newsletter.

During 2015-16 we sought views through the panel on safeguarding and the factors that influence people in reporting suspected abuse. The findings from this survey will help to inform the ongoing work of the Hull Safeguarding Board.

Join the Panel via the Get Involved section at **www.hullccg.nhs.uk**

Hull Ambassadors

The Ambassadors are a group of 20 local residents who have a particular interest in health. A number of them are managing long term health conditions and all are active members of their communities. They are a valuable resource in terms of supporting the CCG with community engagement work, and are the test bed for proposed engagement activity and CCG Plans.

2015-16 has seen changes within the Ambassador membership and this has been an opportunity for the group to revisit the role and purpose of the programme, while continuing to support the tendering of new services and the Healthier Hull Community Fund. This has led to a new found enthusiasm and they are looking forward to being involved in new and more varied ways in the coming year. Join the Ambassadors via **HULLCCG.contactus@nhs.net**

Building Health Partnerships

Building Health Partnerships (BHP) is a group of local voluntary, community and social enterprise sector (VCSE) organisations who are providers of health and wellbeing services and NHS Hull CCG, along with Hull City Council, is an integral member of this partnership. All partners contribute towards the planning and shaping of health, prevention and wellbeing services in Hull.

The BHP group established a pilot social prescribing programme working out of three GP practices in the city, which enables GPs to refer suitable patients into non-medical support and social activities. Throughout the year the group has worked to build on this pilot programme to co-design a sustainable approach to social prescribing which will which will be developed into a city-wide commissioned service model during 2016.

99 Projects To Boost Health In Hull Get The Green Light

Our Healthier Hull Community Fund is all about letting people have their say on which community based projects should each receive up to £5000 in funding to help create a healthier Hull.

Local groups had to demonstrate that their project or work would help people in the community to be healthier, be more active or help them to better look after themselves, and then bravely face the public in their local area who had the final say at four public voting events in January and February 2016. A total of £438,772 was awarded to 99 projects.

Sue Lee, CCG Head of Communications and Engagement, said: "Over the past six months the Communications and Engagement Team has met and worked with a number of amazing groups and individuals who genuinely want to make the health of their local community better. The projects that have received funding couldn't be more deserving; they have shown us how even the smallest of ideas can benefit people living in Hull and help improve health in a number of ways."

Find out more about the winning projects and how you can get involved at **www.hullccg.nhs.uk** or by searching for 'Healthier Hull Community Fund' on Facebook.

Engagement activity during 2015-16

Patient, carer and public views and experiences are fed into all levels of the CCG in a number of different ways. Some examples are outlined over the next two pages:

Working with diverse communities in Hull

In 2015 the CCG undertook an evidence gathering exercise to determine how it was performing against the NHS Equality Delivery System (EDS2) objectives, with the ultimate aim of reviewing and refreshing its own equality objectives and developing a new delivery plan in 2016.

The Engagement Team was asked to identify evidence to support Objective 2: Improved patient access and experience. In particular we were looking for information to inform plans to improve accessibility and information, and deliver the right services that are targeted towards improving patient experience.

Specific engagement activity during August and September 2015 involved a number of voluntary and community groups who represent people with 'protected characteristics'. These characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

101 people participated in a discussion group or completed an online questionnaire. Seven face to face focus groups involved people where English was not their first language. A number of key themes were identified including access to mental health crisis services, language barriers and difficulty contacting many NHS services. These comments have been fed back into the work being done to improve mental health crisis services, the re-procurement of translation and interpretation services and as part of the mobilisation of the new community services contract a single telephone contact – 247111 has been established to replace the dozens of different contact numbers previously in existence.

An Equality Delivery System (EDS) feedback event in February 2016 was attended by representatives of Hull Building Health Partnerships, Humber All Nations Alliance (HANA) and the LGBT Forum. Identified actions included the development of an Equality and Diversity Reference Group and the development of an annual Engagement Calendar, both of which have since been agreed and will be implemented during 2016.

Walk-in Centre engagement

This engagement looked at how and why people use the city's walk-in service at Story Street and why they chose to use this service over other health care provision. The insight has been used to determine how the walk-in service better integrates with other primary care and urgent care services in Hull.

Hull Integrated Care Centre

As part of an extensive consultation around the development of Hull's new Integrated Care Centre (see page 15), a specific engagement stream was developed for the residents immediately surrounding the proposed site. This led to an active involvement group that looked in detail at the impact of the new facility on traffic and parking in the area, with the CCG, Humberside Fire and Rescue Services and Hull City Council developing possible solutions in partnership with residents. This productive and ongoing relationship has directly influenced the final traffic layout and design of the building submitted for planning approval in April 2016.

Service users help improve wheelchair equipment services

In May 2015 we actively involved service users, their parents and carers in the re-tendering of local Community Care Equipment and Wheelchair services to gain their and overall experience of the service.

This included focus groups at Danny's Dream Walker Street and KIDS Parents Forum, a facebook and twitter survey, our Peoples Panel, CCG Ambassadors and Age UK, Healthwatch Kingston upon Hull and other community and voluntary organisations. Although respondents used a variety of equipment, our survey focused on the wheelchair service.

You said: Service users said that repairs to equipment were prompt and delivery for items such as mattresses and hoists were usually delivered the same day. Children's items such as chairs and upholstery were available in different colours. Occupational therapy staff were noted as being helpful and professional.

However, it was agreed that communication with the service could be better, and more frequent, particularly if delivery of items is delayed and when an item was no longer needed the service took a long time to pick the item up. The assessment process should also be more focused on the service user not the carer.

What we did: This valuable feedback helped in developing the new service specification from the new integrated wheelchair equipment service provider from April 2016. The new integrated wheelchair service includes the assessment and provision teams being provided by one organisation with a view to helping improve communication.

We asked for service user feedback forms to be given after each contact, increased use of text messaging, emails and telephone calls to arrange and confirm delivery times. In addition more children's assessments – including repairs and fittings - will be done out of school hours. The standard collection times has been improved from 10 working days to 5 calendar days (7 days a week).

Key engagement work in 2016-17

Over the next 12 months we will be consulting and involving people in our Primary Care Blueprint, non-emergency transport, urgent care and birth preparation services. You can read more about our aims, key objectives and our approach to delivery in our Communications and Engagement Strategy 2014-2017 at **www.hullccg.nhs.uk**

Making Mental Health a Priority

In 2015-16 the CCG has remained focused on improving mental health services and achieving parity of esteem through better integration of physical and mental health care.

Transforming mental health services for children and young people

In October the CCG welcomed the Government's 'Future in Mind' report, which promotes early help and prevention across education, social care and health.

The CCG's own Transformation Plan is ambitious and dedicated to turning things around for young people in this city to give everyone in Hull the best start in life. Investment in 'universal' support services in schools and communities will identify mental health problems earlier and improvee access for the near 2,000 young people in Hull and East Riding who need the support of specialist services like Child and Adolescent Mental Health Services (CAMHS) each year.

The transformation plan is a joint commitment across health and the local authority towards turning this situation around. We are thinking innovatively, putting strong partnerships in place and setting ourselves ambitious targets to deliver the changes needed.

Waiting times

Reducing CAMHS waiting times remains one of the CCG's most important priorities. 2015-16 has seen significant improvement in the local waiting list. From 12 April 2016 no young person in Hull was waiting more than18 weeks for access to specialist treatment. The 18 weeks target is only the start and we are working hard to further improve waiting times so young people in Hull can access support much earlier.

24/7 community crisis response

The launch of Humber Foundation NHS Trust 24/7 community crisis response in January 2016 was an important step in the transformation of emotional health and wellbeing services. The new team will work closely with existing services, to ensure children and young people receive timely and effective support when in crisis and to avoid unnecessary hospital admissions - reaching out to more young people and their families to help them cope through a crisis.

Eating disorder service

Eating disorders, such as anorexia and bulimia, are potentially life-threatening illnesses that affect both emotional and physical health. Providing better access to specialist support for young people and their families is a high priority for Hull CCG and new investment from April 2016 into an enhanced community eating disorder service will see an improvement in waiting times, with no child having to wait over 12 weeks for assessment and treatment and most waiting significantly less.

Earlier intervention

Hull City Council has led the development of a counselling service for 5-19 year olds who are looked after or have social care involvement, and an extension of The Warren's counselling service will support 10-19 year olds in Hull. The Headstart Hull programme is led by Hull City Council, in partnership with the CCG, schools and voluntary services. Headstart Hull works in 13 Hull schools with an overall aim of improving emotional wellbeing and resilience in 10-14 year olds. The Council has submitted an application to the Big Lottery Fund for phase three funding and the outcome of this is expected in June 2016.

Autism

The CCG has agreed a plan and investment to improve local services for autism and address the current waiting list for specialist assessments, with an aim for no waits longer than 18 weeks by July 2016.

Dementia

The CCG achieved the dementia register and diagnosis rates for Hull. The CCG actual dementia diagnosis rate in October 2015 was 77.1% with an estimated prevalence for people over 65 with dementia at 2413. 2015 also saw the development of the Dementia Collaborative in Hull under Better Care in Hull and in 2016-17 the CCG will be focusing on pathway development for assessment, diagnosis and support in primary care.

Mental Health Crisis

Work to ensure 24/7 access to mental health crisis services in the Emergency Department at Hull Royal Information is now compete and the impact and outcomes will be monitored by a project group with representatives from CCG and health providers. A wider review of the Crisis services across Hull and the associated pathways will take place in 2016-17 as part of the adult mental health transformation plan

We continue to work jointly with colleagues in East Riding of Yorkshire and a wide range of agencies from health social care and criminal justice to improve the mental health response for people in crisis and the Crisis Care Concordat.

Psychological Therapies

In 2014 the CCG successfully commissioned the 'Let's Talk Service' to ensure direct access from single point of contact for depression and anxiety services 2015-16 has seen a significant increase in the numbers accessing the service and a virtual elimination of waiting times. Innovative group work has been very well received by people using the service. The service will continue to look for new ways to meet local need.

In 2016-17 a focus will be on the plans for Early Intervention Psychosis (EIP) in line with the new NHS constitution standards, discussions have commenced with Humber NHS Foundation Trust on how the new EIP guidance links with the overall adult mental health transformation plan in Hull.

Learning Disability

The CCG has continued to work with the requirements of the Winterbourne review. A formal system of reviews now takes place prior to and during admissions to ensure that people stay in hospital only as long as is clinically indicated. A Learning Disability Transformation Board has also been established with East Riding and North East Lincolnshire CCGs and relevant local authorities to take forward the LD Transformation Plan

The plan is a response to "Building the right support" and the national service model published in October 2015, which set out a national vision for a radical shift in the delivery of care and support for people with learning disabilities and/or autism. The local vision is to improve safe care and treatment to make sure that children, young people and adults with a learning disability and/or autism have the same opportunities as anyone else to live satisfying and valued lives and are treated with dignity and respect.

Initial discussions have identified the following priorities which will be addressed from 2016 onwards

- **Crisis and Short Breaks Support**
- **Positive Behavioural Support Team**
- **Enhanced complex care service for people with profound and multiple learning disabilities**
- **Acute Hospital Liaison**
- **Advocacy**
- **Increased support to individuals with complex neurological impairments including Autism**
- **Increased Supported Living capacity for those with highly complex needs.**

Maternal mental health

A pathway has been finalised for perinatal mental health and will be subject to wider promotion and monitoring in 2016-17.

Personal Health Budgets

NHS Hull CCG and Hull City Council have adopted a Joint Personal Budget Policy for Children, Young People and Adults. The CCG is working with Hull and East Riding MIND, Humber Foundation Trust and the local authority to develop our local offer for adult mental health personal health budgets. A workshop was held in January 2016 with service users in attendance to ensure engagement with key stakeholders so that their views are included.

Commissioning safe, high quality health care

The CCG is committed to commissioning local services that deliver safe, effective high quality health care and meet nationally set guidance, policy and procedures.

In February 2016 we published our Commissioning for Quality Strategy 2016 - 2020. The strategy is underpinned by the principles of good engagement and involvement of patients, carers and the local community to support our aspirations. Our strategy outlines a number of key objectives for the CCG to help meet the expectations of the NHS Five Year Forward View and Compassion in Practice.

Developing and sustaining our nursing workforce

The sustainability of the nursing workforce has been a priority for commissioners and providers across Hull and the East Riding of Yorkshire. Our collaborative Nursing Strategy was launched in February 2016.

Hull And The East Riding Of Yorkshire Partnership Nursing And Midwifery Strategy

Nurses from across the Hull and East Riding helped to unveil a shared vision for working together in February 2016.

The vision sets out how local nurses, midwives and leaders in health will work together to ensure that patients always receive safe, high quality care and how this partnership plans to empower nurses and midwives in the region to be confident and innovative in practice.

Sarah Smyth, NHS Hull Clinical Commissioning Group (CCG), Director of Quality and Governance/Executive Nurse said: "The launch of the nursing and midwifery strategy for Hull and the East Riding of Yorkshire is pivotal in defining how we continue to provide safe, high quality care across the region."

"As a partnership, we continually work together to ensure patient safety is at the centre of everything we and our teams do, and that we are fit to face future challenges. I'm confident that the strategy will lead to further positive practice across all of our organisations."

In addition, new workstreams designed to attract other professionals allied to medicine including Multi-Disciplinary Team (MDT) roles for primary care and non-registered healthcare workers are being established in 2016/17. Our primary aim is to ensure that we have a workforce with the right skills, values and behaviours, in the right place to deliver the effective healthcare that our population needs.

The Nursing and Midwifery strategy has been launched with staff citywide

Quality in Primary Care

From April 2016 Hull CCG became co-commissioners of primary care. In preparation for this we have established a Primary Care Quality and Performance sub-committee. This sub-committee advises the Primary Care Joint Commissioning Committee on the quality and performance management of primary medical services in Hull, ensuring remedial action plans are developed and implemented when positive assurances are not received.

Serious Incidents

A Serious Incident is something out of the ordinary or unexpected, which has the potential to cause serious injury, harm or unexpected death. We have robust systems in place to encourage open and transparent reporting of serious incidents and concerns. This helps to ensure that learning from these incidents is embedded into practice to prevent a recurrence. We will continue to drive the reduction of Never Events (a serious incident that is wholly preventable) within our commissioned services.
You can find out more about our Commissioning for Quality Strategy 2016 – 2020, Nursing Strategy, Quality Improvement plans and contract monitoring and Commissioning for Quality and Innovation (CQUINS) in our Operating Plan at **www.hullccg.nhs.uk**

Infection prevention

The CCG has achieved its reduction target for incidences of Clostridium difficile (C.diff) target with 72 C.diff cases against an objective of 81. In 2015-16 we reviewed and refreshed the C.diff community case review and now include personal feedback to individual GPs. Infection Prevention education has resulted in a reduction of C.diff relapse cases and reduced repeat sampling and improved review of secondary care C.diff cases with joint commissioner and provider involvement. Antibiotic prescribing reduction targets have been met.

Living life free from harm and abuse

The Safeguarding Children and Adults Strategy sets out the priorities in relation to safeguarding children and adults at risk of abuse or neglect, which supports the CCG's overall vision, strategy and objectives.
We uphold that living a life that is free from harm and abuse is a fundamental right of every person and we acknowledge our statutory responsibility to promote the welfare of children and young people and to protect children and adults from abuse and neglect.

In response to the requirements of Winterbourne View, and the need for greater assurance around ongoing care for people with a learning disability, the CCG is represented at the Yorkshire and Humber Transforming Care Steering Group and a process for Care and Treatment Reviews is in place.

Counter terrorism (Prevent) training and modern day slavery awareness sessions have been delivered to CCG staff during 2015-16.

Female Genital Mutilation (FGM) is a criminal offence under the Female Genital Mutilation Act of 2003. It is an extremely harmful practice and a form of child abuse and violence against women and girls.

The Hull Safeguarding Children Board (HSCB), which the CCG is part of, is taking a lead role in bringing together health, social care and other professionals to develop ways of eliminating this illegal and unacceptable practice. All organisations have a named doctor, midwife or nurse for safeguarding children involved in the work of the HSCB.

Further information about FGM is available via **www.nhs.uk**

Safeguarding professionals aim to share learning at Hull and East Riding conference

Early April 2016 saw almost 100 safeguarding professionals from the local area come together for the first Hull and East Riding Safeguarding Adults and Children Conference, themed on 'Disharmony in the Home'. The conference brought renowned speakers from across the UK to the area to speak to safeguarding professionals from across the patch about a number of issues including elder abuse, domestic violence and dementia in the community. Almost 100% of conference attendees, who completed feedback forms on the day, were impressed with the event. A second annual safeguarding conference is now in the works!

You can read our Safeguarding Children and Adults Strategy at **www.hullccg.nhs.uk**

Enhancing Patient Experience

We are dedicated to involving local people in our decision making, with patient and public engagement embedded into the commissioning process. Recent examples include the involvement of Hull CCG's Ambassadors in the community service contract re-procurement process.

To further improve services, a process of triangulating data from our Patient Advice and Liaison Service (PALs), complaints, Friends and Family Test (FFT) and Serious Incidents is being developed with providers and will be a focus of delivery in 2016-17.
The CCG produces a quarterly patient experience report for the Quality and Performance Committee (Q&P) to inform the work of the CCG and more specifically the Communications and Engagement Team. We also have a regular slot for patient stories at our bi-monthly CCG Board meetings that reports good patient experience and where things need to improve.
The streamlining and standardising of the patient complaints process across our full health system is will continue into 2016-17 via the Putting Patients First Board (a sub-committee of Q&P implemented as a direct result of The Francis Report).

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

Patient Relations Service
Health House
Grange Park Lane
Willerby HU10 6DT
01482 335409
Email: HULLCCG.PALS@nhs.net

Hull 2017 - Creating a healthier Hull through arts and culture

In 2017 the city of Hull will be the UK City of Culture bringing a unique opportunity to celebrate the people and stories of Hull.

As the local leader of the NHS in Hull we have enthusiastically worked with other health partners and the Hull 2017 team to ensure improving health and wellbeing is embedded throughout the year-long programme. Some of the key themes that health partners have prioritised are:

- **Building the broader social health of communities, through belonging, ownership and involvement;**
- **Supporting communities to celebrate the assets of their local area and the positive aspects of their lives;**
- **Addressing the emotional health of individuals by tackling loneliness and isolation;**
- **Obesity is a major challenge for the city;**
- **Many residents feeling they lack a voice, a way to express themselves, both young and old;**
- **Identifying role models who can inspire, motivate and influence;**
- **Hull should be an age-friendly city that supports inclusive activities;**
- **We should celebrate the pride of the city and its people.**

NHS Hull CCG is a now a Hull 2017 'Major Partner' – giving us a place on the 2017 Partnerships and Development Group, working directly with the 2017 team to help the programme have a real and lasting impact on the lives, health and wellbeing of local people.

The learning from the health workshops and the development work that has taken place across the neighbourhoods of the city has shaped the Hull 2017 programme and enabled the Hull 2017 team to prioritise projects in the four areas below:

- **Citywide community interventions**
- **High engagement physical programme (based in localities around Hull)**
- **Key arts in health projects**
- **Hull 2017 volunteer & ambassador programme**

We particularly welcome the recruitment of 4000 volunteers during 2017, with the potential to develop health champions who can inspire, motivate and influence people of all ages to lead healthier lives.

An exciting programme of events throughout the 2017 will be announced in waves during 2016 via www.hull2017.co.uk

2015-16 Highlights in Health Care

New community services contract awarded

In August 2015, following a competitive tendering process, City Health Care Partnership CIC (CHCP CIC) was awarded contracts to provide integrated community care, urgent care and integrated sexual health services across Hull for the next five years.

CHCP CIC is the 'Lead Provider' for all three contracts and will work in partnership with a number of other local providers to deliver integrated services to the population of Hull.

Integrated community care services include community nursing, management of long term conditions, intermediate care and reablement, therapy and rehabilitation and specialist palliative and end of life care. CHCP CIC has previously provided a significant number of these services, and from April 2016 service delivery will be developed and enhanced through care coordination alongside integration with social care, the local hospitals and GP practices.

CCG staff work together to help the homeless

During December 2015 CCG staff began a drive to help the local homeless community in Hull; beginning with a collection of warm clothes and sleeping bags for the Hull Homeless and Rootless Project (Hull Harp).

Staff went on to hold a dress down day, raffle and bake sale to raise funds for the project, the donations provided enough money for the charity to buy much needed bedding, kitchen equipment and essential items for those living on the streets in Hull.

Expressing her thanks to the CCG, Sandy Smith chair of the Trustees at Hull Harp, said: "I would like to take this opportunity to thank the CCG for their donations – they will help make life a little easier for our client group. The ideas that the CCG have given us, around involving in our work and the Citizen's Advice Bureau, will too be extremely beneficial."

CCG staff donating goods to Hull HARP - Photo: Hull Daily Mail

Spring 2016 saw CCG staff donate toiletries and luxury goods, which are often taken for granted, to young homeless people in Hull. The donations came following the Hull Resettlement Project presentation at one of our Healthier Hull Community Fund

vote events. Touched by the need for such seemingly basic items, Emma Latimer implored staff to donate, saying: “Items we so often take for granted, shower gel, hair spray, make up, and so on, can make such a big difference to the lives, confidence and self-esteem of young people living in temporary and supported accommodation.”
In recent months CCG staff have also supported the local campaign ‘a day in my shoes’, by donating used shoes to the campaigns’ Guinness World Record attempt challenge. The challenge aims to collect 25,000 pairs of shoes, break the world record and raise awareness of the issues and problems which the city’s homeless often face.

Hull and East Riding residents encouraged to stay well in cross-county campaign

October 2015 to February 2016 saw Hull and East Riding CCGs and Local Authorities work together to help people in the area to Stay Well through the winter months.
Following the lead of the NHS England backed, national winter health campaign, all involved organisations focused on promoting information around the three most important areas of winter health for the local population; the importance of the flu vaccination, knowing where to receive medical treatment and keeping warm and well.

The campaign ran across broadcast, print and social media; from bus stops, to radio advertising, Twitter and Facebook, the aim was to ensure all Hull and East Riding residents knew how to best look after themselves over the winter months, and where to receive appropriate medical treatment when necessary.
2016/17 will see the cross-county organisations work together again to build on the work undertaken as part of the Stay Well campaign, not only through the winter months, but all year round.

Celebration of older people week 2015

Tackling loneliness and isolation across the city is a key Hull 2020 aim and Older People’s Week (28 Sept – 4 Oct 2015) was an opportunity to celebrate and showcase our older residents and the valuable contribution they make to our communities and society. The CCG is a member of the Older Peoples Partnership which organised the week, bringing together thousands of older people, their families and carers to engage and participate in a range of activities and events held across the city, including tea dances, reminiscence events, a fashion show and Hull’s Got Talent 55+ Competition.

Transforming diabetes care

Work is under way to redesign patient education and primary care (GP) support for people with diabetes in Hull.

An estimated 20,882 people in Hull are currently undiagnosed and at risk of developing diabetes. 14,749 patients registered with Hull GPs aged 17+ years were on the diabetes disease register for 2014-15 representing 6.34% of the population aged 17+ years. Diabetes is a long term health condition and NHS Hull CCG’s ambition is to support patients to become expert self-carers to reduce the risks of complications and improve quality of life. Complexities can occur relating to eyes, kidneys, and circulation leading to stroke and heart attacks. The CCG is currently working with colleagues in East Riding of Yorkshire CCG to establish community based services for diabetes care, with a specialised level supporting the more complex patients and more focus on prevention and out of hospital care

Our review of diabetes care in 2015-16 outlines the significant impact that the use of technology, such as skype consultations, online support and education portals, photo imaging and recording for foot care (replicating digital imaging used in wound management and dermatology) can have on improving care, prognosis and self-care for people with diabetes.

Throughout 2016-17 we will continue to support to GP practices to provide high quality, resilient diabetes care and develop on-line support and education modules health care professionals and patients.

A unique careers event for Hull and East Riding Students

Students from schools and sixth forms across Hull and the East Riding were invited to a unique careers event held at Hull and East Yorkshire Hospitals Foundation Trust. The event, in conjunction with health organisations across the area, gave the young people the change to spend ‘a day in the life’ of a health care professional; from doctors and nurses to paramedics and health care assistants.

Tommy Coyle Academy free to under-17s

NHS Hull CCG helped make dreams become a reality for local boxing champion, Tommy Coyle, by providing funding for East and West Hull Tommy Coyle Academy gyms. Free to young people aged under 17, the gyms provide the perfect opportunity for children and young people to get fit, have fun and look after their health with a unique mix of free training sessions and health and wellbeing classes.

Hull GPs attend Minor Surgery Training

A number of GPs from across Hull attended Minor Surgery training this year organised through the CCG.

Performance Analysis

Financial position 2015-16

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 £7,820k against its revenue resource limit of £389,154k as planned.

The CCG spent £6,196k on the administration of the organisation in 2015-16. This represented an underspend of £320k against a maximum target of £6,516k.

The CCG monitors performance against NHS frameworks and key performance indicators. Initiatives are aligned to the CCG strategy and workplans to ensure any corrective actions are implemented to address any deteriorating indicators. Over the next few pages we present some detailed tables and commentary on our performance during 2015-16.

Financial development and performance 2015-16

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 minimal funding growth 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. Analysis of historic patterns of use and projections in underlying growth in demand indicates that we would expect to see health economy cost growth exceed the funding awarded to the CCG. This challenge falls to both the CCG and the providers of services who are expected to contribute towards this shortfall. The CCG meets its challenge through its Quality, Innovation, Productivity and Prevention or QIPP programme which is a programme of transformation that 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.

Delivering the NHS constitution standards 2015-16

The NHS Constitution sets access standards for emergency care, elective (non-emergency) care and cancer services, and the CCG has an obligation to ensure our all health care providers meet these to ensure patients in Hull receive the right standards and quality of care.

The Hull and East Riding of Yorkshire System Resilience Group (SRG) is the forum where all the partners across the health and social care system come together to plan service delivery and manage pressures across the system using a collaborative approach. All local provider, commissioner, and social care organisations, ambulance services, mental health care, primary care and community care providers are represented within the SRG and play a key role in service delivery.

Performance tables detailing our local position on the NHS Constitution Standards and Quality Indicators and Better Care Fund (BCF) Metrics are below.

Performance Tables and Commentary

Performance Tables and commentary 2015-16 (Note: The 'Actual' position quoted is at 31 March 2016 unless year to date (YTD) position is stated otherwise in brackets).

NHS HULL CCG PERFORMANCE		Actual (YTD)	Target
NHS CONSTITUTION STANDARDS			
Number of GP written referrals in the period in all specialties	2015-16	61727 (Dec 2015)	
All first outpatient attendances (consultant-led) in all specialties	2015-16	77273 (Dec 2015)	73032
Number of other (non-GP) referrals for a first consultant outpatient episode in the period in all specialties	2015-16	18635 (Feb 2016)	16740
A&E Attendances - Total, SitRep data	2015-16	89549 (Jan 2016)	
A&E Attendances - Type 1, SitRep data	2015-16	66824 (Jan 2016)	73511
A&E waiting time - patients who spent 4 hours or less in A&E from arrival to transfer, admission or discharge.	2015-16	73642 (Jan 2016)	
A&E waiting time - Total number of A&E attendances	2015-16	90144 (Jan 2016)	73512
A&E waiting time - total time in the A&E department, SitRep data	2015-16	82.24% (Jan 2016)	95%

Commentary
Performance against the 4 hour standard remains a concern. There does not seem to be a correlation between activity and performance with average daily attendances remaining static. Those days with a higher than average number of attendances do not necessarily translate into a higher number of patients waiting above 4 hours. Operational plans for each work stream designed to impact on performance, have been reviewed and refreshed by the System Resilience Group, with key milestones and benefits realisation. These have been agreed with the Emergency Care Improvement Programme and Hull & East Yorkshire Hospitals. These will continue to be monitored monthly by the SRG.

NHS HULL CCG PERFORMANCE		Actual (YTD)	Target
Ambulance clinical quality – Category A (Red 1) 8 minute response time - trust (%)	2015-16	71.1% (Feb 2016)	75%
Ambulance clinical quality – Category A (Red 2) 8 minute response time - trust (%)	2015-16	71.6% (Feb 2016)	75%
Ambulance clinical quality - Category A 19 minute transportation time (Hull CCG) (%)	2015-16	93.1% (Feb 2016)	95%

Commentary
The indicators above relate to Yorkshire Ambulance Service regional information. In Hull area the January position for Category A (Red 1) 8 minute response is 75.4% and Category A (Red 2) 8 minute response is 76.3% and is on target. This remains a priority workstream for SRG and plans in 2016/17 detail work to increase utilisation of alternative pathways for the ambulance service. The data above is shown at trust level which we must report on for assurance and at CCG level.

NHS HULL CCG PERFORMANCE		Actual (YTD)	Target
Ambulance Handover Time - Delays of +30 minutes - YAS trust level	2015-16	18726 (Feb 2016)	0

Commentary
Long delays in ambulance handover and turnaround are detrimental to clinical quality and patient experience and are costly to the NHS. Ideally, ambulance turnaround should be complete within 30 minutes, allowing 15 minutes for patient handover to the emergency department (ED) and 15 minutes to clean and prepare the ambulance vehicle to be ready for the next call.

NHS HULL CCG PERFORMANCE		Actual (YTD)	Target
RTT - The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.	2015-16	86.59% (Feb 2016)	92%

Commentary
There have been significant performance issues within the RTT Pathways. There is a working group to redesign pathways at specialty level which continues to make progress. GP uptake of referral information on the pathway information portal (PIP) continues to increase on a monthly basis with the aim of ensuring referrals are of a consistent quality. Priorities for the working group include:
- Increased utilisation of NHS E referral for all specialties (including cancer)
- New pathway models are being developed for ENT, diabetes and dermatology.

NHS HULL CCG PERFORMANCE		Actual (YTD)	Target
No urgent operations cancelled for a 2nd time - Hull CCG	2015-16	1	0

Commentary
This is a zero tolerance indicator within the Constitution

NHS HULL CCG PERFORMANCE		Actual (YTD)	Target
Diagnostics Test Waiting Times	2015-16	0.53% (Feb 2016)	<1%
Cancer- All Cancer two week wait	2015-16	92.35% (Feb 2016)	93%
Cancer - Two week wait for breast symptoms (where cancer not initially suspected)	2015-16	85.95% (Feb 2016)	93%
Cancer - Percentage of patients receiving first definitive treatment within 31 days of a cancer diagnosis.	2015-16	97.26% (Feb 2016)	96%
Cancer - 31 Day standard for subsequent cancer treatments -surgery	2015-16	93.72% (Feb 2016)	94%
Cancer - 31 Day standard for subsequent cancer treatments -anti cancer drug regimens	2015-16	100% (Feb 2016)	98%
Cancer - 31 Day standard for subsequent cancer treatments - radiotherapy	2015-16	96.61% (Feb 2016)	94%
Cancer - All cancer 62 day urgent referral to first treatment wait	2015-16	76.68% (Feb 2016)	85%
Cancer - 62 day wait for first treatment following referral from an NHS cancer screening service	2015-16	87.5% (Feb 2016)	90%
Cancer - 62 day wait for first treatment for cancer following a consultant's decision to upgrade the patients priority	2015-16	88.89% (Feb 2016)	90%

Commentary
The Cancer Tripartite working group monitors waiting time standards on a fortnightly basis and challenges the provider where standards are breached, agreeing the remedial actions and ongoing monitoring of the high risk NHS England returns.

Hull and East Riding CCGs have been having fortnightly meetings with HEYHT managers to develop, agree, monitor and review an action plan to improve the 62 day cancer standard, this will expand from late March to a wider group of CCGs which will meet on a monthly basis.

Performance for 2 week waits has improved significantly in line with plans and expectations. Hull & East Yorkshire Hospitals are monitoring performance on a daily basis which includes slot availability, booking 2 week wait appointments and delivery of 62 day waiting times.

NHS HULL CCG PERFORMANCE		Actual (YTD)	Target
The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	2015-16	97.14% (Nov 2015)	50%
The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.	2015-16	100% (Nov 2015)	75%
% of people who have depression and/or anxiety disorders who receive psychological therapies	2015-16	13.57% (Nov 2015)	10.64%
Recovery following talking therapies for people of all ages	2015-16	32% (Sep 2015)	35%
People who are moving to recovery	2015-16	35.11% (Nov 2015)	50%
Dementia - Estimated diagnosis rate	2015-16	77.99%	69.91%
Cancelled Operations - Hull CCG	2015-16	3.9% (Dec 2015)	2.7%

Commentary
The Surgical Health Group has also improved the escalation process for managing cancelled operations which has resulted in improved performance in Q3 2015-16.

CCG Outcome Indicators

Quality		YTD	Target
Patient experience of GP out of hours services	2015-16	73.8%	72.81%
Patient experience of hospital care - HEYHT	2015-16	74.3	75
Patient safety incidents reported	2015-16	25	27
Healthcare acquired infection (HCAI) measure (clostridium difficile infections)	2015-16	72	82
Healthcare acquired infections (HCAI) measure (MRSA)	2015-16	2	0

Commentary
This is a zero tolerance indicator within the Constitution

Quality		YTD	Target
Incidence of healthcare associated infection (HCAI): Clostridium difficile (C.difficile).	2015-16	72	82
Incidence of healthcare associated infection (HCAI): MRSA	2015-16	2	0

Commentary
This is a zero tolerance indicator within the Constitution

Mortality		YTD	Target
One year survival from all cancers	2015-16	65.9%	65.7%
Mortality within 30 days of hospital admission for stroke	2015-16	1.25	1.3
Potential years of life lost from causes considered amenable to healthcare (All ages)	2015-16	2595.2	2565.4
Under 75 mortality from respiratory disease	2015-16	55.8	44.1
Under 75 mortality rate from cardiovascular disease	2015-16	97.7	80.6
Under 75 mortality rate from liver disease	2015-16	18.6	16.6

Commentary
Hull City Council Public Health team has published a mortality report www.hullpublichealth.org

Maternity		Actual (YTD)	Target
Antenatal assessments <13 weeks	2015-16	99.78% (Jan 2016)	95%
Number of maternities	2015-16	2806 (Jan 2016)	
Maternal smoking at delivery	2015-16	20.92% (Jan 2016)	<21%
Breast feeding prevalence at 6-8 weeks	2015-16	32.73% (Jan 2016)	31%
Primary Care information		**YTD**	
GP registered population counts by single year of age and sex (under 19s)	2015-16	64776 (Dec 2015)	
GP registered population counts by single year of age and sex from the NHAIS (Exeter) Systems	2015-16	293091 (Dec 2015)	

Further summary analysis of performance is on page 58 of the Annual Governance Statement

Urgent Care		YTD	Target
Emergency admissions for children with lower respiratory tract infections (LRTIs)	2015-16	467.6	483.6
People who have had a stroke and are admitted to an acute stroke unit within four hours of arrival to hospital - Hull Royal Infirmary	2015-16	67.02%	67.37%
People who have had a stroke who are admitted to an acute stroke unit within four hours of arrival to hospital	2015-16	67%	65.3%
People who have had an acute stroke who receive thrombolysis - Hull Royal Infirmary	2015-16	9.9%	10.43%
People who have had an acute stroke who receive thrombolysis following an acute stroke	2015-16	12.3%	11.3%
People with stroke who are discharged from hospital with a joint health and social care plan - Hull Royal Infirmary	2015-16	93.02%	81.44%
People with stroke who are discharged from hospital with a joint health and social care plan.	2015-16	100%	93.8%
Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s).	2015-16	333.5	384.3
Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions	2015-16	999.8	1030

Commentary
The CCG monitors emergency hospital admissions monthly to ensure pathways commissioned are delivering key outcomes.

Urgent Care		YTD	Target
Emergency admissions for acute conditions that should not usually require hospital admission.	2015-16	1455.4	1452.3

Commentary
The CCG continues to work closely with the community services to ensure patients are being supported in the community rather than being admitted to hospital. Improvements have been made in 2015-16 and initiatives in place for 2016/17

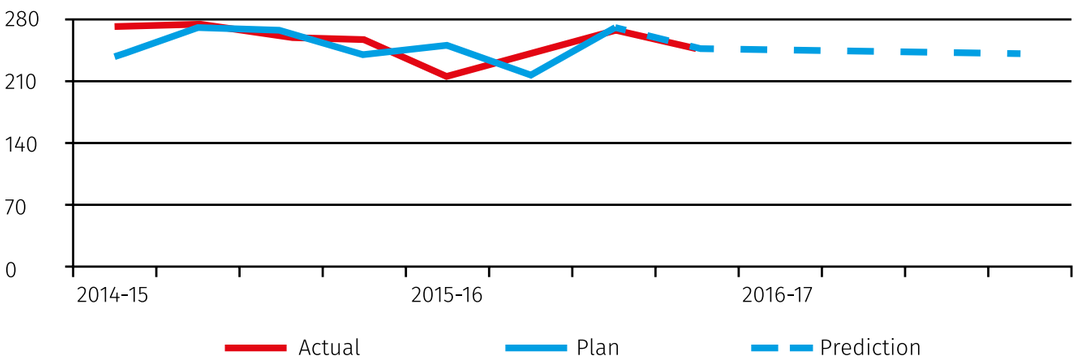
Urgent Care		YTD	Target
Emergency admissions for alcohol-related liver disease.	2015-16	20.8	17.5

Commentary
This area is being monitored with Hull City Council Public Health to understand underlying issues and current services in place to prevent emergency admissions to hospital. There is a project group in place to support improvements during 2016/17.

Better Care Fund (BCF) performance indicators

The following table presents a summary of our BCF performance indicators. The indicators are set nationally with the exception of falls which was chosen as a local measure.

1	**Non – elective admissions** We remain on track to reduce non-elective (unplanned) admissions to hospital against the plan during 2016-17. We intend to sustain this improvement against growth in activity by creating more alternatives to community based care.	On track
2	**Residential/ nursing home admissions** The Vulnerable Adults Review Panel (VARP) has been in operation since October 2015 and it reviews all cases before a permanent admission is made. Although we have not reached the target we are improving and will be closely monitored in 2016-17.	Off target
4	**Reablement – at home 91 days after discharge** The reablement measure is collated annually and the 2015-16 figures are currently being collated	Awaiting data
4	**Delayed Transfers of Care (DToC)**	Off track
5	**Local measure – Admissions due to a fall aged 65 plus** This key performance indicator was our local metric chosen to measure the impact of some of the BCF falls initiatives. There has been some variability (see table below) and we will continue to monitor this area as our initiatives become embedded in 2016/17	Off target
6	**Patient experience indicator**	Awaiting data



Next Steps

The Hull BCF is managed and monitored by a steering group and all highlight reports and the BCF dashboard are reviewed at the group on a monthly basis. The quarterly assurance reports to NHS England are taken to the Hull Health and Wellbeing Board. Information is also regularly taken through the local authority corporate senior team (CST) and the CCG Planning and Commissioning Committee.

Managing our resources 2016-17 and beyond

NHS Hull CCG will receive approximately £396m of resources in 2016-17. Of this £6m is allocated for the running of the CCG and £8m is the return of the 2015-16 surplus. In order to manage these resources and deliver the £8m required surplus for 2016-17 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 secondary care, prescribing, and continuing healthcare growing at rates over and above the levels anticipated. In addition to this the CCG works with the local council as part of the 'Better Care Fund' initiative. Should the level of planned integration not deliver as expected there is a risk that the level of dual running could be costly.

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

The CCG contracts with Yorkshire and Humber Commissioning Support (YHCS) for a range of commissioning support functions. Future commissioning support arrangements will be provided by eMBED Health Consortium following the NHS England lead provider framework exercise.

Sustainability Report 2015-16

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020.

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

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:

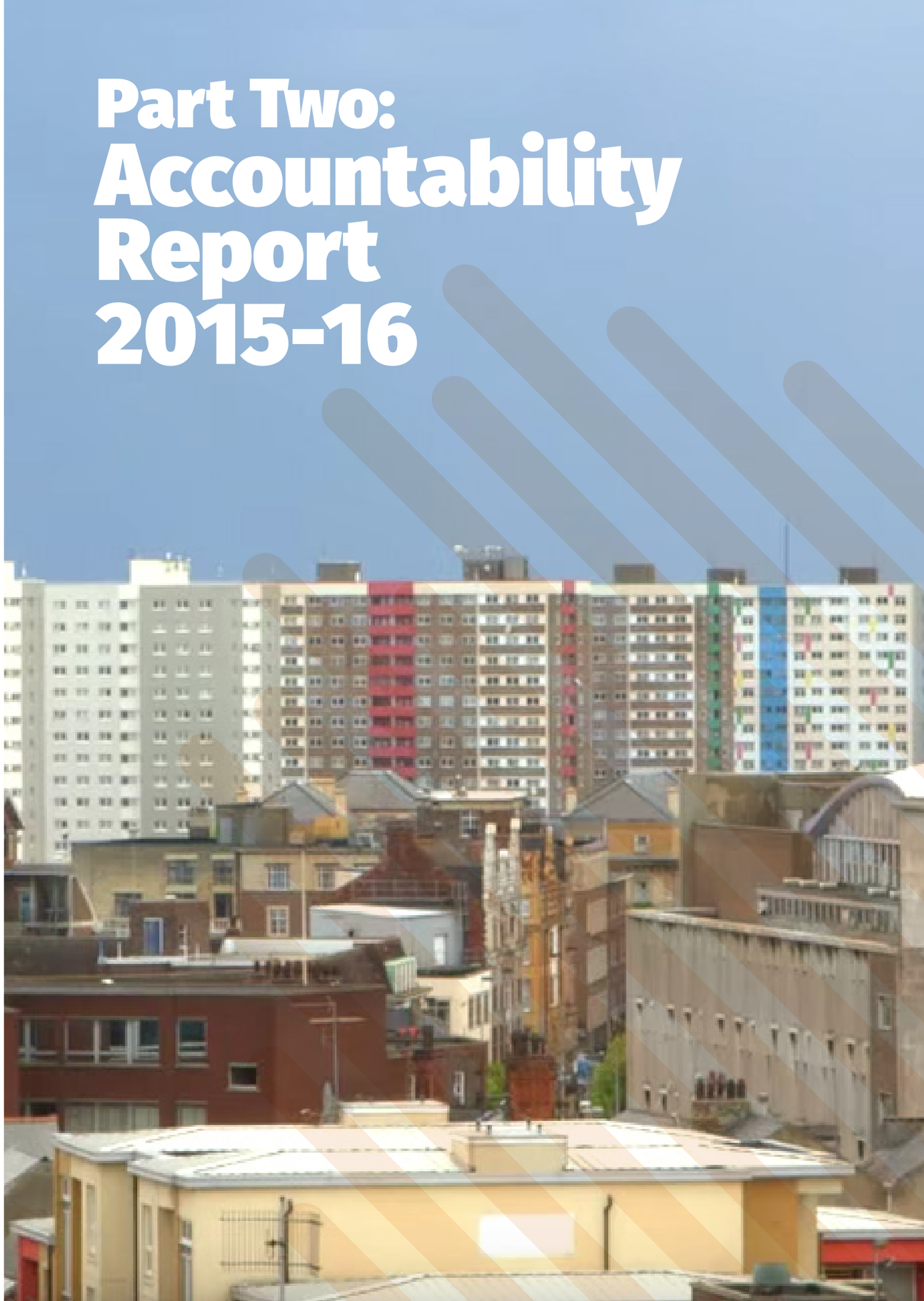
- the introduction of a new policy, project, or function; or
- the implementation of an existing policy, project, or function within the organisation.

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).

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 information on energy usage. We pay a service charge for the building and all the costs for water, waste and energy are part of this.

Emma Latimer
Chief Officer, NHS Hull Clinical Commissioning Group
23 May 2016

Part Two: Accountability Report 2015-16



Our CCG Membership

NHS Hull CCG is a clinically-led organisation that brings together local GP practices and other health professionals to plan and design services to meet local patients' needs. Our GP practices served a registered patient population of 293,091 across 23 local authority awards during 2015-16.

During 2015-16, the following 55 practices comprised the membership of NHS Hull Clinical Commissioning Group. This is a reduction of two practices from 2014-15 as a consequence of the Kingswood Surgery (previously named Haxby Group Kingswood Surgery) merger with Haxby Group Priory Surgery and Haxby Group Orchard Park on 1 April 2016.

Practice Name	Address
Dr AK Choudhary and Dr SR Danda Practice	Bransholme Health Centre, Goodhart Road, Bransholme, Hull, HU7 4DW
Morrill Street Group Practice	Morrill Street Health Centre, Morrill Street, Hull, HU9 2LJ
Kingston Health (Hull)	Kingston Health, Wheeler Street, Hull, HU3 5QE
Kingston Medical Group	Kingston Medical Centre, 151 Beverley Road, Hull, HU3 1TY
Dr RK Awan and Partners	Orchard 2000 Medical Centre, 480 Hall Road, Hull, HU6 9BS
Sutton Manor Surgery	St Ives Close, Wawne Road, Hull, HU7 4PT
Faith House Surgery	Faith House Surgery, 723 Beverley Road, Hull, HU6 7ER
St Andrews Group Practice	St. Andrews Group Practice, Elliott Chappell Health Centre, 215 Hessle Road, Hull, HU3 4BB
Wilberforce Surgery	Wilberforce Health Centre, 6-10 Story Street, Hull, HU1 3SA
The Avenues Medical Centre	The Avenues Medical Centre, 149 - 153 Chanterlands Avenue, Hull, HU5 3TJ
Dr IA Galea and Partners	The Oaks Medical Centre, Council Avenue, Hull, HU4 6RF
Dr JAD Weir and Partners	Marfleet Group Practice, Preston Road, Hull, HU9 5HH
The Bridge Group Practice	The Orchard Centre, 210 Orchard Park Road, Hull, HU6 9BX
Wolseley Medical Centre	Londesborough Street, Hull, HU3 1DS
Dr JR Lorenz and Partners	Alexandra Health Centre, 61 Alexandra Road, Hull, HU5 2NT
Dr VA Rawcliffe and Partners	New Hall Surgery, Oakfield Court, Cottingham Road, Hull, HU6 8QF
Dr J Musil and Partner	Princes Court, 2 Princes Avenue, Hull, HU5 3QA
Diadem Medical Practice	Bilton Grange Health Centre, 2 Diadem Grove, Bilton Grange, Hull, HU9 4AL
Clifton House Medical Centre	263 - 265 Beverley Road, Hull, HU5 2ST
The Springhead Medical Centre	376 Willerby Road, Hull, HU5 5JT
St Andrews-Newington	Newington Health Centre, 2 Plane Street, Hull, HU3 6BX
Dr MS Lovett & Partner	Elliott Chappell Health Centre, 215 Hessle Road, Hull, HU3 4BB

Practice Name	Address
Dr GM Chowdhury and Partner	Park Health Centre, 700 Holderness Road, Hull, HU9 3JA
Dr RJ Westrop and Partners	Alexandra Health Centre, 61 Alexandra Road, Hull, HU5 2NT
Dr AK Rej	Southcoates Medical Centre, 225 Newbridge Road, Hull, HU9 2LR
Dr MK Mallik	919 Spring Bank West, Hull, HU5 5BE
Dr GS Malczewski	Longhill Health Care Centre, 162-164 Shannon Road, Hull, HU8 9RW
New Green Surgery	Morrill Street, Hull, HU9 2LJ
Burnbrae Medical Practice	445 Holderness Road, Hull, HU8 8JS
Dr L Witvliet	358 Marfleet Lane, Hull, HU9 5AD
Dr AK Datta and Partner	The Surgery, Littondale, Sutton Park, Hull, HU7 4BJ
Dr BF Cook	Field View Surgery, 840 Beverley Road, Hull, HU6 7HP
Holderness Health Open Door Surgery	Park Health Centre, 700 Holderness Road, Hull, HU9 3JA
Dr JK Nayar & Partner	Newland Health Centre, 187 Cottingham Road, Hull, HU5 2EG
St Andrews - Bransholme	Bransholme Health Centre, Goodhart Road, Bransholme, Hull, HU7 4DW
Dr G Palooran and Partner	Bransholme Health Centre, Goodhart Road, Bransholme, Hull, HU7 4DW
Dr GT Hendow	Bransholme Health Centre, Goodhart Road, Bransholme, Hull, HU7 4DW
Dr R Raut and Partner	Highlands Health Centre, Lothian Way, Bransholme, Hull, HU7 5DD
Dr Raghunath	Bransholme Health Centre, Goodhart Road, Bransholme, Hull, HU7 4DW
Dr G Dave	Laurbel Surgery, 14 Main Road, Bilton, Hull, HU11 4AR
Chestnut Farm Surgery	174 Dunvegan Road, Hull, HU8 9LF
East Park Practice	Park Health Centre, 700 Holderness Road, Hull, HU9 3JA
Dr JC Joseph	Longhill Health Care Centre, 162-164 Shannon Road, Hull, HU8 9RW
CHCP Newington	Newington Health Centre, 2 Plane Street, Hull, HU3 6BX
Dr M Shaikh and Partner	Longhill Health Care Centre, 162 - 164 Shannon Road, Hull, HU8 9RW
Dr AS Raghunath and Partners	Newington Health Centre, 2 Plane Street, Hull, HU3 6BX
Dr NA Poulose and Partners	Bransholme Health Centre, Goodhart Road, Bransholme, Hull, HU7 4DW
Dr KV Gopal	Bransholme Health Centre, Goodhart Road, Bransholme, Hull, HU7 4DW
St Andrews Northpoint	Bransholme Health Centre, Goodhart Road, Bransholme, Hull, HU7 4DW
The Quays Medical Centre	Wilberforce Health Centre, 6-10 Story Street, Hull, HU1 3SA
Riverside Medical Centre	Riverside Medical Centre, The Octagon, Walker Street, Hull, HU3 2RA
The Calvert Practice	The Calvert Centre, 110a Calvert Lane, Hull, HU4 6BH
Northpoint	Bransholme Health Centre, Goodhart Road, Bransholme, Hull, HU7 4DW
Kingswood Surgery	Kingswood Healthcare Centre, 10 School Lane, Hull, HU7 3JQ
Story Street Practice And Walk In Centre	Wilberforce Health Centre, 6-10 Story Street, Hull, HU1 3SA

Our CCG Board

The NHS Hull CCG Board meets in public on a bi-monthly basis. It is responsible for agreeing and overseeing delivery of NHS Hull CCG's priorities. It makes sure the CCG works effectively, efficiently and economically.

NHS Hull Clinical Commissioning Group Board Membership 2015-16

(Board membership dates are 1 April 2015 - 31 March 2016 unless stated otherwise)

Chair
Dr Dan Roper

Chief Officer
Emma Latimer

GP MEMBERS

Dr Vince Rawcliffe

Dr James Moult

Dr John Parker

Dr Amy Oehring

Period of CCG Board membership:
01.04.15 – 31.07.15,
Absent for maternity leave:
1.08.15 – 30.01.16.
Period of CCG Board membership:
31.01.16 – 31.3.16

Dr Lucy Chiddick

31.07.15 - 29.01.16
(to cover maternity)

Dr Raghu Raghunath

Lay Representative
Karen Marshall

Lay Representative and Vice Chair
Paul Jackson

Lay Representative
Jason Stamp

Chief Finance Officer
Emma Sayner

Director of Integrated Commissioning
Erica Daley
23.11.15 – 31.03.16

Director of New Models of Care
Geoff Day
01.02.16 – 31.03.16

Secondary Care Doctor
Dr Richard Grunewald
01.04.15 - 01.07.15

Secondary Care Doctor
Dr David Heseltine
01.09.15 - 31.04.16

Practice Manager Member
Carole Robinson

Registered Nurse Representative
Angie Mason

Director of Quality and Clinical Governance/ Executive Nurse
Sarah Smyth

Director of Public Health and Adult Services
Julia Weldon

Director of Commissioning and Partnerships
Julia Mizon
01.04.15 - 01.07.15

The register of interests for our board members is available at **www.hullccg.nhs.uk** (Historical declarations of interest can be obtained via **HULLCCG.contactus@nhs.net**)

Membership of the NHS Hull CCG Integrated Audit & Governance Committee for 2015-16 is detailed on page 52 within the Annual Governance Statement. Please refer to the Remuneration Report on page 63 for details of the membership of the Remuneration Committee and the Annual Governance Statement for details and membership of all other governing body and membership body committees.

Access to Information

During the period 1 April 2015 to 31 March 2016, the CCG processed the following requests for information under the Freedom of Information Act (FOI) 2000.

	2015-16
Number of FOI requests processed	247
Percentage of requests responded to within 20 working days	100%
Average time taken to respond to an FOI request	13.1 days

Where information was held by the CCG, it provided either all or some of the material requested in all but one case. In this instance the information was already intended for future publication by the CCG.

There were 40 instances during the year where the CCG did not hold any of the information requested. In these circumstances the applicant was redirected, wherever possible, to another organisation that may have been able to assist them with their enquiries.

Our publication scheme contains documents that are routinely published; this is available on our website 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.

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 toolkit. **The CCG has had no such incidents during 2015-16.**

Handling complaints

There may be occasions when your experiences of local health services falls short of your expectations.

All local providers of NHS services have well established complaints procedures which enable such concerns to be investigated and responded to and further information is available directly from the relevant organisation.

The CCG's complaints process aims to provide a full explanation and resolve all concerns promptly and with the minimum of bureaucracy. It is keen to learn from complaints, wherever possible, in order to improve services, patient care and staff awareness.

The CCG's complaints policy is regularly reviewed and is consistent with latest guidance and recommendations, including current guidance and reports including Francis 2 , The Hart Clwyd Report, My Expectations for Raising Concerns and Complaints and The Care Quality Commission's "Complaints Matter".

During 2015-16, the CCG received nine complaints. All of these related to the commissioning of services by the CCG, with three relating specifically to decisions made under the Individual Funding Request process, four relating to provider services and two relating to general commissioning of the CCG. Seven of the complaints were not upheld and two remain under investigation. Two complainants chose to exercise the right to approach the Parliamentary and Health Service Ombudsman to consider their case. For further information regarding the CCG complaints process please visit the CCG website at **www.hullccg.nhs.uk**

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 is a member of the North Yorkshire and Humber Local Health Resilience Partnership and the Humber Health Sub Group.

The CCG's Business Continuity Plan has been prepared in line with the national Emergency Preparedness Resilience and Response (EPRR) core standards. A Business Continuity Plan exercise in July 2015 assisted the completion of the Plan which was approved by the CCG Board in January 2016.

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 of Accountable Officer's Responsibilities

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

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year. In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health and in particular to:

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

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the entity's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make himself or herself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.
- the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Emma Latimer
Accountable Officer
23 May 2016

Annual Governance Statement 2015-16

Introduction and context

The Clinical Commissioning Group was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2015, the Clinical Commissioning Group was licensed without any conditions or directions. It is a membership organisation comprising 55 general practitioner member practices within the boundary of Kingston upon Hull. It serves a population of approximately 290,000 local residents and in 2015-16 had a programme allocation of £389m.

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.
I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the UK Corporate Governance Code

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

In particular, we have described through the narrative within this annual governance statement and our annual report and accounts 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 within this annual governance statement and our annual report and accounts how we have discharged our responsibilities with regards to our members and the general public.

The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L (2) (b) states:
The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

The CCG maintains a Constitution and associated Standing Orders, Prime Financial Policies and a Scheme of Delegation, all of which has been approved by the CCG's membership and certified as compliant with the requirements of the NHS Commissioning Board (NHS England).

During 2015-16, confirmation was received by NHS England for the establishment of a joint committee for the co-commissioning of primary care services. A Programme Delivery Board has also been established to agree priorities and monitor progress against a programme of work to deliver the CCG Commissioning Strategy and Operational Plan.

The Constitution sets out the group's Standing Orders, Prime Financial Policies and Scheme of Delegation. Taken together these enable the maintenance of a robust system of internal control. The CCG remains accountable for all of its functions, including those which 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), CCG committees, individual officers and other employees.
The Council of Members comprises representatives of the 55 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 the 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 provide 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 2015-16 is summarised in diagram 1 below:

Council of Members (Bi-Monthly)

- Final (highest) level of authority for all CCG business
- CCG Constitution
- Vision, values and overall strategic direction
- Commissioning Strategy / Annual Commissioning Plan
- Election of GP members of CCG Board
- Ratification of lay members, registered nurse and secondary care doctor appointments to the CCG Board.

Clinical Commissioning Group Board (Bi-monthly)

- Assurance with regards to delivery of strategic priorities of the CCG.
- Strategic quality, planning and performance management
- Commissioning strategy / Annual Commissioning Plan (draft)

- HR policies (approval)
- Equality & Diversity Objectives / Plans (approval)
- Assurance and Risk Management (approval)

Senior Leadership Team (weekly)

- General consideration of strategy and policy / operational plans
- Risk Register
- Governance
- Organisational Development & HR
- Communication
- Operational Health and Safety
- CSU Interface (Monthly)
- Senior Managers Interface (Monthly)

- HR policies (draft)
- Equality & Diversity Objectives
- / Plans (draft)

Planning & Commissioning Committee (Monthly)

- Service redesign
- Procurement
- Joint Commissioning
- Engagement
- CCG Commissioning programmes
- Financial Strategy

- Commissioning policies
- Engagement strategies
- Planning

Quality & Performance Committee (Monthly)

- Financial management
- Contract management
- Performance management
- Value for money
- Quality improvement including safeguarding
- Patient experience
- Equality & Diversity
- IFR

- Quality
- Safeguarding
- Performance
- Clinical governance

Primary Care Joint Commissioning Committee (Bi-monthly)

- GMS, PMS and APMS contracts
- Newly designed enhanced services (LES and DES)
- Local incentive schemes
- Decision making on establishment of new GP practices
- Practice mergers
- Discretionary payments
- Extended primary care medical services
- Newly designed services to be commissioned from primary care.

Integrated Audit & Governance Committee (Bi-monthly)

- Independent assurance
- Governance, systems and control
- Internal control and audit
- Declarations / conflicts of interest
- Standards or business conduct
- Legal compliance
- Health and safety
- Information governance

- Governance
- Risk management (draft)
- Assurance (draft)

Remuneration Committee (Bi-annually)

- Remuneration and Terms of Service of VSM and Board Members
- Performance review of VSMs

- VSM remuneration / Terms of Service Policies

Programme Delivery Board (Monthly)

- Scrutinise progress against critical milestones for each workstream within the Annual Commissioning Operational Plan. Confirm and challenge the adequacy and timeliness of remedial steps in underperforming areas, effecting further action where necessary
- Rolling programme of detailed review of the Operational Plan workstreams and other core programmes of CCG work
- Identify and oversee risks to the delivery of work programmes and ensure these are reflected in the Corporate Risk Register or Board Assurance Framework, where appropriate

Membership, Attendance and Activity Summary

Council of Members

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 Governing Body.

During 2015-16, the Council met on eight occasions and was quorate on seven occasions. It ratified appointments to the vacancies for GP members of the CCG Governing Body and approved an annual workplan. The Council also considered a wide range of agenda items pertaining to its responsibilities including papers relating to quality, performance and strategy.

Attendance was as follows:

Date of Meeting	14/05/15	25/06/15	09/07/15	10/09/15	01/10/15	12/11/15	14/01/16	18/03/15
Practice								
Awan and Partners	✓	X	✓	X	✓	✓	X	✓
Bridge Group Practice	✓	✓	✓	X	✓	X	✓	✓
Burnbrae Medical Centre	✓	X	X	X	✓	X	X	X
Clifton House Medical Practice (Previously known Chauhan & Partners)	X	✓	✓	X	✓	✓	✓	✓
Chestnut Farm Surgery	✓	✓	X	X	X	✓	X	X
Choudhary AK & Danda SR Practice	X	✓	✓	X	✓	X	✓	X
Chowdhury GM	X	✓	X	X	X	X	X	X
City Healthcare Partnerships Newington Surgery	X	✓	✓	X	✓	✓	✓	✓
Cook BF	✓	✓	✓	X	✓	X	✓	✓
Dave G	X	✓	X	X	✓	X	X	✓
Diadem Medical Practice	✓	✓	✓	X	✓	✓	✓	✓
East Park Practice	✓	✓	✓	X	✓	✓	X	X
Faith House Surgery (Previously known as Wong and Partners)	X	✓	X	X	X	✓	✓	✓
Galea & Partners (Previously known as The Oaks)	✓	✓	X	X	✓	✓	X	✓
Hastings Medical Practice (Previously known as MK Mallik)	✓	✓	✓	X	✓	X	✓	✓
Haxby Group (Previously known as Kingswood Surgery, Orchard Park Surgery and Priory Surgery)	✓	✓	X	X	✓	X	✓	✓
Hendow GT	✓	✓	✓	X	✓	✓	✓	✓
Holderness Health Open Door Surgery (Previously known as Dr Yagnik Surgery)	X	X	X	X	✓	X	X	X
JK Nayar	X	X	X	X	X	X	X	X
Joseph JC	✓	✓	✓	X	✓	✓	X	X
Kingston Health Hull	X	✓	✓	X	✓	X	✓	✓
Kingston Medical Centre	X	X	✓	X	✓	✓	✓	✓
KV Gopal Surgery	X	X	X	X	✓	X	X	X
Malczewski GS	X	X	X	X	X	X	X	X
Morrill Street Group Practice	✓	✓	X	X	✓	✓	✓	✓
Musil J	X	✓	✓	X	X	✓	✓	✓
Newland Group Practice	X	X	X	X	✓	X	X	X
New Green Surgery	✓	X	X	X	✓	✓	✓	✓
Northpoint	X	X	X	X	✓	✓	X	X
Palooran & Koshy (Previously known as Palooran, George & Koshy)	✓	✓	X	✓	✓	✓	✓	✓
Percival & Partners (Previously known as Westrop & Partners)	X	✓	X	X	X	X	X	X
Poulose NA, Awan & Basheer	✓	X	X	X	✓	X	X	X
Quays Medical Centre	✓	X	✓	X	✓	X	X	✓

Date of Meeting	14/05/15	25/06/15	09/07/15	10/09/15	01/10/15	12/11/15	14/01/16	18/03/15
Practice								
Raghunath & Partners	X	✓	X	✓	✓	✓	X	X
Raut Partnerships	✓	✓	X	✓	✓	✓	✓	✓
Rawcliffe and Partners	✓	✓	✓	X	✓	✓	✓	✓
Riverside Medical Centre	✓	X	✓	X	✓	X	X	✓
Roper & Partners	✓	X	X	✓	✓	✓	X	✓
Shaikh Partnership	X	✓	X	X	X	X	X	✓
Southcoates Medical Centre (Previously known as Rej AK)	X	X	X	X	X	X	X	X
St Andrews Bransholme	X	X	X	✓	✓	✓	X	X
St Andrews Group Practice, Newington	X	✓	X	✓	✓	✓	X	X
St Andrews Group Practice	X	✓	X	✓	✓	✓	X	X
St Andrews Northpoint	X	✓	X	✓	✓	✓	X	X
Story Street Practice & Walk-In Centre	✓	X	✓	X	✓	✓	X	X
Sutton Manor Surgery	✓	✓	✓	X	✓	X	X	X
Sutton Park Medical Centre	X	X	X	X	✓	✓	✓	✓
Sydenham Group Practice	X	✓	X	X	✓	X	✓	X
The Avenues Medical Centre	X	✓	✓	X	✓	✓	X	X
The Calvert Practice	X	X	X	X	X	✓	✓	✓
St Andrews (Koul) (Previously known as Venugopal J & Partners)	X	X	X	X	✓	✓	X	X
Weir & Partners (Previously known as Marfleet Group Practice)	✓	✓	X	✓	✓	✓	X	X
Wilberforce Surgery	X	✓	X	X	✓	X	X	X
Witvliet L	X	✓	X	X	✓	X	✓	✓
Wolseley Medical Practice	✓	X	X	X	✓	✓	✓	✓

Extraordinary Meeting

Integrated Audit and Governance Committee

The Integrated Audit & 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 2015-16, the committee met eight 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.

Date of Meeting		21/04/15	12/05/15	21/05/15	07/07/15	08/08/15	10/11/15	12/01/16	08/03/16
Surname	**First Name**								
Marshall	Karen	✓	✓	✓	✓	✓	X	✓	✓
Jackson	Paul		✓	✓	✓	X	✓	✓	✓
Stamp	Jason	✓	✓	X	✓	✓	✓	✓	✓

Extraordinary Meeting

Governing Body

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

- ensuring that the Clinical Commissioning Group 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);
- determining the remuneration, fees and other allowances payable to employees or other persons providing services to the Clinical Commissioning Group 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
- those matters delegated to it within the Clinical Commissioning Group's Constitution

The CCG Governing Body has met seven 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.

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 its 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 development as a team. Activities in the last financial year have included conflicts of interest training and case study, inclusive leadership / equality and diversity considerations, improved Governing Body effectiveness and development of the CCG strategic objectives.

Date of Meeting		24/04/15	22/05/15	31/07/15	25/09/15	27/11/16	29/01/16	18/03/16
Surname	**First Name**							
Chiddick	Lucy			✓	✓	X	✓	
Heseltine	David			✓	✓	✓	X	✓
Grunewald	Richard	✓	X					
Jackson	Paul	X	✓	✓	✓	✓	✓	✓
Latimer	Emma	✓	✓	✓	✓	✓	X	✓
Marshall	Karen	✓	✓	✓	✓	✓	✓	X
Mason	Angie	✓	✓	✓	✓	✓	✓	✓
Mizon	Julia	X	✓					
Moult	James	✓	✓	✓	✓	✓	✓	✓
Oehring	Amy	✓	✓	✓				✓
Parker	John	✓	✓	✓	✓	✓	X	✓
Raghunath	Raghu	✓	✓	✓	✓	✓	✓	✓
Rawcliffe	Vince	✓	✓	✓	✓	✓	✓	X
Robinson	Carole	✓	✓	✓	✓	✓	✓	✓
Roper	Dan	✓	✓	✓	✓	✓	✓	✓
Sayner	Emma	✓	✓	✓	✓	✓	✓	✓
Smyth	Sarah	✓	✓	✓	X	✓	✓	✓
Stamp	Jason	✓	✓	✓	✓	✓	✓	✓
Weldon	Julia	✓	✓	✓	✓	✓	✓	✓

Was not a member at the time

Planning and Commissioning Committee

The Planning & 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 twelve times during the year and was quorate on each occasion. The committee's activities included:

- Development of the community services re-procurement specifications;
- Receiving and reviewing a wide range of clinical commissioning policies and prescribing rebates; and
- Consideration of a number of re-commissioned clinical service areas, including end of life care and interpretation and translation services.

Date of Meeting		01/04/15	06/05/15	03/06/15	01/07/15	05/08/15	02/09/15	07/10/15	04/11/15	02/12/15	06/01/16	03/02/16	02/03/16
Surname	**First Name**												
Parker	John	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Raghunath	Raghu	✓	✓	✓	✓	✓	✓	✓	x	x	✓	✓	✓
Jackson	Paul	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mizon	Julia	✓	✓	✓									
Billany	Karen	✓	x	x	✓	✓	✓	✓	✓	✓	✓	✓	✓
Davis	Philip	✓	x	✓	✓	✓	✓	x	✓	✓	✓	✓	✓
Daley	Erica	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓
Dawson	Bernie	✓	✓	x	x	✓	✓	✓	✓	x	x	x	x
Dodson	Joy	✓	✓	x	✓	✓	✓	✓	✓	✓	x	✓	✓
Taylor/Harris	Andrew/Vicky	✓	x	x	x	x	x	x	x	✓	✓	x	x
Lee	Sue	x	✓	✓	x	✓	x	✓	✓	✓	✓	x	✓
Smyth	Sarah	x	x	x	x	x	x	x	x	x	x	x	x
Storr	Danny	x	✓	✓	✓	✓	x	✓	✓	x	✓	✓	x
Robinson	Carole	✓	✓	✓	✓	x	✓	✓	✓	x	✓	✓	✓
Oehring	Amy	x	x	✓	✓							✓	✓
Bradbury	Melanie	✓	✓	x	✓	✓	✓	x	✓	x	✓	✓	✓
Lyon	Jackie	✓	✓	✓	✓	x	x	✓	✓	✓	✓	✓	
Peckitt	Sue	✓	✓	✓	✓	✓	✓	x	✓	✓	✓	✓	✓
Barker	Alison		✓	x	x	x	x	x	x	x	x	x	x
Fielding	Tim			✓	✓	✓	✓	✓	✓	x	x	✓	✓
Chiddick	Lucy					✓	x	✓	✓	✓	✓		

Was not a member at the time

Remuneration Committee

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 three times during the year and was quorate on each occasion. Highlights of the Committees activity included pay progression considerations, honorary contracts reviews and VSM and Agenda for Change performance frameworks.

Date of Meeting		16/06/15	30/10/15	08/12/15
Surname	**First Name**			
Marshall	Karen	✓	✓	✓
Roper	Dan	✓	✓	✓
Stamp	Jason	✓	✓	✓
Jackson	Paul	✓	✓	✓

Was not a member at the time

Extraordinary Meeting

Quality and Performance Committee

The Quality & 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 nine times during the year and was quorate on eight 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 during the year included:

- Provider quality monitoring and performance escalation;
- Commissioning for Quality Strategy;
- Monitoring of CQUINS, incidents and serious untoward incidents, and
- Scrutiny of financial delivery

Date of Meeting		21/04/15	26/05/15	25/06/15	28/07/15	24/09/15	27/10/15	19/11/15	21/01/16	24/03/16
Surname	**First Name**									
Moult	James	✓	✓	✓	✓	✓	x	✓	✓	✓
Ramsay	Carla	x	✓	✓	✓	✓	x	✓	✓	x
Blain	David		✓	✓	✓	✓	x	x	✓	✓
Stamp	Jason	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dodson	Joy	✓	x	✓	x	✓	x	✓	✓	✓
Morris	Lorna	x	✓	x	✓	✓	x	✓	✓	x
Smyth	Sarah	✓	✓	✓	✓	x	✓	✓	✓	✓
Lee	Susan	✓	✓	✓	✓	✓	✓	x	✓	✓
Mason	Angie	✓	✓	x	✓	✓	✓	x	x	✓
Peckitt	Sue			✓	x	✓	✓	✓	✓	✓
Memluks	Kate			✓	✓	x	✓	x	✓	x
Crick	James						✓	✓	✓	✓

Was not a member at the time

Primary Care Joint Commissioning Committee

The Primary Care Joint Commissioning Committee is a joint committee between NHS England and the CCG with responsibility for commissioning primary medical services across the city. In particular, the committee is responsible for considering General Medical Services (GMS), Personal Medical Services (PMS) and Advanced Personal Medical Services (APMS) contracts, enhanced services, local incentive schemes, decision making on establishment of new GP practices and practice mergers and newly designed services to be commissioned from primary care.

The Committee met on seven occasions during the year and was quorate on each occasion. During the year it considered the development of a primary care blueprint for Hull, primary care infrastructure development and re-procurement options for APMS.

Date of Meeting		24/04/15	26/06/15	28/28/15	25/09/15	30/10/15	18/12/15	26/02/16
Surname	**First Name**							
Jackson	Paul	x	✓	x	✓	✓	✓	✓
Daley	Erica						✓	x
Day	Geoff	✓	✓	✓	✓	x	✓	✓
Finch	Julie	✓	✓	✓	✓	✓	✓	x
Latimer	Emma	✓	x	✓	✓	✓	✓	x
Marshall	Karen	✓	✓	✓	✓	✓	✓	x
Mason	Angie	✓	x	x	✓	✓	x	✓
Mizon	Julia	x	✓	✓				
Parker	John	✓	✓	✓	✓	✓	x	✓
Sayner	Emma	✓	✓	✓	✓	x	✓	✓
Smyth	Sarah	✓	✓	x	x	✓	✓	✓
Stamp	Jason	✓	✓	✓	✓	✓	✓	✓
Weldon	Julie	✓	✓	x	✓	✓	x	✓

Was not a member at the time

Extraordinary Meeting

The Clinical Commissioning Group Risk Management Framework

The Clinical Commissioning Group 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 Clinical Commissioning Group.
- 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 March 2015.
The CCG's Chief Officer has overall responsibility for risk management. Through delegated responsibility the Associate Director of Corporate Affairs has day to day management of the organisations risk management process. The specific responsibilities of other committees, senior officers, lay members and all other staff within the CCG are clearly articulated.

The Clinical Commissioning Group maintains a Risk Register through an electronic reporting system which is accessible to all staff.

Risks are systematically reviewed at the Corporate Operations Group, the Integrated Audit and Governance Committee and other committees of the Governing Body, 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 Clinical Commissioning Group 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 2015/16 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 Clinical Commissioning Group's external auditors, a comprehensive internal audit programme and the work of NHS Protect.

In May 2015 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, the Building Health Partnership with local community and voluntary organisations 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 2016 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 2016/17.

Risk Assessment

All risks to the Clinical Commissioning Group are assessed for their impact and likelihood and are profiled against the NHS England balanced. The Clinical Commissioning Group'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 Clinical Commissioning Group and the Integrated Audit and Governance Committee has assessed the adequacy of the assurances available in relation to performance.

At the start of 2015/16 the CCG had six extreme (red) rated risks and five high (amber) rated risks within its Corporate Risk Register. By the end of 2015/16 the CCG had four extreme risks and nine high risks within its Corporate Risk Register. The extreme rated risks were as follows:

Risk	Controls	Assurance
Risk that Accident & Emergency 4-hour wait time is not delivered in 2015/16.	Formally monitored through Hull & East Yorkshire Hospitals NHS Trust Contract Management Board, Senior Leadership Team and CCG Quality & Performance Committee and Board	Weekly reporting information received. Daily analysis of activity is also available and being scrutinised. Detailed information of types of attendance (majors, minors and paediatrics) is routinely received and monitored.
Risk that the performance target for cancer 62-day wait for treatment will not be achieved in 2015/16	Monitoring of cancer performance and breach reports at Hull & East Yorkshire Hospitals NHS Trust Contract Management Board	Business Intelligence reporting to Board and Quality & Performance Committee. Breach reasons are provided and investigated further where required. Recovery trajectories now received. NHS England systems and Contract Management Board reporting. Weekly meetings held with Hull & East Yorkshire Hospitals NHS Trust specifically to review cancer performance
Risk that the 18 week Referral To Treatment targets are not delivered in 2015/16	Monitored through monthly Hull & East Yorkshire Hospitals NHS Trust Contract Management Board. Weekly attendance by commissioners at the provider's Performance Executive meeting	Contract Query notice issued to Hull & East Yorkshire Hospitals NHS Trust April 2014. Escalation has progressed to second Exception Notice. NHS England systems and Contract Management Board reporting requirements
Risk of breaching national objective set at 82 cases of C.difficile for 2015/16.	Action plan in place 2015/16, all cases receive C.difficile information card and phone call from City Health Care Partnerships Infection Prevention & Control Team. This team conducts Root Cause Analysis on all primary care cases and Medicines Management Team conduct medication review within GP practice recommending changes in practice where applicable.	Update report monthly to Quality & Performance Committee. The CCG Board will be updated via this committee. Communications out to GPs via Hot Topics and GP prescribing lead. Hull & East Yorkshire Hospitals NHS Trust Contract Management Board, Hull & East Yorkshire Hospitals Clinical Quality Forum, Humber wide Healthcare Associated Infection Forum.

The Clinical Commissioning Group Internal Control Framework

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

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

The 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

Information Governance

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

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

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

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 receive a regular update from the Quality and Performance Committee as to the economic, efficient and effective use of resources by the Clinical Commissioning Group. 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 Clinical Commissioning Group in relation to the economic, efficient and effective use of resources. The findings are reported to the Integrated Audit and Governance Committee.

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

The CCG undertakes a regular process of review of its internal control mechanisms, including an annual internal audit plan. All internal audit reports are agreed by senior officers of the CCG and reviewed by the Integrated Audit and Governance Committee.

A review of the effectiveness of the CCG governance structure and processes has been undertaken during the year; including a systematic self-review of effectiveness by the Governing Body and its Committees. Committee action plans were developed and progress against their delivery monitored by the Integrated Audit and Governance Committee. Budgets were established and maintained against all CCG business areas and performance monitored via a business intelligence report as a standing item at the Governing Body and Quality and Performance Committee.

Individual budget holders have regular budget review meetings to ensure that any cost pressures are adequately considered, managed or escalated as necessary.

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 2015/16.

The CCG currently contracts with a number of external organisations for the provision of support services and functions. 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. I have been advised that adequate assurances have been provided for 2015/16 for the following:

- Sheffield Teaching Hospitals NHS Foundation Trust (Victoria Payroll Services);
- NHS Shared Business Service;
- NHS Business Services Authority;
- Yorkshire & Humber Commissioning Support.

Capacity to Handle Risk

The Chief Officer is the Accountable Officer of the CCG and leads the executive team. She has overall responsibility for governance, statutory functions, quality and performance. This includes ensuring the implementation of an effective risk management system, development of the corporate governance framework, meeting all statutory requirements and ensuring that appropriate accountability statements for risk management and governance are in each Director's job profiles, as well as ensuring that all Directors have appropriate arrangements in place to address any shortfalls identified from the risk profile. The Chief 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 Clinical Commissioning Group.

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

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

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

Internal Audit has an important role in the risk assessment of the Clinical Commissioning Group 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.

Head of Internal Audit Opinion

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

Significant Assurance can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of a particular objective at risk.

During the year the Internal Audit issued seven audit reports with a conclusion of significant assurance. One audit report reported limited assurance in relation to Business Continuity Management, however, no significant concerns were identified and auditors were satisfied that significant assurance had been achieved by the year-end.

Data Quality

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

Business Critical Models

The CCG recognises the principles set out in the Macpherson Report as a direction of travel for business modelling in respect of service analysis, planning and delivery. It has an appropriate framework and environment in place to provide quality assurance of business critical models to the Clinical Commissioning Group, in line with the recommendations in the Macpherson report.

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

In addition, the Clinical Commissioning Group 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 2015/16.

Performance

The CCG achieved a high level of performance across the operating framework requirements. However the following areas of performance fell below the target level:

- **Healthcare Associated Infection: Methicillin-resistant Staphylococcus aureus (March 2016 data) - the CCG had a target of 0 MRSA infections for 2015/16, however, 2 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.
- **2 week wait urgent referral services including cancer (February 2016 data) - The 2015/16 Clinical Commissioning Group target is 93%; the latest year-to-date position is 92.35%.**
- **2 week wait - Breast (February 2016 data) - The 2015/16 Clinical Commissioning Group target is 85%; the latest year-to-date position is 85.95%.**
- **62 day cancer referral to treatment time following urgent GP referral (February 2016 data) - The 2015/16 Clinical Commissioning Group target is 85%; the latest year-to-date position is 77.32%.**
- **62 day cancer referral to treatment time following referral from NHS Cancer Screening Services (February 2016 data) - The 2015/16 Clinical Commissioning Group target is 90%, the latest year-to-date position is 88.37%.**

  Regular scrutiny takes place of all cancer target breaches through both the Quality and Performance Committee and the provider Contract Management Board.
- **Incomplete pathways - (February 2016 data) - The Clinical Commissioning Group did not meet the overall target of 92% of patients treated within 18 weeks on incomplete pathways, only achieving 86.59%.**

  Referral to treatment times are subject to significant review and are being monitored against the Hull and East Yorkshire Hospitals NHS Trust recovery plan and managed through contractual reviews and System Resilience Group.
- **Mixed Sex Accommodation (MSA) Breaches (March 2016 data) - The Clinical Commissioning Group had a target of 0 Mixed Sex Accommodation breaches for 2015/16; however, 3 cases were reported during the year.**
- **Accident and Emergency – total time spent in department (January 2016 data) – The Clinical Commissioning Group did not meet the overall target for 95% of patients attending accident & emergency to spend four hours or less in the department, only achieving 82.24%**
- **Ambulance response times (February 2016 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 71.1%. However, performance for incidents within the Clinical Commissioning Group area was above target at 75.63%**
- **Humber Foundation Trust access standards (all services) – The CCG has established a range of local performance targets in relation to the services provided by the Trust. As at March 2016 the year-to-date position was below the performance thresholds.**

Discharge of Statutory Functions

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

In light of the Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the 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.

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.

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
Chief Officer, NHS Hull Clinical Commissioning Group
23 May 2016

Remuneration and Staff Report

Introduction

The Remuneration and Staff Report 2015-16 sets out the organisation's remuneration policy for directors and senior managers. It reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers.

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. It is usually considered that regular attendees of the CCG's Board meetings are its senior managers.

Our Remuneration Committee 2015-16

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. Membership of the NHS Hull CCG Integrated Audit & Governance Committee for 2015-16 is detailed on page 52 within the Annual Governance Statement

Membership of the NHS Hull CCG Remuneration Committee is comprised of the following: (All memberships run from 1 April 2015 to 31 March 2016)

Karen Marshall (Chair)
CCG Lay Representative

Paul Jackson (Vice Chair)
CCG Lay Representative

Jason Stamp
CCG Lay Representative

Dr. Dan Roper
CCG Chair

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

Salaries and Allowances of CCG Senior Managers 2015-16 (subject to audit)

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).

Name	Title	Period In Office	Salary & Fees (bands of £5000) £000's	Expense payments (taxable) to nearest £100 £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 2015 - 31 March 2016	85-90	0	0	0	12.5-15	100-105
Dr Raghu Raghunath	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	35-40	0	0	0	0	35-40
Dr James Moult	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	55-60	0	0	0	85-87.5	140-145
Dr John Parker	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	35-40	0	0	0	0	35-40
Dr Lucy Chiddick	Clinical Commissioning Group Governing Body Member	31 July 2015 - 29 Jan 2016	25-30	0	0	0	250-255	275-280
Dr Vincent Rawcliffe	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	35-40	0	0	0	2.5-5	40-45
Dr Richard Grunewald	Secondary Care Doctor	1 April 2015 - 1 July 2015	0-5	0	0	0	0	0-5
Dr David Heseltine	Secondary Care Doctor	1 Sept 2015 - 31 March 2016	0-5	0	0	0	0	0-5
Dr Amy Oehring	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	15-20	0	0	0	12.5-15	30-35
Paul Jackson	Lay Member / Vice Chair	1 April 2015 - 31 March 2016	10-15	0	0	0	0	10-15
Karen Marshall	Lay Member	1 April 2015 - 31 March 2016	10-15	0	0	0	0	10-15
Jason Stamp	Lay Member	1 April 2015 - 31 March 2016	25-30	0	0	0	0	25-30
Emma Latimer	Chief Officer	1 April 2015 - 31 March 2016	115-120	78	0-5	0	27.5-30	155-160
Emma Sayner	Chief Finance Officer	1 April 2015 - 31 March 2016	90-95	24	0-5	0	15-17.5	110-115
Julia Mizon	Director of Commissioning and Partnerships	1 April 2015 - 1 July 2015	90-95	44	0	0	27.5-30	125-130
Sarah Smyth	Director of Quality and Clinical Governance	1 April 2015 - 31 March 2016	75-80	42	0	0	40-42.5	120-125
Erica Daley	Director of Integrated Commissioning	24 Nov 2015 - 31 March 2016	70-75	0	0	0	67.5-70	140-145
Angela Mason	Governing Body Nurse	1 April 2015 - 31 March 2016	5-10	0	0	0	0	5-10
Carole Robinson	Practice Manager	1 April 2015 - 31 March 2016	5-10	0	0	0	0	5-10

Pension Benefits of CCG Senior Managers 2015-16 (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 1 April 2015 £000's	Real increase in Cash Equivalent transfer value £000's	Cash Equivalent transfer value at 31 March 2016 £000's	Employer's contribution to stakeholder pension £
Dr Daniel Roper	Chair of Clinical Commissioning Group Governing Body	1 April 2015 - 31 March 2016	0-2.5	2.5-5	20-25	65-70	426	23	455	0
Dr Raghu Raghunath	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	0	0	0	0	0	0	0	0
Dr James Moult	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	2.5-5	10-12.5	15-20	55-60	227	53	283	0
Dr John Parker	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	0	0	0	0	0	0	0	0
Dr Lucy Chiddick	Clinical Commissioning Group Governing Body Member	31 July 2015 - 29 Jan 2016	10-12.5	32.5-35	10-15	35-40	27	135	163	0
Dr Vincent Rawcliffe	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	0-2.5	0-2.5	10-15	30-35	227	9	239	0
Dr Richard Grunewald	Secondary Care Doctor	1 April 2015 - 01 July 2015	0	0	0	0	0	0	0	0
Dr David Heseltine	Secondary Care Doctor	01 Sept 2015 - 31 March 2016	0	0	0	0	0	0	0	0
Dr Amy Oehring	Clinical Commissioning Group Governing Body Member	1 April 2015 - 31 March 2016	0-2.5	0-2.5	10-15	35-40	115	8	124	0
Paul Jackson	Lay Member / Vice Chair	1 April 2015 - 31 March 2016	0	0	0	0	0	0	0	0
Karen Marshall	Lay Member	1 April 2015 - 31 March 2016	0	0	0	0	0	0	0	0
Jason Stamp	Lay Member	1 April 2015 - 31 March 2016	0	0	0	0	0	0	0	0
Emma Latimer	Chief Officer	1 April 2015 - 31 March 2016	0-2.5	5-7.5	30-35	95-100	455	14	474	0
Emma Sayner	Chief Finance Officer	1 April 2015 - 31 March 2016	0-2.5	2.5-5	15-20	50-55	224	5	232	0
Julia Mizon	Director of Commissioning and Partnerships	1 April 2015 - 01 July 2015	0-2.5	5-7.5	35-40	105-110	590	38	635	0
Sarah Smyth	Director of Quality and Clinical Governance	1 April 2015 - 31 March 2016	0-2.5	5-7.5	15-20	50-55	206	20	228	0
Erica Daley	Director of Integrated Commissioning	24 Nov 2015 - 31 March 2016	2.5-5	10-12.5	25-30	85-90	432	123	560	0
Angela Mason	Governing Body Nurse	1 April 2015 - 31 March 2016	0	0	0	0	0	0	0	0
Carole Robinson	Practice Manager	1 April 2015 - 31 March 2016	0	0	0	0	0	0	0	0

Fair Pay disclosure
(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 2015-16 was £125-£130k (2014-15 - £120k-£125k). This was 3.4 times the median remuneration of the workforce (2014-15 – 3.3), which was £37.5K (2014-15 - £37.5k).

In 2015-16, three employees received remuneration which, when grossed up to a full time equivalent, is in excess of the highest-paid member of the Governing Body. All 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.

The whole time equivalent salaries paid to CCG staff in 2015/16 range from bands £15k - £20k to £185k - £190k. Please note that the highest values relate to part time clinical advisors whose salaries have been grossed to a full time equivalent value.

Please note that for the purposes of this calculation the GP members of the Board have been considered to be akin to the Non-Executives as described in the Hutton Fair Pay Review and as such their salaries have not been grossed up to a standard whole time equivalent.

Better payments practice code
(subject to audit)

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 2015-16 NHS Hull CCG paid 97.30% of non NHS trade invoices within target and 98.72% of NHS trade invoices within target. Further details are on page 27 of the Annual Accounts.

Our Staff
Promoting Equality

Hull CCG is committed to developing, supporting and sustaining a diverse workforce that is representative of the community it serves. Central to our function is commissioning health services that meets the needs of the local population, and does not discriminate on the grounds of gender, gender identity, race, ethnic origin, nationality, disability, sexual orientation, religion or age.

The CCG also takes an asset-based approach to equality and diversity, which means that we recognise the expertise in our diverse communities and we seek to work together with communities to improve access to and experience of local health services.

Social, community and human rights obligations

The CCG understands its duty to comply equality and human rights legislation, as well as NHS England mandatory standards. 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, 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
  - Fostering good relations between people who share a protected characteristic and people who do not
- The Human Rights Act 1998
- The Equality Delivery System (EDS2)
- The Workforce Race Equality Standard (WRES)
- The Accessible Information Standard

We publish an annual report showing how we meet these duties, which can be found in our equality and diversity section at **www.hullccg.nhs.uk**

We review our workforce data quarterly and submit Workforce Race Equality Standard reports annually (starting in 2015-16).

At the end of 31 March 2016 the following breakdowns for NHS Hull CCG in terms of gender of CCG Board, employees and Council of Members were as follows:

	Female	Male
CCG Board	9	10
CCG Employees	46	14
CCG Memberships (Council of Members)*	8	47

* Council of Members has 49 members in total, with some representing more than one practice.

We have made significant progress this year in implementing the Equality Delivery System (EDS) which has helped us to define our new equality objectives. Evidence was gathered from a range of sources, including public surveys and focus groups. Local interest groups were involved in grading and reviewing our equality objectives. Our EDS report can be found at **www.hullccg.nhs.uk**

Hull CCG's equality objectives

The CCG defined a set of draft objectives in January 2016, which were shared with staff and local interest groups for consultation. The initial set of objectives was refined as a result of their feedback. The CCG has set four equality objectives for the period April 2016 to March 2019:

1. Improve access to information and minimise communications barriers
2. Streamline and strengthen equality impact analysis across the commissioning cycle
3. Recruit and maintain a well-supported, skilled workforce, which is representative of the population we serve
4. Ensure the that NHS Hull Clinical Commissioning Group is a welcoming and accessible place for people from all backgrounds and with a range of access needs

Key achievements during 2015-16

- A Board development session was held focusing on equalities, which raised the profile of equalities and resulted in a shared recognition that championing equality is the responsibility of all Board members. The CCG's lay member for Lay Member for Patient and Public Involvement has been closely involved with the engagement on the Equality Delivery System, and has provided invaluable scrutiny and support on equalities.
- The implementation of the Equality Delivery System has raised the profile of equality throughout the organisation
- Staff and local interest engagement on the development of our equality objectives has led to refinement of the objectives and substantive suggestions for actions to meet those objectives
- The CCG is setting in motion an Equality Reference Group, which will include community representatives, and CCG staff. The aim of the Group will be to develop and challenge equality impact assessments and to ensure information is accessible to particular audiences that are currently experiencing barriers to accessing information. Engagement on the EDS has led to a number of people representing protected characteristics registering an interest to be involved in the Equality Reference.

The CCG has published its first Workforce Race Equality Standard (WRES) report and is working with local providers to ensure WRES is incorporated in a meaningful way (see **www.hullccg.nhs.uk**)

NHS England has published a new Information Standard for accessible information and communication: ISB 1605 Accessible Information (see **www.england.nhs.uk/ourwork/patients/**).

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 pages 20.

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 Yorkshire and Humber Commissioning Support. 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.

Policies regarding 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

Our 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 that 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 2015-16

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 and updated during the year in relation to health and safety, with a revised local induction process ensuring that CCG staff receive necessary information within their first week and complete all necessary health and safety training within 12 weeks of commencement. Overall compliance for statutory and mandatory Health & Safety Training at 31st March 2016 was 95.6%, against a target of 95%.

In late September 2015, the organisation started face-to-face Prevent training for all staff. As at 31st March 2016, 51% of staff had completed.

There were 4 minor Health & Safety incidents reported within the organisation in 2015/16. 2 related to facilities matters affecting Health & Safety, and 2 were minor injuries to staff, one due to a wasp sting and one due to a slip on a wet floor in a communal area controlled by the landlord. All incidents were thoroughly investigated and none met the external reporting threshold (RIDDOR). Lessons learned have been shared with staff in order to prevent re-occurrence. In conjunction with the Human Resources team, a wellbeing strategy has been developed for the organization.

Staff engagement

Our annual staff survey helps to identify priority areas to address within staff health and wellbeing strategy and Staff Health, Safety and Wellbeing action plan.

A staff engagement group meets regularly and is well attended, providing a more informal way of discussing issues and improving the day to day working environment – including the opportunity to influence the development of new working space for our expanded organisation. In response to a request for support and information on living a healthy lifestyle a walking group meets each week and there is a health newsletter for staff called An Apple a Day. A Stress Survey carried out in 2015 has led to the development of mindfulness and mental health awareness training for 2016-17.

Ensuring that we set a good example in creating a healthier city, during 2015-16 a number of CCG team members took part in long distance cycle rides, marathon runs and a bowling evening. The CCG participated in A New You 2015, a major health campaign in partnership with the Hull Daily Mail throughout 2015. 2016-17 will also see the development of a staff volunteering programme to encourage and support staff that wish to volunteer for programmes the CCG supports.

In addition to statutory and mandatory training CCG staff were offered CPR and defibrillator training, bite-sized first aid, Dementia Awareness, modern day slavery and counter terrorism training.

The focus of our staff AGM in April 2015 was on reflecting on the priorities of the organisation and reviewing the organisational objectives. Our recent CCG restructure benefitted from the input of staff across the organisation.

The CCG encourages all individuals to raise any concerns that they may have about the conduct of others in the CCG or the way in which it is run. The CCG has a Whistleblowers Policy to enable staff to raise concerns or suspicions about any issues of malpractice at an early stage and in the right way.

Additional staff data 2015-16

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** Data on sickness absence between 1 April 2015 and 31 March 2016, CCG staff numbers and costings is included on page 24 within Section three: Financial Statements.

During 2015-16 the CCG paid £109k in consultancy fees in relation to specialist technical programme management advice.

Emma Latimer
Chief Officer, NHS Hull Clinical Commissioning Group
April 2016

Part Three: Financial Statements 2015-16

Part three:
Financial Statements 2015-16

Foreword to the Accounts

NHS Hull Clinical Commissioning Group

These accounts for the year ended 31 March 2016 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 THE GOVERNING BODY OF NHS HULL CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Hull CCG for the year ended 31 March 2016 comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the NHS Commissioning Board 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 and Staff Report that is subject to audit.

This report is made solely to the Members of the Governing Body of NHS Hull CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body 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 Governing Body 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 and is also responsible for the regularity of expenditure and income. 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. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General under the Local Audit and Accountability Act 2014 ('the Code of Audit Practice').

As explained in the Annual Governance Statement the Accountable officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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 and accounts 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.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice 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 2016.

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

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 2016 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

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 other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

KPMG

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We have nothing to report in respect of the above responsibilities.

Certificate

We certify that we have completed the audit of the accounts of NHS Hull CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

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

Chartered Accountants
KPMG LLP
1 Sovereign Square
Sovereign Street
Leeds LS1 4DA

25 May 2016

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

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	2,676	2,360
Operating Expenses	5	379,094	368,532
Other operating revenue	2	(416)	(704)
Net operating expenditure before interest		**381,354**	**370,188**
Investment Revenue		0	0
Other (gains)/losses		0	0
Finance costs		0	0
Net operating expenditure for the financial year		**381,354**	**370,188**
Net (gain)/loss on transfers by absorption		0	0
Total Net Expenditure for the year		**381,354**	**370,188**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	2,493	2,186
Operating Expenses	5	3,778	4,857
Other operating revenue	2	(75)	(88)
Net administration costs before interest		**6,196**	**6,955**
Programme Income and Expenditure			
Employee benefits	4.1.1	183	174
Operating Expenses	5	375,316	363,675
Other operating revenue	2	(341)	(616)
Net programme expenditure before interest		**375,158**	**363,233**

Other Comprehensive Net Expenditure	2015-16 £000	2014-15 £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		
On disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year	**381,354**	**370,188**

The notes on pages 10 to 37 form part of this statement

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment		0	0
Intangible assets		0	0
Investment property		0	0
Trade and other receivables		0	0
Other financial assets		0	0
Total non-current assets		0	0
Current assets:			
Inventories		0	0
Trade and other receivables	8	2,139	2,190
Other financial assets		0	0
Other current assets		0	0
Cash and cash equivalents	9	2	4
Total current assets		2,141	2,194
Non-current assets held for sale		0	0
Total current assets		2,141	2,194
Total assets		2,141	2,194
Current liabilities			
Trade and other payables	10	(21,411)	(20,726)
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions	11	(8)	(8)
Total current liabilities		(21,419)	(20,734)
Non-Current Assets plus/less Net Current Assets/Liabilities		(19,278)	(18,540)
Non-current liabilities			
Trade and other payables		0	0
Other financial liabilities		0	0
Other liabilities		0	0
Borrowings		0	0
Provisions		0	0
Total non-current liabilities		0	0
Assets less Liabilities		(19,278)	(18,540)
Financed by Taxpayers' Equity			
General fund		(19,278)	(18,540)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		(19,278)	(18,540)

The notes on pages 10 to 37 form part of this statement

The financial statements on pages 6 to 9 were approved by the Governing Body on 23rd May 2016 and signed on its behalf by:

Emma Latimer
Chief Officer, NHS Hull Clinical Commissioning Group

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(18,540)	0	0	**(18,540)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(18,540)**	**0**	**0**	**(18,540)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(381,354)			(381,354)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(381,354)**	**0**	**0**	**(381,354)**
Net funding	380,616	0	0	380,616
Balance at 31 March 2016	**(19,278)**	**0**	**0**	**(19,278)**

	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 of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	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 costs for the financial year	(370,188)			(370,188)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(370,188)**	**0**	**0**	**(370,188)**
	369,828	0	0	369,828
Balance at 31 March 2015	**(18,540)**	**0**	**0**	**(18,540)**

The notes on pages 10 to 37 form part of this statement

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

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(381,354)	(370,188)
Depreciation and amortisation	5	0	0
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	8	51	(1,262)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	10	685	1,621
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	11	0	0
Increase/(decrease) in provisions	11	0	0
Net Cash Inflow (Outflow) from Operating Activities		**(380,618)**	(369,829)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(380,618)**	(369,829)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		380,616	369,828
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**380,616**	369,828
Net Increase (Decrease) in Cash & Cash Equivalents	9	**(2)**	(1)
Cash & Cash Equivalents at the Beginning of the Financial Year		**4**	5
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		**2**	4

The notes on pages 10 to 37 form part of this statement

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

1.5 **Charitable Funds**

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

1.6 **Pooled Budgets**

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

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

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

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

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

1.7 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

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

1.7.1 **Critical Judgements in Applying Accounting Policies**

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

- 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.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

Where a large asset, for example a building, includes a number of components with

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 valuation.

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

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

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

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

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

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

1.12.2 **Measurement**

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

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 **Depreciation, Amortisation & Impairments**

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

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets.

The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over their estimated useful lives.

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

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

1.14 **Donated Assets**

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

1.15 **Government Grants**

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

1.16 **Non-current Assets Held For Sale**

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

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

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

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

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

1.17 **Leases**

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

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.17.2 **The Clinical Commissioning Group as Lessor**

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

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

1.18 **Private Finance Initiative Transactions**

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

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

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

1.18.1 **Services Received**

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

1.18.2 **PFI Asset**

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

1.18.3 **PFI Liability**

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

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

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

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

1.18.4 **Lifecycle Replacement**

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

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

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

1.18.5 **Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme**
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

1.18.6 **Other Assets Contributed by the Clinical Commissioning Group to the Operator**
Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.
On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.
The balance is subsequently released to operating income over the life of the concession on a straight-line basis.
On initial recognition of the asset, an equivalent deferred income balance is recognised, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.
The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.19 **Inventories**

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

1.20 **Cash & Cash Equivalents**
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

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

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

1.24 **Continuing healthcare risk pooling**
In 2014-15 a risk pool scheme was 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 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.

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

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

1.32 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 **Subsidiaries**
Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.
Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 **Associates**
Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

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

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

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

1.38 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

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

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

2 Other Operating Revenue

	2015-16 Total	**2015-16 Admin**	**2015-16 Programme**	2014-15 Total
	£000	**£000**	**£000**	£000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research ***1**	10	0	10	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies ***2**	334	75	259	666
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue ***3**	72	0	72	38
Total other operating revenue	**416**	**75**	**341**	**704**

***1** One off Support for Older Peoples Pathway Project
***2** Admin - Less employees seconded in 2015/16 to previous year. Programme - Costs of prescribing recharges reduced (Some now paid for direct by provider)
***3** Increased support for Sexual Health campaign in 2015-16

3 Revenue

	2015-16 Total	**2015-16 Admin**	**2015-16 Programme**	2014-15 Total
	£000	**£000**	**£000**	£000
From rendering of services	416	75	341	704
From sale of goods	0	0	0	0
Total	**416**	**75**	**341**	**704**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	2015-16	Total			Admin			Programme	
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	2,223	2,076	147	2,073	1,926	147	150	150	0
Social security costs	188	188	0	174	174	0	14	14	0
Employer Contributions to NHS Pension scheme	265	265	0	246	246	0	19	19	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	**2,676**	**2,529**	**147**	**2,493**	**2,346**	**147**	**183**	**183**	**0**
Less recoveries in respect of employee benefits	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,676**	**2,529**	**147**	**2,493**	**2,346**	**147**	**183**	**183**	**0**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,676**	**2,529**	**147**	**2,493**	**2,346**	**147**	**183**	**183**	**0**

4.1.1 Employee benefits	2014-15	Total			Admin			Programme	
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	1,954	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
Total - Net admin 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**

4.2 Average number of people employed

	2015-16 Total Number	2015-16 Permanently employed Number	2015-16 Other Number	2014-15 Total Number
Total	**49**	**46**	**3**	43.21
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	739	911
Total Staff Years	69	40
Average working Days Lost	**10.7**	**22.7**

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	1	0
	£000	**£000**
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Pension costs

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

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

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

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

4.4.1 Full actuarial (funding) valuation

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

For 2015-16, employers' contributions of £265,288 were payable to the NHS Pensions Scheme (2014-15: £234,679) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.

5. Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	2,150	1,967	183	1,906
Executive governing body members	526	526	0	454
Total gross employee benefits	**2,676**	**2,493**	**183**	**2,360**
Other costs				
Services from other CCGs and NHS England	3,906	2,518	1,388	4,743
Services from foundation trusts	37,518	89	37,429	36,951
Services from other NHS trusts ***1**	185,318	0	185,318	186,902
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies ***2**	94,003	0	94,003	84,260
Chair and Non Executive Members	436	436	0	447
Supplies and services – clinical	735	0	735	760
Supplies and services – general	376	41	335	442
Consultancy services	109	0	109	0
Establishment	774	288	486	757
Transport	15	14	1	12
Premises ***3**	1,299	188	1,111	2,313
Impairments and reversals of receivables	0	0	0	5
Inventories written down	0	0	0	0
Depreciation	0	0	0	0
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	72	72	0	96
Other non statutory audit expenditure				
· Internal audit services ***4**	0	0	0	1
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	49,677	0	49,677	48,111
Pharmaceutical services	0	0	0	0
General ophthalmic services	46	0	46	41
GPMS/APMS and PCTMS	1,543	0	1,543	1,600
Other professional fees excl. audit ***5**	612	47	565	94
Grants to other public bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	119	0	119	190
Education and training	144	85	59	156
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
Funding to group bodies	0	0	0	0
CHC Risk Pool contributions ***6**	1,629	0	1,629	529
Other expenditure ***7**	763	0	763	122
Total other costs	**379,094**	**3,778**	**375,316**	**368,532**
Total operating expenses	**381,770**	**6,271**	**375,499**	**370,892**

***1** The decrease in costs relates to the full year effect retendering of MSK services to the independent sector.
***2** The increase in costs relates to the full year effect of Let's talk service, increased Spire costs and an increased proportion of estates charges now going through providers.
***3** The decrease in costs relates to an increased proportion of estates charges now going through providers.
***4** Internal audit fees are included in Services from Foundation Trusts
***5** The increased spend is on the 2020 programme and integrated care centre.
***6** This cost is nationally determined.
***7** See table below

Description of Other Expenditure	£000
Hull UK City of Culture 2017	450
Catzero LTD	75
OPPG Celebration Week / Fareshare	35
Lifestyle & Rock Challenge	18
Hull Medical, Health & Social Acadamy	128
Other	57
Total	**763**

6 Better Payment Practice Code

Measure of compliance	2015-16 Number	2015-16 £000	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	11,985	102,475	11,037	89,238
Total Non-NHS Trade Invoices paid within target	11,661	101,080	10,668	86,987
Percentage of Non-NHS Trade invoices paid within target	**97.30%**	**98.64%**	**96.66%**	**97.48%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,430	227,049	2,382	232,122
Total NHS Trade Invoices Paid within target	2,399	226,662	2,347	228,521
Percentage of NHS Trade Invoices paid within target	**98.72%**	**99.83%**	**98.53%**	**98.45%**

7. Operating Leases

7.1 As lessee

7.1.1 Payments recognised as an Expense

	2015-16				2014-15			
	Land £000	Buildings £000	Other £000	Total £000	Land £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense								
Minimum lease payments	0	1,280	10	**1,290**	0	2,290	23	**2,313**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**1,280**	**10**	**1,290**	**0**	**2,290**	**23**	**2,313**

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 all buildings.

7.1.2 Future minimum lease payments

	2015-16				2014-15			
	Land £000	Buildings £000	Other £000	Total £000	Land £000	Buildings £000	Other £000	Total £000
Payable:								
No later than one year	0	173	16	**189**	0	0	20	**20**
Between one and five years	0	692	30	**722**	0	0	28	**28**
After five years	0	346	0	**346**	0	0	0	**0**
Total	**0**	**1,211**	**46**	**1,257**	**0**	**0**	**48**	**48**

8 Trade and other receivables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	177	0	376	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	1,326	0	1,404	0
NHS accrued income	34	0	0	0
Non-NHS receivables: Revenue	343	0	239	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	124	0	88	0
Non-NHS accrued income	18	0	0	0
Provision for the impairment of receivables	0	0	0	0
VAT	117	0	81	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	2	0
Total Trade & other receivables	**2,139**	**0**	**2,190**	**0**
Total current and non current	**2,139**		**2,190**	
Included above:				
Prepaid pensions contributions	0		0	

8.1 Receivables past their due date but not impaired	**2015-16 £000**	2014-15 £000
By up to three months	60	32
By three to six months	0	0
By more than six months	22	0
Total	**82**	**32**

NHS Hull CCG did not hold any collateral against receivables outstanding at 31 March 2016.

9 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	4	5
Net change in year	(2)	(1)
Balance at 31-March-2016	**2**	**4**
Made up of:		
Cash with the Government Banking Service	2	4
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**2**	**4**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31-March-2016	**2**	**4**
Patients' money held by the clinical commissioning group, not included above	0	0

10 Trade and other payables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000
Interest payable	0	0	0
NHS payables: revenue	1,117	0	1,204
NHS payables: capital	0	0	0
NHS accruals	1,490	0	1,540
NHS deferred income	0	0	0
Non-NHS payables: revenue	3,477	0	3,822
Non-NHS payables: capital	0	0	0
Non-NHS accruals ***1**	15,190	0	14,065
Non-NHS deferred income	0	0	0
Social security costs	39	0	27
VAT	0	0	0
Tax	43	0	29
Payments received on account	0	0	0
Other payables ***2**	55	0	39
Total Trade & Other Payables	**21,411**	**0**	**20,726**
Total current and non-current	**21,411**		**20,726**

***1** The increase in accruals relates to Healthier Hull Community Fund, City of Culture 2017, charges from the local authority an costs associated with the reallignment of community provision.
***2** Other payables include £55k outstanding pension contributions at 31 March 2016

11 Provisions

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	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**	

	Pensions Relating to Former Directors £000s	**Pensions Relating to Other Staff £000s**	**Restructuring £000s**	**Redundancy £000s**	**Agenda for Change £000s**	**Equal Pay £000s**	**Legal Claims £000s**	**Continuing Care £000s**	**Other £000s**	**Total £000s**
Balance at 01-April-2015	**0**	**0**	**0**	**0**	**0**	**0**	**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-2016	**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-2016	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**0**	**0**	**8**

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them.
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 2016 is £838k (2014/15 - £2,084k).

12 Contingencies

	2015-16 £000	2014-15 £000
Contingent liabilities		
Equal Pay	0	0
NHS Litigation Authority Legal Claims	0	0
Employment Tribunal	0	0
NHSLA employee liability claim	2	2
Redundancy	0	0
Continuing Healthcare	0	0
Amounts recoverable against contingent liabilities	0	0
Net value of contingent liabilities	**2**	**2**

13 Financial instruments

13.1 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 Hull 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 Hull Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Hull Clinical Commissioning Group and internal auditors.

13.1.1 Currency risk

The NHS Hull 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 Hull Clinical Commissioning Group has no overseas operations. The NHS Hull Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

13.1.2 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.

13.1.3 Credit risk

Because the majority of the NHS Hull Clinical Commissioning Group and revenue comes parliamentary funding, NHS Hull 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.

13.1.3 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 Hull Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Hull Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

13 Financial instruments cont'd

13.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	**Loans and Receivables 2015-16 £000**	**Available for Sale 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	211	0	211
· Non-NHS	0	360	0	360
Cash at bank and in hand	0	2	0	2
Other financial assets	0	0	0	0
Total at 31-March-2016	**0**	**573**	**0**	**573**

	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-2016	**0**	**621**	**0**	**621**

13.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	**Other 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,607	2,607
· Non-NHS	0	18,723	18,723
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2016	**0**	**21,330**	**21,330**

	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
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2016	**0**	**20,670**	**20,670**

14 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	381,770	(416)	**381,354**	2,141	(21,419)	**(19,278)**
Total	**381,770**	**(416)**	**381,354**	**2,141**	**(21,419)**	**(19,278)**

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 £171.9m.

15 Pooled budgets

The NHS Hull Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the 2015/16 financial year are detailed in the table below (there were no pooled budget arrangements during 2014/15):

	Hull CCG 2015-16 £'000	KUHCC 2015-16 £'000	Section 75 Payment 2015-16 £'000	Total 2015-16 £'000	Total 2014-15 £'000
Income	(26,427)	(13,479)	8,749	(31,157)	0
Expenditure	26,427	13,479	(8,749)	31,157	0
Surplus	0	0	0	0	0

The Better Care Fund is a government plan to integrate health and social care across the country by 2020.

Locally, Hull Clinical Commissioning Group have implemented the Better Care Fund via a Section 75 Pooled Budget agreement with Hull City Council. The actual contractual arrangements did not result in joint control being established, therefore under '*IAS 18 Revenue Recognition'* the CCG has accounted for its transactions on a gross accounting basis.

The Section 75 agreement allocated budgets across schemes called Community Hubs, Primary Care / Self Care, Falls, Reablement and Rehabilitation, Ambulatory Care, Home Care and Residential Care, Longterm Conditions and Mental Health / Learning Disability. The performance of each of these schemes has been monitored throughout the year by a joint BCF Steering Group and reported to the Health and Wellbeing Board.

16 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 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 The Newcastle Upon Tyne Hospitals 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 :

Hull City Council
East Riding Council
HM Revenue and Customs
National Insurance Fund

16 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.

Details of related party transactions with individuals are as follows:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Emma Latimer - Chief Officer				
CityCare Board Director – non remunerated.	46	0	0	0
Trustee of Emmaus – non remunerated.	13	0	0	0
Dr Dan Roper - Chair of the Clinical Commissioning Group				
Partner in Springhead Medical Centre	36	0	0	0
Dr Amy Oehring - GP Member of the Clinical Commissioning Group				
GP Partner of Sutton Manor Surgery	18	0	0	0
Dr James Moult - GP Member of the Clinical Commissioning Group				
GP Partner at Faith House Surgery	16	0	0	0
Dr Ragh Raghunath - GP Member of the Clinical Commissioning Group				
GP Partner at St Andrews Group Practice which has 6 practices across Hull	50	0	0	0
A Partner at St Andrews Bransholme	7	0	0	0
A Partner at St Andrews Newington	6	0	0	0
A Partner at St Andrews Northpoint	4	0	0	0
A partner at Raghunath & Partners	3	0	0	0
Dr Vince Rawcliffe - GP Member of the Clinical Commissioning Group				
GP Partner at Newhall Surgery. – Pecuniary Interest	23	0	0	0
Carol Robinson - GP Member of the Clinical Commissioning Group				
General Interest as a Practice Manager in a GP Practice. - Newland Group Practice	58	0	0	0
Jason Stamp - Lay Member of the Clinical Commissioning Group				
Chief Officer of North Bank Forum, a voluntary sector infrastructure organisation currently commissioned to support the building health partnerships and social prescribing. – Remunerated.	24	0	0	0
Danny Storr - Head Of Finance				
Cousin is a Director of Eskimo Soup that provides services to the CCG.	134	0	0	0

17 Events after the end of the reporting period

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

18 Losses and special payments

18.1 Losses

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

	Total Number of Cases 2015-16 Number	**Total Value of Cases 2015-16 £'000**	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Administrative write-offs	0	0	1	5
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	**0**	**0**	**1**	**5**

18.2 Special payments

	Total Number of Cases 2015-16 Number	**Total Value of Cases 2015-16 £'000**	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	0	0	2	2
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**0**	**0**	**2**	**2**

19 Financial performance targets

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

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

	2015-16 Target	**2015-16 Performance**	2014-15 Target	2014-15 Performance
Expenditure not to exceed income	389,590	381,770	380,788	370,892
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	389,174	381,354	380,084	370,188
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	6,516	6,196	7,521	6,963

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Jeśli potrzebują Państwo wyjaśnienia tych informacji w języku polskim, proszę zaznaczyć właściwą kratkę i odesłać formularz na adres:

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Kama ungependa kupata habari hii kwa lugha yako, tafadhali tia alama katika kisanduku kinachofaa, na utume kwa:

Mandarin ☐

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Farsi

اگر مایل هستید این اطلاعات به زبان خودتان برای شما شرح داده شود، لطفاً در مربع مربوطه علامت زده و به اینجا بفرستید:

Kurdish ☐

ئەگەر دەخوازیت ئەم زانیارییەت بە زمانی خۆت بۆ بۆ ڕوونبکرێتەوە، ئەوا تکایە نیشانە لە خانەی گونجاو بدە و بیگەڕێنەرەوە بۆ:

Arabic ☐

لك لثتغلب، ءاجرلاف يرشأتلا في عبرملا بسانملا مث هلاسرإ لإ اذإ تنك بغرت في جيضوت هذه ةمولعملا

نانوعلا هاندأ:

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