NHS
North Durham
Clinical Commissioning Group

# Annual report and accounts

## 2014/15

Better health for the people of North Durham

# Contents

# Council of Members' introduction

NHS North Durham Clinical Commissioning Group (CCG) is a group of 31 GP member practices who came together in April 2013. We have established ourselves as a commissioning organisation, responsible for planning and buying a wide range of health care services across the North Durham area. This year we have consolidated on the successes of our first year and have also faced a number of challenges.

We have worked with our member practices to ensure that decisions about local health care services are clinically led, as GPs understand how best to improve local health services and make a difference for our whole community.

The CCG faces many health challenges including increased levels of heart disease, stroke, cancer and dementia. Along with the rest of the UK, we also have a growing elderly population with multiple long-term conditions and a growing reliance upon health services in a time of constrained finances and rising costs. We have put plans in place to address these challenges and are making improvements in our services that will benefit our patients and communities now and in the future.

As doctors and health professionals we see patients and providers of health services every day. We now have a great opportunity to use the knowledge gained from these relationships to make changes that will improve the health and experiences of local people.

We work closely with hospitals and other health care providers, Durham County Council, the Health and Wellbeing Board (a joint group that plans how health and social care services will work together better) and the newly established Healthwatch County Durham. We are also committed to working with our patients, those who live in the area and with voluntary organisations to ensure that as many people as possible are involved in decisions made about local health services.

In this document we have outlined our successes and highlights from 2014/15 as well as setting out our longer term ambitions to improve health care in our area.

**David Smart**
**Chair**
**On behalf of the Council of Members**

# Strategic report

The purpose of this strategic report is to both help inform and assess how NHS North Durham Clinical Commissioning Group (CCG) has performed over the last year.

## About us

NHS North Durham CCG is a membership organisation made up of 31 GP practices, serving a population of around 250,000 local people across Chester-le-Street, Derwentside and Durham. We have a total annual budget of over £330 million which we receive from NHS England.

The CCG was established on 1 April 2013 by the *Health and Social Care Act 2012*, which resulted in the abolition of primary care trusts (PCTs) and the transfer of a range of commissioning responsibilities to CCGs.

We are responsible for planning and buying NHS services for people in North Durham. These include health services that are delivered in a non-emergency way such as:

- planned operations,
- rehabilitation and short-term services to support people in regaining their health,
- community services such as district nursing,
- services for people who have mental health issues,
- services specifically for people with learning disabilities.

We also arrange emergency and urgent care services for the people in North Durham, including any unregistered patients who live locally.

During 2014/15 we were not responsible for the provision of general primary care services, including GP services, pharmacists, dentists and opticians. From 1 April 2015 NHS England has delegated responsibility for certain GP services to the CCG, although the provision of other primary care services, such as dentists and opticians, remains the responsibility of NHS England.

CCGs are organisations led by doctors and nurses that bring together a range of health care professionals and managers who have a leading role in making sure that local people receive the services they need. CCGs should:

- understand the health needs of the population,
- agree plans and priorities to improve the health status,

- develop and design services for patients,
- purchase the best providers of health care local to population needs,
- robustly manage provider contracts against agreed standards of care.

## Our area

Our 31 member general practices are organised into three constituency areas – Chester-le-Street, Derwentside and Durham. Derwentside comprises a mixture of urban, semi-urban and rural areas with the population concentrated in Stanley and Consett. Durham and Chester-le-Street cover a mixture of rural and urban areas with two main population centres, Durham City and Chester-le-Street. The University of Durham is home to a large and internationally diverse student population. There are significant variations in health across these three areas.

The CCG is coterminous with Durham County Council and about 97% of our population live within the council boundaries. The remainder live in Gateshead and Sunderland.

## Our health challenges

People who live in the North Durham area have significant health challenges and problems. They are also more likely to die sooner than those living in other parts of the country. The main causes of early death include high levels of cancer and diseases of the heart or blood vessels.

With an ageing population, we also experience greater demand for hospital services and an increase in illnesses related to older people such as stroke, long-term conditions and dementia. The large student population in Durham City results in a demand for sexual health, alcohol and harm reduction services.

Other key challenges facing North Durham include:

- poor lifestyle issues such as smoking, alcohol and obesity,
- economic inequality related to unemployment and low incomes,
- people with disabilities have worse health than those without,
- children's health and lifestyles are poorer than elsewhere in the country,
- environmental factors such as changes in weather, and lots of cars and traffic in some areas,
- social isolation.

The CCG is committed to ensuring that people get the same quality and access to health services, wherever they live. We aim to ensure that health services meet the needs of patients, the health of the community is improved, health inequalities are reduced and that the CCG obtains value for money and efficiency from available resources.

Our strategic aims are to:

- improve the health status of the population,
- address the needs of the changing age profile of the population,
- commission clinically effective better quality services closer to home,
- make best use of public funds to ensure health care meets the needs of patients and is safe and effective.

# Our approach

## How we are delivering our commissioning programmes and initiatives

The CCG has focused on getting a better understanding of our use of secondary care services, prescribing practice and use of continuing health care in order to allow us to manage demand more effectively. We have aimed to take stock of the full range of services we commission to identify gaps in quality that might exist and work with our current providers to ensure a more holistic service is provided in the most appropriate setting for our patients. This has enabled us to invest resource to improve the health outcomes and reduce the health inequalities of our population for the future. By focusing on the seven programme areas outlined below, we believe we can make the greatest improvements to meet our health challenges:

- unplanned emergency care,
- frail elderly,
- end of life care,
- transforming primary care,
- mental health,
- learning disabilities,
- diabetes.

For each of the commissioning programme areas we have set out clear plans and goals by which we can measure our success. Outlined in this strategic report are a number of initiatives within each commissioning work programme which support the delivery of each of our commissioning intentions.

Some examples of other commissioning projects undertaken in 2014/15 have also been included.

The CCG is supported by the North of England Commissioning Support (NECS) in commissioning services.

## How we are commissioning safe and effective care

As outlined above, our strategic aims include:

- commissioning clinically effective better quality services closer to home,
- making the best use of public funds to ensure health care meets the needs of patients and is safe and effective.

Outlined in this report are some of the initiatives as listed below:

- securing quality in health services (SeQiHS),
- clinical quality assurance framework,
- safeguarding,
- medicines optimisation,
- electronic prescribing service,
- promoting health.

These initiatives contribute to the delivery of safe and effective care and the commissioning of better quality services.

## The Better Care Fund (BCF)

The CCG has worked in collaboration with Durham County Council and Durham Dales, Easington and Sedgefield CCG to develop a Better Care Fund (BCF) plan for 2015/16 to 2016/17. The plan has been agreed by the County Durham Health and Wellbeing Board. The total budget allocated to the BCF for County Durham is £43.735 million in 2015/16. Further detail is contained in this report.

## Engaging with our patients and the public

In developing our priorities we have worked closely with GP practices and have engaged with patients and other local organisations who provide services as well as voluntary organisations. The CCG continues to develop our relationships with partners, providers and our communities as we deliver this strategic plan. We will ensure that we

have a range of ways in which we communicate and engage with our patients and population. The CCG uses what we know about our communities to engage with different people and groups in ways that best meet their needs, and in order to improve the health of our population we communicate messages which give clear directions to the choice of services available and which are easy to access. Outlined in this report is further detail of the ways in which we deliver this.

### Working in partnership

The CCG is committed to working with a range of local partners and organisations so that we can develop the best health care services for local people. Detail of how we do this is outlined in this report.

### Performance

This report contains information about the CCG's performance against the requirements under the NHS Constitution and the health outcome measures against which the CCG is assessed under the Assurance Framework developed by NHS England. It includes information about plans that have been put in place to address those areas where performance has been below expectations.

### Financial review

Also included in this report is a financial overview with regard to the CCG. As referred to above, a strategic aim of the CCG is to make the best use of public funds to ensure health care meets the needs of patients and is safe and effective. The financial review section includes information about the systems and processes in place to achieve this.

## Commissioning programme areas

### Unplanned emergency care

Strategic Resilience Group

There is currently a national focus on urgent and emergency care services across England. In response to this, the County Durham and Darlington System Resilience Group (which the CCG is a member of) has been established. The System Resilience Group (SRG) is a forum of partners from across the health and social care system who come together to undertake the regular planning of service delivery. The SRG maintains an oversight of the health and social care system and enables the integration of effective high quality accessible services. In 2014/15 the SRG has:

- developed and signed off operational resilience and capacity plans by involving all key local organisations, in order to fulfil both planning requirements and to ensure a good system working in the future,
- developed an over-arching Urgent Care Strategy specifically focusing on the standards in *Everyone Counts 2015/16 to 2019/20*. The strategy sets out a joint vision and patient centred principles, together with solutions to achieving them.

Gateshead Queen Elizabeth Hospital Emergency Care Unit

The CCG has looked at system pressures at our local hospital, the University Hospital North Durham (UHND), which are related to an increase in the number of ambulances waiting 30 minutes or more to handover patients to the Accident and Emergency department. There are also times when patients who require an unplanned admission are transferred to Darlington Memorial Hospital (DMH) from North Durham particularly when the system is busy and under pressure.

The CCG has commissioned additional non-elective hospital bed capacity from the new state of the art emergency care centre that has been developed by Gateshead Health NHS Foundation Trust on the Queen Elizabeth hospital site. The additional capacity is a pre-planned arrangement to provide additional resource in the system for North Durham patients, particularly those who are closer or of equal distance to the UHND site.

In collaboration and agreement with Gateshead Health NHS Foundation Trust, County Durham and Darlington NHS Foundation Trust (CDDFT) and the North East Ambulance Service NHS Foundation Trust (NEAS), we have implemented a local divert policy to enable a planned and timely response to system pressure and times of increased demand. The aim is to reduce the number of ambulance handovers at 30 minutes or above and transfers of care from UHND, for North Durham patients, to DMH.

Review of urgent care services

A public engagement report to inform the CCG's model of urgent care was published in July 2014 to develop a greater focus on provision of urgent care support within primary care settings. An outline urgent care strategy was developed following initial consultation with GP practices and clinicians. The aim was to enhance the provision of primary care services for patients who need to be seen urgently, and to develop effective communication and social marketing to ensure that patients understand how to access appropriate services.

To do this, we established an urgent care project team, led by the GP lead for urgent care and representatives from a cross-section of partner organisations. Early engagement took place within the urgent care centre at Shotley Bridge Hospital. The aim of this early engagement was to enhance current understanding of why patients use urgent care services in North Durham.

A programme of further service user and stakeholder engagement in relation to urgent care services was also completed. This included the provision of more primary care based urgent care support within GP practices. This has ensured that patients, members of the public, key stakeholders and other partners have been given the opportunity to give their views on proposed changes and to influence the decision-making process.

The CCG is currently working on the contractual aspects of changing Shotley Bridge Hospital Urgent Care Centre to an in-hours (8.00 am – 6.00 pm) minor injuries unit.

NHS '111' remote appointment booking

The remote booking function was offered to North Durham CCG in June 2014; following a successful test period at Linthorpe practice in Middlesbrough. The function is of great benefit to patients and NHS 111 call handlers. If, as a result of contacting NHS 111 the patient receives a disposition to 'see own GP', call handlers are able to book the patient direct into the practice appointment ledger, taking away the requirement for the patient or call handler to contact the practice to arrange an appointment. At the practice's discretion, this could be for a telephone consultation with a GP or Nurse Practitioner for a face-to-face appointment.

During July 2014, practices from North Durham CCG were invited to test out the remote booking function with support from North of England Commissioning Support Unit Service Planning and Reform Team (NECS SPR). A total of six North Durham practices expressed an interest to participate.

The 'interoperability guide' was shared with all participating practices to configure their system.

In January 2015 a teleconference took place between all parties involved; NHS 111, Cleric and TPP and a successful test took place with Consett Medical Centre.

Following the successful test the 'interoperability guide' was updated and all practices who expressed an interest were contacted by the NECS SPR team to participate during February 2015.

NHS 111 have secured funding from NHS England to take this project forward and include other clinical systems such as EMIS. A relationship manager has been recruited and plans are in place for NECS SPR team to hand over the project during March/April 2015. NHS 111 will discuss the plan to move forward with CCGs and the support required for practice participation.

## Frail elderly

Dementia diagnosis rates

Dementia diagnosis performance levels in North Durham were reported by NHS England to be lower than the national target of 67.0% in 2014. A number of initiatives were outlined to practices, which included a dementia quality toolkit, a NECS call centre to support practices to download SUS data to update their dementia quality outcomes framework register, or take action to determine the needs and/or diagnosis of the individual patient, all helped increase the diagnosis rates of dementia in North Durham.

We appointed a dementia clinical nurse lead in January 2015 to support the on-going work on the dementia agenda.

With the continued support from GP practices in North Durham, the dementia diagnosis rate has improved significantly from 58.1% (August 2014) to 67.4% (March 2015).

The next year (2015/2016) will be equally important in maintaining North Durham CCG's dementia diagnosis rates, but more so, our focus moves towards post-diagnosis support.

Frail elderly services

A model of care and outcomes for frail elderly services has been developed and agreed by partners to develop a new pathway across primary care, care homes and secondary care services. The model has an element of patient identification, assessment and case management in primary care, while existing and new community matrons will be aligned to care homes and practices in order to better care for older patients.

A service specification has been developed for primary care and is currently undergoing consultation with general practices and partners. Work continues in primary care to align care homes and surgeries, with Chester-le-Street constituency already having undertaken this task. Durham constituency began the same process in January 2015.

In secondary care, a rapid improvement workshop has taken place with secondary care, community care and primary care clinicians and managers to agree a pathway and to integrate existing elderly care services to offer a range of rapid access clinics across North Durham's acute and community hospital sites.

The pathway for primary care, secondary care and care homes will be implemented by October 2015.

Home equipment loans service

A collaboration agreement between North Durham CCG, Darlington CCG, Durham Dales, Easington and Sedgefield CCG and Durham County Council and Darlington

Borough Council was signed-off and a new service designed and procured in late 2014. A new provider will be mobilised in July 2015.

Work with health and social care professionals is underway to review the current Home Equipment Loan Service (HELS) catalogue, with a list of 'stock' items developed and disseminated to health and social care requisitioners for comment. Work on reviewing existing HELS care home policies, for County Durham and Darlington, to bring the two policies in line with each other has begun and will be completed before the new service start date.

Intermediate care plus (IC+)

Working together with Durham Dales, Easington and Sedgefield CCG, Durham County Council, County Durham and Darlington NHS Foundation Trust, and Tees, Esk and Wear Valleys NHS Foundation Trust, the CCG offers a service that provides intermediate health and social care from a single access point 24 hours a day, seven days a week. It brings together a range of existing provider organisations into a single, integrated 'hub', ensuring a more joined-up approach to care. The benefits of the service include improved support for vulnerable patients and easy access to support services both during the day and out-of-hours. It also supports more timely hospital discharges and helps to avoid the need for admission/re-admission to hospital.

In January 2015, the IC+ single point of access (SPA) was re-launched to offer a wider service to referrers with a new phone number. It is intended that the SPA will take more comprehensive referrals so that follow-up calls can be avoided where possible and to give detailed information to referrers on the services available. This will include those that do not require a multi-disciplinary team (MDT) referral. The SPA signposts referrers to additional services where appropriate although at all times the referrer will remain in charge of making the decision on the appropriate course of action for their patient. The SPA will be working more closely with Social Care Direct and MDT colleagues and will be co-located with them to improve communication and joint working.

Wheelchair review

A review of the current wheelchair service was undertaken in 2014. This review is ongoing and will provide information on the current service provision. This information will enable the CCG to reach a decision on whether to re-procure this service or look at other options to improve the quality of the existing service.

## End of life care

Palliative care

This year, the CCG has committed to invest in palliative and end of life care; securing recurring funding to increase the number of palliative care specialists to support practitioners across primary, secondary and community care. It has also invested in the

provision of specialist lymphoedema services. The positive impact of these investments will mean more patients will be able to have increased specialist support in their preferred place of care and lived experience until they die.

The strategic palliative and end of life care group for County Durham and Darlington continues to meet, progressing the knowledge and confidence of staff, ensuring that our member practices are clear about those patients that would benefit from palliative care support and ensuring that our care home staff are also equipped and supported to give good care.

## Transforming primary care

Improving access

Weekend appointments have continued during 2014 to April 2015 allowing patients access to their GP practice. Patients have been able to access a choice of pre-bookable appointments for routine issues or urgent appointments booked on the day via NHS 111 or Accident and Emergency. GP practices continue to work together to provide cross-cover arrangements. This means if there are no appointments available at the patient's own practice an appointment will be offered at a neighbouring practice. It has been successful in widening access for patients whilst providing better quality and continuity of care as it offers flexibility for those working through the week and care closer to home.

The current scheme is being evaluated and reviewed as part of our ongoing planning process.

Clinical support information (CSI)

The expected outcomes of this project were, by the end of March 2015, to have an easily accessible electronic toolkit available to support referrers to determine the most appropriate pathway of care for patients for a range of conditions within certain clinical areas, and it is also hoped to see a reduction in GP practice initiated referrals to secondary care.

The core working group, including a clinical lead, have met regularly since September 2014 to progress this project. This project is being led by North Durham CCG and is being rolled out across all three CCGs in County Durham and Darlington. There have been some excellent sessions with primary care GPs from all three CCGs and secondary care consultants from County Durham and Darlington Foundation Trust.

The original aim was to have clinical guidelines for five clinical areas, (cardiology, ear nose and throat, gynaecology, orthopaedics and dermatology) agreed between primary and secondary care clinicians from County Durham and Darlington NHS Foundation Trust by the end of March 2015. This was subsequently expanded to nine areas to cover the requirements and expectations of all three CCGs. The additional areas were

Musculoskeletal (MSK), rheumatology, gastroenterology and cancer.

All three CCGs in County Durham and Darlington have given their support for the project to continue into 2015/16. Further clinical areas to be included in the toolkit will be identified and reviewed in 2015/16.

Primary care outcomes schemes

Each practice within the CCG was allocated £10 per head of registered population to be used to implement innovative ideas to improve outcomes in primary care. The scheme is for two years, giving investment of £2.5 million each year into primary care.

Practices have used their funding in a variety of ways to address issues specific to them. Schemes include;

- the appointment of additional nursing staff to support housebound and nursing home patients,
- providing additional GP appointments during extended hours,
- the appointment of in- house pharmacists to review medication including face-to-face appointments with patients,
- increasing the uptake for screening programmes.

The feedback from practices and patients has been positive. Following evaluation at the end of the two years, schemes which have been successful will be considered for rollout across the CCG.

Primary care strategy

The CCG has developed a primary care strategy which outlines the vision and direction of travel over the next five years within local primary care to meet the challenges currently faced. Some of the issues which are explored as part of the strategy include access to general practice, information and technology, workforce, premises and working together across practices. This strategy will be implemented over the next five years.

One of the key elements within the strategy outlines the need for practices to work together to provide services closer to home which may have been traditionally provided in hospital. The CCG is committed to supporting practices in coming together as super organisations or federations to support the delivery of the CCG's key priorities over the coming years. Currently within North Durham there are three federations emerging which cover the three geographical localities – Chester-le-Street, Derwentside and Durham.

The 'Five Year Forward View' which was published in October 2014 by NHS England outlined the desire to extend the current role of CCGs to include the commissioning of

primary care. North Durham CCG was successful in applying to take on the delegated responsibility for commissioning primary care services and this came into effect on 1 April 2015.

## Mental health

Children and adolescent mental health services (CAMHS)

Work has been undertaken to collate intelligence on the current state of mental health services for children and adolescents, as well as desk-top mapping of current services and availability of service specifications, funding and contract arrangements.

A draft strategy was developed and presented to the Mental Health Partnership Board for comment in August 2014 and was endorsed by Health and Wellbeing Board in November 2014. Currently an action plan is being developed to sit alongside the strategy document to support the delivery of the key services outlined in the strategy.

Crisis care concordat

A draft Mental Health Crisis Care Concordat (MHCCC) Declaration and draft MHCCC Action Plan was shared with partners at the County Durham 'Big Tent' consultation event. The declaration has been approved by the Health and Wellbeing Boards and members of the Concordat project group, as well as published on the National Crisis Care Concordat website portal.

Draft collective MHCCC Action Plan has been revised and approved by all key partner organisations in February/March 2015.

Parity of esteem

The CCG is committed to the delivery of Parity of Esteem and has developed a financial framework whereby mental health commissioning budgets benefit from growth which is in line with the CCG allocated growth figure as a minimum position. Any efficiencies generated through mental health services remain within the ring-fence budget for investment in mental health services. The 2015/16 budgets and financial plan approved by Governing Body in March 2015 demonstrated a commitment to continued increased investment in mental health and learning disabilities services, in line with the Parity of Esteem focus.

Additionally, other funding resources which are available to CCGs, for example system resilience funding is allocated to mental health schemes using the same principles. There are also a range of commissioned mental health liaison services working in acute hospitals, community services and care homes to ensure that people with concurrent mental health problems are able to access services appropriately. Further to this commitment, the CCG is developing a process whereby all commissioning intentions are considered for mental health impact and accessibility.

Improving access to psychological therapies (IAPT)

Working in collaboration with Durham Dales, Easington and Sedgefield CCG, and Darlington CCG we have taken steps to improve the quality of our talking therapy services, including IAPT, counselling and psychological therapies. This work has focused on improving access for patients and addressing some of the individual service issues. The CCG ran a focus group in July 2014 to capture the views of our patients on their experience of talking therapy services. This information has been used to inform the improvements we are currently making to these services.

'No Health without Mental Health'

The 'No Health without Mental Health' plan has been developed and shared with partners. The Mental Health Partnership Board provides the oversight of the work of 'No Health without Mental Health' plan, while an implementation group has been established to oversee delivery. The plan has been presented and agreed by the County Durham Health and Wellbeing Board.

Suicide community response

In recognition of the need to reduce rates of suicide the CCG has established a process of 'suicide cluster and increasing trend community response'. This has been done in partnership with the Public Health team of Durham County Council Public Health and Durham Dales, Easington and Sedgefield CCG. This process involves early identification of suicide increasing trends and clusters, and then the establishment of regular meetings of stakeholders to agree actions to minimise risk of further suicides. Two community response processes have been managed throughout the year, one involving children and young people throughout the County and the other involving a local community in North Durham. Actions have included,

- setting up a process for GPs to send letters to bereaved families,
- designing leaflets and posters signposting helplines (Papyrus and Samaritans) and funding the extension of Papyrus helpline to cover weekends,
- cascading these electronically to local services (targeted where possible at those aged under 35),
- advertising via social media as part of the wider communications strategy,
- liaising with local schools, Area Action Partnerships, the police and the probation service,
- developing a training strategy aimed at staff working with 'looked after children' and community support services.

## Learning disabilities

Transforming care

Following the Winterbourne View Concordat. North Durham CCG sought assurance on the delivery of our statutory responsibilities for care programme approach reviews for learning disability patients. Following the recruitment of additional capacity the percentage of care programme approach reviews with CCG input has increased significantly. In addition to this, the appropriateness of placements has been reviewed (outside of the care and treatment reviews) resulting in planned discharge into a community setting.

The Northern CCG Forum (which is a collaboration of all the CCGs in the North East and Cumbria) has identified learning disabilities as a priority for transformation with a focus on achieving the national requirement to reduce inpatient beds. The initial scoping work has been carried out and will be presented back to CCGs at a visioning event to be held on 28 April 2015. The event will see individual locality groups working together to agree the standards of practice set out by the transformation team and will develop plans to deliver these 'on the ground' changes.

Improving health for people with learning disabilities

The uptake of annual health checks (AHCs) for people with learning disabilities has been identified as an issue for many years, and the introduction of a NHS England Directed Enhanced Service (DES) was helped to improve this. Nationally, and for North Durham CCG, this still remains an area of underperformance.

During 2014/15 the CCG worked closely with the Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) health facilitation team (HFT) to offer training to GP practices around offering reasonable adjustments for patients with learning disabilities to improve the uptake of AHCs and validating learning disabilities registers to improve data quality and reporting. As a result of this work, 27 out of 31 practices have had their learning disabilities register validated in the last 12 months and 12 of these also accessed additional training from the HFT.

Going forward, we will be working with practices and to implement a Did Not Attend (DNA) pathway for learning disabilities health checks to enable the HFT to follow up patients and assess individual requirements for reasonable adjustments and continue to work with service providers to highlight the importance of learning disabilities health checks on improving health for people with learning disabilities. We will also be looking to develop local reporting arrangements around exclusions for patient choice.

## Diabetes

Integrated model of care for diabetes

2014/15 saw a review of existing diabetes services across County Durham and Darlington CCGs, including an evaluation of the Tier 2 service in North Durham CCG. This information has been used to develop consensus on why we need to change the way we deliver diabetes services in the future.

Other achievements for 2014/15 include:

- Development and distribution of North Durham specific patient information packs for living with Type 2 diabetes. Packs are issued to all newly diagnosed diabetes patients and work will be undertaken in 2015/16 to evaluate the effectiveness of these packs to support any future funding requests.
- Development of draft prescribing guidelines for primary care – guidelines to be finalised following the publication of latest NICE guidance.
- An increase in the number of referrals into structured education (DESMOND) from 2013/14 to 2014/15 and a 2014/15 uptake rate of 24.7%*.
- A 27.4% increase in the use of non-analogue insulin prescribing vs a 0.6% increase in the use of analogue insulins from 2013/14 to 2014/15** as well as a significant increase in the use of formulary blood glucose testing strips (341 in 2013/14 to 8,987 in 2014/15) and needles (47 in 2013/14 to 5206 in 2014/15).

**compared to 1% uptake reported in the National Diabetes Audit 2011/12*
*** Based on pro-rated data from January 2015*

Going forward we will continue to work with key stakeholders from primary and secondary care to develop a new integrated model of care for diabetes, agree the commissioning approach and to develop a full business case.

Podiatry review

Pressures have been identified for the community podiatry services and a review of these services is ongoing.

In order to alleviate some of the pressure on podiatry services we have worked with our local hospital trust's podiatry team which has delivered training and competency checks to practice based health care assistants (HCAs).

Over two courses held in May and September 2014, a total of 26 general practice staff successfully undertook the training.

## Other examples of commissioning projects delivered in 2014/15

Outpatient review programme

Ten specialties were selected using the 'Better Care Better Values' tool. These programmes were then prioritised

- Phase 1-pain management, ophthalmology and dermatology
- Phase 2-rheumatology, paediatrics and diabetic medicine.
- Phase 3-trauma and orthopaedics, clinical haematology, respiratory medicine and general medicine.

The main focus of the project was to review the new ratios for each of the specialties identified and, where appropriate, reduce the ratios to improve the patient experience and alleviate some activity pressures resulting in potential financial savings to the CCG.

Dissociative seizure service

The service commenced in October 2014 and was delivered from Sacriston Surgery, Queens Road Surgery and Stanley Primary Care Centre.

As part of establishing the service, service development meetings have taken place and were attended by psychologists, CCG members, neurologists, and epilepsy specialist nurses. These will continue to take place bi-monthly.

A wide range of training has been undertaken, attendance has included GPs, physiotherapists, nurses, geriatricians, neurologists etc. Training will continue via protected learning times (PLTs) and also within secondary care. A training plan has been developed and will include paramedics, hospital and community staff, and future PLTs. This service will be evaluated during 2015/16.

Eye care

Primary Eyecare North East (PENE) were awarded a sole-supplier contract to provide the community intra-ocular pressure referral refinement and cataracts pre-operative assessment service that North Durham CCG; Durham Dales, Easington and Sedgefield CCG, and Darlington CCG are collaboratively commissioning for the period of 1 November 2014 to 31 October 2016 with an option to extend for one year.

PENE is acting as principal contractor, subcontracting the service to a range of participating optical practices from mainly within the catchment area of the three CCGs.

The aim of the services is to achieve a reduction in inappropriate referrals to secondary care (outpatient ophthalmology) and to see an improvement in the detail included on the referrals.

It would appear from an initial review that levels of activity for this service are lower than expected. The CCG will continue to monitor the situation through 2015/16.

## The Better Care Fund (BCF)

The government announced nationally that it would be allocating £3.8 billion to a pooled budget known as the Better Care Fund (BCF) between health and social care. The aim of the BCF is to support the aim of providing people with the right care, in the right place, at the right time, including a significant emphasis upon care in community settings, with the express aim of reducing admissions and readmissions to secondary care and alleviating pressures on the acute hospital sector. There is a requirement to develop a two year plan focused on health and social care initiatives to enable greater integration of services in the community.

The CCG has worked in collaboration with Durham County Council and Durham Dales, Easington and Sedgefield CCG to develop a BCF plan for 2015/16 to 2016/17. The plan has been agreed by the County Durham Health and Wellbeing Board. The total budget allocated to the BCF for County Durham is £43.735 million in 2015/16.

There are seven programmes within the BCF plan:

Intermediate care plus - this service has been jointly commissioned and is in place. The service provides integrated short term care in the community to ensure timely discharge and support from hospital and stepped up care to avoid unnecessary hospital admissions by allowing people to be supported at home or in settings close to home.

Transforming care - which focuses on integrated ways of working through mobile technology, integrated IT systems, workforce development and training, and redesigning pathways of care.

Equipment and adaptations for independence **-** the re-procurement of the home equipment loans service has been completed and the redesigned service is being implemented. This service aims to improve access to equipment and adaptations and make greater use of advancing technologies. This will build on current services which are already highly valued and of good quality.

Supporting independent living **-** this will focus on some of the wider determinants of health such as accommodation and employment. We will review our current services and redesign a range of integrated jointly commissioned services with an end point of March 2016.

Supporting carers - recognising the value and contribution that carers make to the health and social care economy we are committed to improving their support mechanisms to enable them to maintain their caring role and their own health and

wellbeing, addressing the expected changes to the Care Bill. We will review our current services and redesign a range of integrated jointly commissioned services by March 2016.

Social isolation - through an asset-based approach we will work to increase community capacity and resilience working with third sector and community services with the potential to transform services at a pre-health and social care delivery stage, diverting people away from formal health and social care services and preventing the need for such in the future for people who are often isolated. Areas of development include befriending services and supporting people who hoard items in their home.

Care home support - we are committed to supporting high quality care home provision and ensuring the competency and capability to provide high quality care thereby reducing unnecessary admission to hospital ensuring dignity and safeguarding standards are met.

# Commissioning for safe and effective care

## Securing quality in health services (SeQiHS)

North Durham CCG is fully committed to seeking and sustaining quality care and services across health and social care. The securing quality in health services (SeQiHS) work will continue to drive this, working across the five CCGs and the three foundation trusts in Durham, Darlington and Tees. The programme is focused on understanding the opportunities and challenges in achieving agreed clinical quality standards in acute hospital services, within the likely financial environment and workforce constraints over the coming years.

This programme is being delivered in three phases;

- Phase one established a consensus in relation to the key clinical quality standards that should be commissioned in acute hospitals.
- Phase two worked with individual organisations to update the assessment of where we are in terms of meeting the clinical quality standards, the implications of meeting them and challenges that exist to ensuring high quality services are sustainable for the long term.
- Phase three is looking at how organisations and services might work together differently in the future and identify a model of care across the Durham, Darlington and Tees area that will maximise our ability to meet the standards within the resources available.

The programme has established a Clinical Leadership Group to lead this work and it has also commissioned independent research with the public to gain an understanding of what local people feel is important about hospital services and gauge levels of

understanding of the balance that has to be achieved between quality, access and affordability. The report from this research will be available in spring 2015.

## Clinical quality assurance framework

Within North Durham CCG, and working together with neighbouring CCGs, we continue with our structured approach to ensuring that our patients receive the right standard of care, the right outcomes and have a positive experience. The refresh of our clinical quality strategy has taken into account the learning from the Mid Staffordshire NHS Foundation Trust Inquiry, strengthening our approach and the intelligence we have about patient commissioned services.

## Safeguarding

We continue to meet our statutory requirements in relation to safeguarding adults and children. The Director of Nursing, Quality and Development has remained an active member of the safeguarding adults' and safeguarding children's boards, being appointed as the Vice Chair of the Durham Safeguarding Children's Board. The implications of the *Care Act 2014* and NHS England safeguarding assurance framework have been taken into account, through local quality requirements of providers and the role and contribution of the designated and named safeguarding professionals aligned to the CCG, to evidence that our providers are compliant with national and local requirements. The CCG also continues to have good engagement with its member practices to ensure that robust safeguarding policies and procedures are in place and understood.

## Medicines optimisation

The decision to prescribe is the most common intervention in the NHS. North Durham CCG work collaboratively with other health professionals and social care providers to deliver evidence-based cost effective use of medication to maximise patient outcomes from medication prescribed to them. This is facilitated through CCG membership in the North Region Treatment Advisory Group, County Durham and Darlington Area Prescribing Committee and its shared formulary process with secondary care, along with individual funding request processes for medication.

The County Durham and Darlington Drugs and Therapeutics Clinical Advisory Group, North Durham CCG Prescribing and Medication Safety Group, joint working with community pharmacy, and targeted education for prescribers new to North Durham facilitate the clinical engagement of health care professionals with the broad medicines optimisation agenda. Use of prescribing support software, regular prescribing newsletters and memos support the delivery of key messages and promote the use of the formulary and medicines optimisation websites and the associated agreed prescribing guidelines. The waste medication campaign, run in conjunction with Durham Dales, Easington and Sedgefield CCG, raised the awareness of medication waste to patients, care workers and health care professionals, and highlighted that waste

medication is estimated to be £1.5 million across the CCG. The campaign also resulted in the development of medication training for care homes.

The CCG has a medicines optimisation lead, and all member practices receive practice based prescribing support, targeted by the prescribing and medication safety sub group. There is a two year prescribing plan in place that covers priority areas, and is regularly updated through horizon scanning. All practices receive monthly prescribing reports, detailing budget and performance against the indicators in the County Durham and Darlington Prescribing Incentive Scheme; these include antibiotic prescribing rates and dovetails with NHS England's Antimicrobial Resistance Strategy.

## Electronic prescription service (EPS)

An electronic prescription service was launched in May 2014, a free NHS service that reduces the need for patients to visit the GP surgery to collect a paper prescription. This meant that patients can choose for their prescriptions to be securely sent electronically from their GP to a pharmacy or dispensing appliance contractor of their choice. Benefits include:

- choosing a pharmacy that is most convenient, such as one near work, home or the weekly shop,
- no trips to the GP practice just to collect prescriptions, which will especially help those who receive repeat prescriptions,
- shorter waits at the pharmacy as prescriptions can be prepared in advance.

## Promoting health

Over the last year, the CCG has supported a number of high profile health campaigns developed to increase awareness of symptoms, improve wellbeing and to promote local health care services.

For the second year running the **Keep Calm** campaign urged local people to 'keep calm and look after yourself' to combat the usual winter coughs, colds, aches and ailments that are common in usually healthy people in winter and to address the increasing demand for NHS services, particularly pressure on Accident and Emergency. The campaign was launched during Self Care Week 17 – 23 November 2014. The campaign lasted six weeks and used a variety of media with a reach of 1.9 million people, which equates to 73% of the north-east population having seen or heard the campaign.

We supported the **NHS Flu** campaign encouraging those who were eligible for the free flu vaccination to take up the offer. It was targeted at those with long-term health conditions, pregnant women and parents of children aged two and four. The message was promoted via planned media i.e. supplements in the Northern Echo as well as via the CCG website and e-bulletins to stakeholders.

The **Medicines Waste** campaign ran in conjunction with Durham Dales, Easington and Sedgefield CCG aimed to reduce unnecessary medicines waste. Currently, unused medicines cost the local NHS around £1.5 million each year – money which could be used to improve local health services. The campaign encouraged people to only order what they need, to return their unwanted medicines to their pharmacy for safe disposal, take their medicines with them when they go into hospital and have regular reviews of their medicines, discussing any medication issues with their GP or pharmacist in order to minimise any medicine wastage. The campaign proved to be successful and generated a substantial amount of media coverage.

**'My Medicines, My Health'** campaign was supported by North Durham CCG aimed at helping older patients to better understand their medicines, improve how well they take their medicine, which helps to manage their health condition and feel better for it. Targeting patients in the North Durham area over 60 years old with long-term medical conditions, 'My Medicines, My Health' urged people to value the medicine they have been prescribed for their health condition by keeping them safe, together in one place and in one bag, and to take them with them for key medical appointments such as visits to hospital. The campaign introduced the idea of a green medicine bag as a key way of doing this, although any bag or container would do as long as medicines are kept together in one easy place.

'My Medicines, My Health' campaign was funded by North Durham CCG, South Tees CCG, Darlington CCG, Hartlepool and Stockton-on-Tees CCG, and Durham Dales Easington and Sedgefield CCG and was supported by the County Durham and Darlington NHS Foundation Trust. The campaign featured on regional TV adverts, radio, social media, and in shopping centres as well as being promoted via the CCG website and planned media.

## Principles of remedy

In all aspects of our activity, NHS North Durham Clinical Commissioning Group adhered to the revised 'principles of remedy' published by the Parliamentary and Health Service Ombudsman in May 2010. Incident and risk procedures ensured that any serious incidents were reported, and lessons learned and applied.

## Emergency preparedness

We certify that the CCG has incident response plans in place, which are fully compliant with the NHS England Emergency Preparedness Framework 2013. The CCG regularly reviews and makes improvements to its Business Continuity Plan and is developing a programme for regularly testing this plan, the results of which will be reported to the Governing Body.

# Engaging with our patients and the public

## Community engagement project

We have commissioned a voluntary sector organisation, Durham Community Action (DCA), to deliver our public engagement project. The CCG developed a model of engagement with the local population which DCA deliver. This includes our membership scheme, focus groups and patient congress. Information is collected routinely to feed into the CCG's commissioning processes and the local population are kept informed about the work of the CCG.

The focus groups have covered the following themes;

- NHS literature,
- dementia strategy,
- home equipment loan scheme,
- mental health strategy,
- urgent care services,
- talking therapies,
- cancer services,
- how young people access health services,
- dental pathways,
- diabetes services,
- frail and elderly,
- hard to reach communities.

## Volunteering awards

The CCG supported the Durham Community Action Volunteering Awards. The awards showcased the work of individual volunteers and organisations from across County Durham. This year's event was held at Ramside Hall, Durham in October 2014 with a formal dinner. It recognised and celebrated the fantastic work undertaken by volunteers and what was being done to encourage wider participation. Presentations were made to award several category winners to recognise volunteers who give up their time, without financial reward to improve the lives of others.

## Governing Body

Our Governing Body meetings are held in public so that the public can observe the Governing Body at work. Members of the public are encouraged to submit any questions they might have prior to the meeting to enable a full answer to be provided. At each Governing Body meeting there is a standing item on the agenda for public questions so that the questions can be answered. The Governing Body meetings are promoted by regional press advertising.

## Annual General Meeting (AGM)

The 'Council of Members' Annual General Meeting (AGM) took place on 10 June 2014 at the Rivergreen Centre, Aykley Heads, Durham. The meeting proved to be successful and provided an opportunity for the CCG to report on the following;

- Clinical Quality Annual Report,
- Final Annual Report and Annual Accounts 2013/14,
- Financial Performance Review 2013/14,
- Amendments to NHS the CCG's Constitution.

## NHS North Durham CCG membership scheme

The CCG's own public membership scheme, My NHS, aimed at getting people throughout the North Durham area involved in developing and improving local health services is building on its success. Free and easy to join, the aim is to get local people to input into how the CCG plans and provides its services, how those services can be changed when needed and to get involved in decisions that may affect how those services operate. In return, members receive regular updates about the work of the CCG, receive invitations to events and have the opportunity to voice their opinion about what concerns them about their local health care provision.

Members can choose their level of membership.

By choosing Type 1 (INFORM) they receive regular information about health services, issues and decisions in their geographical area.

By choosing Type 2 (INVOLVE) they also have the opportunity to shape and influence what services are needed and brought into their area for the public, patients and carers by attending focus groups and meetings.

We also have three Type 3 members who are represented on the Patient, Public and Carer Engagement (PPCE) Committee.

The membership scheme is open to all residents, patients and carers in North Durham as well as voluntary organisations who reside within and/or serve the population of North Durham. The aim is to enable those who are interested to learn more about the CCG and how it assesses needs, reviews current service provision, decides priorities, designs services and manages demand to ensure appropriate access to care, reviews the success of the contracts and meets the needs of service users. People can register via our website at www.northdurhamccg.nhs.uk or call to register on 01207 529621/01642 745 046

## Patient, Public and Carer Engagement Committee

This is a new strategic committee which will provide information to the Governing Body for the CCG about local experiences of local health services. The CCG held interviews and sought nominations for patient representation onto the committee.

## North Durham Patient Reference Group

North Durham Patient Reference Group (PRG) has refreshed its membership and those who are members of practice PRGs who are not already represented in the group are encouraged to get in touch. The group aims to unite and represent all the patients in the North Durham area and there is currently a team of valuable and effective representatives from several GP practices who are keen to involve more practices and patients to focus on local issues, and to provide a voice for patients, giving local people a say on how their local GP surgery services can be improved. Involvement can take different forms, from attending meetings to being part of a 'virtual group'.

## Public congress

We organise regular public events where members of the public can meet members of the CCG and give their views about local services. This year, as well as inviting the public to attend our Governing Body meetings we have also held both a Spring and an Autumn Patient Congress. The spring event was held in May 2014.

Over 100 local patients and stakeholders attended our autumn Patient Congress in Stanley on 19 November 2014. Held in the Civic Hall, the event featured an update on the CCG's five year vision for health care in the North Durham area and more about how the CCG engages with its local population through PRGs. Those in attendance also had the chance to ask any burning questions about local health services during a question and answer session with CCG staff.

As well as updates from the CCG, many local voluntary and community groups had information stalls at the event, to raise awareness of their support and local activity. These included: Macular Support Group, British Red Cross, Durham Deafened Support, Willowburn Hospice, Derwentside MIND and many more.

We held a young people's summer health event in August 2014 at Houghall College in Durham. The free event was open to young people aged from 8-18 who live in the Chester-le-Street, Durham or Derwentside areas. The event provided the opportunity to talk to young people about their experiences of local health services across North Durham. 91 children and young people attended the event with 54 adults including parents/guardians, carers and volunteer support staff. 26 of the young people were registered disabled.

Our next patient congress will be held in Chester-le-Street in April 2015.

## Website

Our website (www.northdurhamccg.nhs.uk) provides people with information about our services, a range of key documents such as the CCG prospectus and commissioning plans, feedback from Governing Body meetings, news and events and any proposed developments in health and social care in the region.

The CCG is developing a strategic approach to using social media to convey our key messages. We currently use Facebook and are looking at harnessing Twitter more to raise awareness of the CCG and also interact and engage with the public. We will also develop opportunities for people to get involved and have their say via interactive surveys which will be held on the website.

# Working in partnership

People's health and wellbeing is dependent on more than just the health services that we commission. We are very clear that in order to improve people's wellbeing and reduce their need for services we need to work with a wide range of partners including education, public health, the police, and voluntary and third sector organisations. By working closely with such partners we can ensure we commission joined up pathways of care irrespective of organisational boundaries.

As an example of this approach, NHS England introduced the Better Care Fund in 2014. As a joint initiative across the CCGs and local authority it is intended as a driver to improve preventative community services and as such it is a real opportunity to co-ordinate and improve the community based service that can pre-empt the need for emergency care and help people remain well and independent within their local communities.

We will be developing and delivering this in partnership with the local authority and our providers, through the work of the Health and Wellbeing Board.

The CCG is a member of County Durham Health and Wellbeing Board and has contributed to the development of the Joint Health and Wellbeing Strategy, which aims to inform and influence decisions about health and social care services in County Durham, so that they are focused on the needs of the people who use them and tackle the factors that affect health and wellbeing.

During 2014/15 we have worked closely with a range of partners to:

- design and implement the new Intermediate Care Plus (IC+) service,
- develop and deliver the Mental Health Crisis Concordat,
- deliver the winter resilience plan,
- improve standards in care homes including the establishment of a training programme and a clinical forum.

We are working with other CCGs across Teesside, Durham and Darlington to improve the quality of hospital care in our region. Over the past year, the Securing Quality in Health Services (SeQHiS) project has focused on establishing and implementing the key clinical quality standards that should be commissioned in acute hospitals in the areas of paediatrics and maternity services, acute care and end of life care.

# Performance

The CCG Assurance Framework, published by NHS England in November 2013, outlines the process to be used by NHS England to monitor and gain assurance on the performance of CCGs.

A key element of the framework is the quarterly assurance process with NHS England, including the production of a 'delivery dashboard' which provides information on performance against certain targets and metrics.

The CCG assurance process has been designed to provide confidence to internal and external stakeholders and the wider public that CCGs are operating effectively to commission safe, high quality and sustainable services within their resources. This framework for 2014/15 set out six broad 'assurance domains' under which this assessment was made.

- Are patients receiving clinically commissioned, high quality services?
- Are patients and the public actively engaged and involved?
- Are CCG plans delivering better outcomes for patients?
- Does the CCG have robust governance arrangements?
- Is the CCG working in partnership with others?
- Does the CCG have strong and robust leadership?

The quarterly delivery dashboards are published on the CCG's website once finalised, together with an overall 'assurance report' received from NHS England summarising the outcome of the quarterly assurance meetings.

These delivery dashboards present the latest performance against relevant targets contained within the NHS Constitution and the NHS Outcomes Framework, as well as certain other quality and financial indicators.

Although performance against certain targets within the NHS Constitution and the CCG outcome indicators for 2014/15 has been below expectations, relevant actions have been implemented in all areas and plans have been put in place to provide NHS England assurance that the issues are being managed appropriately.

## Performance against NHS Constitution targets and Outcomes Framework

Patients have a number of rights under the NHS Constitution.  In addition, the CCG Outcomes Indicator Set contains a range of measures developed from the NHS Outcomes Framework indicators that can be measured at CCG level together with additional indicators developed by NICE and the Health and Social Care Information

Centre. These provide clear, comparative information for CCGs, Health and Wellbeing Boards, local authorities and patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes.

They are useful for CCGs and Health and Wellbeing Boards in identifying local priorities for quality improvement and to demonstrate progress that local health systems are making on outcomes.

Full details of the CCG's performance against both the NHS Constitution targets and the outcomes indicators during 2014/15 is included within the performance reports presented at each Governing Body meeting, which can be found on the CCG's website. A summary of the key performance areas is also set out below:

## Referral to treatment (waiting times)

Patients have the legal right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral. The CCG has achieved its overall target of 90% of admitted and 95% of non-admitted patients being treated within the timescale. As at 31 March 2015, all North Durham patients had been treated within the required 52 weeks target.

## Diagnostic test waiting times

No more that 1% of patients should wait over six weeks for a diagnostic test. Overall for the year ended 31 March 2015 this target has not been achieved with 4.4% of North Durham patients waiting over six weeks, largely as a result of pressures at our main provider, County Durham and Darlington NHS Foundation Trust (CDDFT) where 7.6% of total patients at the Trust have waited over six weeks during 2014/15.

This is extremely disappointing for the CCG and as a matter of priority a range of actions have been implemented to ensure the situation is rectified. This includes an investment in increased capacity from Independent Sector providers along with additional locum capacity within County Durham and Darlington Foundation Trust. Review of the Trusts demand and capacity modelling, along with the actions implemented to deliver improved performance, have provided assurance that waiting times will be back within target by 30 June 2015.

## Cancer waiting times

Overall, target waiting times for cancer treatment have been achieved at a CCG level for 2014/15. These include patients being seen within two weeks of an urgent referral and receiving treatment within 31 days and 62 days. Some pressures have been identified at individual specialty level throughout the year which are being addressed with service providers. Each case that exceeded the timeframe is reviewed to understand the reasons for the delay and identify relevant solutions. Work has commenced through the Strategic Clinical Network, incorporating representatives from

all regional providers and commissioners, to look at opportunities to streamline and develop new pathways.

## Accident and emergency (A&E) performance

Patients should wait no more than four hours for treatment in the A&E department. Overall this target has not been met by our two main providers, CDDFT and City Hospitals Sunderland NHS Foundation Trust with performance for the year being 94.3% and 92.1% respectively.

This is particularly disappointing given the performance issues experienced during the previous year and the level of work performed and actions implemented to address the pressures. Actions have included investment in increased capacity in primary care and community services, together with the investment of significant resilience funding across the whole health and social care system. An emergency divert policy has also now been agreed with CDDFT, Gateshead Health NHS Foundation Trust and the North East Ambulance Service NHS Foundation Trust, to utilise additional capacity commissioned from the new emergency care centre in Gateshead from April 2015, which should help to manage pressures at CDDFT and reduce related ambulance handover delays.

Pressures within the emergency care system, over the winter period in particular have been well documented at both a regional and national level. Regional discussions have taken place with all provider and commissioner organisations to share knowledge in areas of good practice and review options to improve performance.

## Ambulance response times

All ambulance trusts are expected to respond to 75% of immediately life threatening calls within eight minutes. Where onward transport is required, 95% of life-threatening calls will receive an ambulance vehicle capable of transporting the patient safely within 19 minutes of the request for transport being made. The North East Ambulance Service NHS Foundation Trust (NEAS) provides ambulance services to North Durham. For 2014/15, NEAS have not met the required targets with performance being 73.8% against the eight minute target and 94.6% against the 19 minute target.

Performance has been affected by a number of factors including pressures across the whole health and social care system together with capacity issues within NEAS arising from a significant shortage of qualified paramedics. A range of actions have been agreed with NEAS in response to these issues, although the capacity issues will take time to resolve through the increased recruitment of paramedics and student intake.

## Healthcare associated infection

Reducing healthcare associated infection remained a key challenge for the CCG and the local NHS throughout the year.

• *MRSA (methicillin resistant Staphylococcus Aureus)*
There is a zero tolerance of MRSA which means that all commissioner and provider targets are zero. The CCG reported two cases in total during the year.

• *Clostridium difficile*
The performance position at end of March 2015 (validated data) for the CCG showed 38 cases in total against a target of 62, which is pleasing to note and reflects a continued improvement on previous years.

## Improving access to psychological therapies (IAPT)

This indicator aims to measure the response to depression and anxiety disorders through the delivery of the Improving Access to Psychological Therapies (IAPT) programme.

The national target for the proportion of people entering therapy is 15% of an estimated population group. The CCG's current performance is below this at 11.8%, although it should be noted that additional talking therapies are commissioned by way of a counselling service, which is not included in the figure. Work is continuing with the provider of the IAPT programme to improve access to the service, with performance improved during 2014/15 in comparison to the previous year.

# Financial review

## Overview

During the year we have worked hard to secure high quality services, making every effort to ensure we use the resources allocated to North Durham CCG economically and with effectiveness and efficiency.

Robust systems of financial governance and financial management processes have allowed all financial risks to be appropriately managed during the year enabling the delivery of financial targets.

2013/14 was the first year of operation as a stand-alone organisation and all financial targets were met. This relatively stable financial position has been consolidated in the current year and it is pleasing to report that we have again been successful in achieving our key statutory and administrative financial duties during the financial year ended 31 March 2015.

This continues to be a challenging time for the NHS and a period of significant change and the financial performance outlined in the CCG's annual accounts is pleasing to see, reflecting the strong financial management within the organisation.

## CCG allocations

Two distinct funding streams are provided to CCGs:

- Programme Budget Allocation – this funding relates to direct health care expenditure,

- Running Cost Allowance – this funding, amounting to an average of £25 per head of population, is to cover the administrative costs of running the CCG.

The funding resources available to the CCG during the year were as follows:

| | Programme Budget Allocation £'000 | Running Cost Resources £'000 | Total £'000 |
|---|---|---|---|
| Initial baseline allocations | 317,870 | 6,116 | 323,986 |
| In-year non-recurring allocation adjustments * | 8,537 | 456 | 8,993 |
| **Total final allocations** | **326,407** | **6,572** | **332,979** |

| | | | |
|---|---|---|---|
| *Total funding per head of population ** | *£1,302* | *£26.22* | *£1,329* |

** in-year non-recurring running cost allocation relates to quality premium award which was received as a running cost allocation but has been utilised on health care spend*

*** funding per head of population has been calculated based on the registered population of the CCG, as published by NHS England, of 250,627.*

## Financial targets and performance for the year

In accordance with NHS England financial planning guidance, the CCG is required to deliver a surplus of at least 1% of available resources. A surplus of £5 million was initially planned at the start of the year, with a revised surplus of £7.757 million subsequently agreed with NHS England during the year. This revised surplus level has been successfully delivered as planned.

The CCG's successful results in 2014/15 are set out in the table below, with further detail included in note 24 of the full annual accounts published alongside this Annual Report.

| Target | Outcome | Target Met? |
|---|---|---|
| Deliver surplus on revenue budgets of at least 1% | Total surplus of £7.75 million against a total revenue resource limit of £332.979 million | ✓ |
| Maintain running costs within £25 per head running cost allowance | Surplus of £0.749 million delivered on running cost budgets | ✓ |
| Maintain capital spending within capital resource limit | No capital resource required and no capital spend in year | N/A |
| Ensure cash spending is within the cash limit set | Cash managed within available resources | ✓ |

## Expenditure not to exceed resource limits

Unlike commercial companies which make a profit or loss, CCGs are set resource limits within which they must contain net expenditure for the year. There are separate resource limits set for revenue and capital expenditure, with revenue expenditure limits further split between programme spend and running costs.

The CCG's final programme budget allocation for the year was £326.407 million. The value of the programme allocation in 2014/15 is largely still derived from a baseline mapping exercise performed by the former County Durham PCT to allocate the PCT's resources to the relevant successor organisations, including the CCG.

## Operational financial balance

The funding of the former PCT was based upon a weighted capitation formula. This formula was based on the population served by the PCT amended for factors including age, need and market forces. For 2014/15 a revised CCG allocation formula was introduced, taking into account population growth, deprivation and the impact of an ageing population, which has provided target allocations at a CCG level.

A minimum rate of growth funding was applied to all CCGs in 2014/15 of 2.14%, which amounted to £6.5 million for North Durham CCG.

This funding is used to fund health care services including hospital and community health services (for both physical and mental health), prescribing costs for drugs and appliances, and continuing health care.

Relevant costs amounted to £319.406 million and resulted in surplus being delivered on programme budgets of £7.001 million.

When combined with the position reported on running costs below, this resulted in a total surplus being delivered on all revenue budgets of £7.750 million.

## Running costs

As highlighted above, a separate running cost allowance is provided to all CCGs, amounting to £25 per head of population served, to cover the administrative costs of running the CCG. As part of the drive to reduce the administrative costs of the NHS and release additional funding to invest in frontline health care services, there is a requirement to manage administrative costs within this allowance.

Total running costs for the year amounted to £5.823 million, compared to a running cost allowance of £6.572 million.

## Capital resource limit

The CCG had no capital expenditure in 2014/15 and therefore did not require any capital resource, hence this target is not applicable in the current year. In future the capital requirements of the CCG, and any related capital resource received, are expected to be minimal and would relate only to potential IT equipment replacement.

## Other financial targets and disclosures

In addition to the above statutory duties, CCGs have similar responsibilities to other NHS organisations to record performance against the Better Payment Practice Code (BPPC) published by the Department of Health.

## Compliance with Better Payment Practice Code

The BPPC requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms.

Details of compliance with the code are given in note 5.1 to the financial statements.

Performance against the target is monitored by the CCG on a monthly basis with performance maintained at over 95% of invoices paid within 30 days of receipt, measured against both total invoice value and overall volume of invoices.

## Prompt payments Code

In addition to compliance against the BPPC, on 11 February 2014 the CCG became an approved signatory of The Prompt Payment Code. This initiative was devised by the government with The Institute of Credit Management (ICM) to tackle the crucial issue of late payment and to help small businesses. Suppliers can have confidence in any company that signs up to the code that they will be paid within clearly defined terms, and that there is a proper process for dealing with any payments that are in dispute.

Approved signatories undertake to:

- pay suppliers on time,
- give clear guidance to suppliers and resolve disputes as quickly as possible,
- encourage suppliers and customers to sign up to the code.

## Setting of charges for information

The CCG has complied with HM Treasury's guidance on setting charges for information.

## Utilisation of resources

Financial pressures arise each year, but the CCG was able to manage these by prudent financial planning and careful financial management.

One of the CCG's main objectives during the year was to maintain financial stability and probity while ensuring that resources were used as efficiently and effectively as possible in meeting the strategic aims as set out in the CCG's strategic and operational plans.

One of the strategic aims of the CCG is to bring care closer to home, reducing the historic reliance on secondary care acute services in particular. This will be essential over the coming year to deliver the shifts in activity from secondary care services to primary and community care settings that will be required to support the implementation of the Better Care Fund (BCF) in 2015/16.

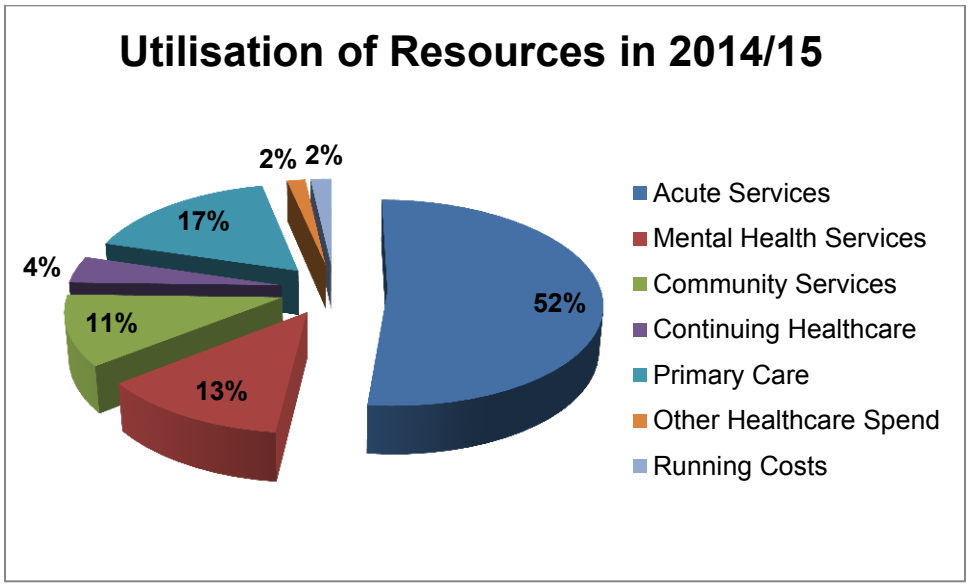
It is important that this transformation of care is managed in a planned and progressive manner and the CCG has remained committed to supporting its main providers of secondary care services to maintain a balanced local health economy. This is to ensure the delivery of key targets and in overall terms the majority of funding currently continues to be spent on acute hospital services.

Although spend on secondary care acute services continued to increase in 2014/15, significant additional investment has also been identified for a range of new and innovative services including for example:

- weekend opening of GP practices across North Durham,
- implementation of a pilot integrated short-term intervention service, designed to prevent hospital admissions and facilitate early discharge,
- primary care outcomes scheme incorporating a range of services designed to improve the quality and access of primary care services and enable additional services to be performed in a primary/community care setting,
- development of services for our frail and elderly population designed to prevent emergency admissions and provide care closer to home.

The CCG has also successfully worked with providers to deliver planned efficiencies under the quality, innovation, productivity and prevention (QIPP) programme of £15.6 million in total, through release of efficiencies and subsequent re-investment into priority areas.

The utilisation of available resources in 2014/15, across the relevant areas of programme spend, can be seen below:




## Pensions

Details of the accounting for pension liabilities can be found in the accounting policies and pension costs notes in the CCG's financial statements (notes 1.8.2 and 3.5 respectively). Further details of senior managers' pension benefits can be found in the remuneration report.

## Risk and Audit Committee

A Risk and Audit Committee has operated throughout the year, chaired by Tom Stevenson, Lay Member for Governance and Audit.

Other members of the Risk and Audit Committee are:

- Verna Fee, Lay Member for Patient and Public Involvement (from 1 April 2014 to 31 March 2015),
- Feisal Jassat, Lay Member for Patient and Public Involvement (from 1 April 2015),
- Dr David Smart, GP Constituency Lead Representative (from 1 April 2014 to 30 September 2014),
- Dr Patrick Wright, GP Constituency Lead Representative (from 1 October 2014),
- Susan Elsbury, GP Practice Manager Representative (from 1 April 2014 to 31 October 2014).

## External auditors

Following a procurement and selection process undertaken by the Audit Commission, Deloitte LLP were appointed as auditors to the CCG for 2013/14 and 2014/15.

The cost of audit services can be found in note 4 of the CCG's financial statements.

The auditors bring an annual work plan to the risk and audit committee for approval. This states that the audit team are independent of the CCG and also would include any details of non-audit work if applicable. When considering whether the level of any non-audit work is appropriate the CCG would consider the composition of the team (and whether any audit team members are involved) and the level of fees.

## Looking forward

The financial pressures facing the NHS are substantial and well documented, with the impact of an aging and growing population leading to significantly increased costs against a backdrop of limited financial resources.

These pressures are highlighted in the 'Five Year Forward View' published by NHS England in October 2014, which sets out a vision for the future of the NHS and describes a range of potential new models of care designed to integrate services and allow a more effective and efficient delivery of care.

The CCG has refreshed its strategic and operational plan, demonstrating how these pressures will be addressed over the coming years. This will include a particular focus on care for the frail and elderly amongst our population, the transformation of urgent care, implementation of seven day services, short-term intervention services to prevent acute admissions and delivery of integrated primary and community services on a wider scale.

A key element of the CCG's plan is the BCF, a single pooled budget across the CCG and local authority, designed to enable transformation in integrated health and social

care. Nationally the BCF amounts to £3.8 billion, with the total value of the fund (between North Durham CCG and Durham Dales, Easington and Sedgefield CCG) across County Durham amounting to £43.7 million. The BCF is designed to deliver significant shifts in activity from secondary care acute services to primary and community settings, enabling care to be provided closer to home and supporting integration of health and social care.

The implementation of this plan in 2015/16 represents a significant challenge for the CCG in delivering the level of reductions required in acute activity to release the resources necessary to support investment in appropriate community-based health and social care services. The scale of this challenge is particularly evident given the unprecedented pressures on secondary care acute services experienced during 2014/15.

The CCG's strategic plan is built upon a financial plan which incorporates the expected impact of the BCF and other strategic objectives, and provides a stable financial foundation upon which to deliver the transformational change required to shift activity, and related costs, out of hospital care.

The 2015/16 budget approved by the CCG's Governing Body in March 2015 reinvests existing funding as well as growth monies totalling almost £6.2 million in a range of priority areas as detailed in the CCG's operational plan. This includes the significant investment required in the BCF. Significant non-recurring resource will continue to be utilised in 2015/16 to support the transformation that is required in both primary and community services in particular, to aid the implementation of the BCF from 1 April 2015.

## Sustainability and the environment

Our approach to sustainable development sets out our commitment to work in ways which maximise the health, social and economic benefits our activities bring to the community while minimising our impact on the environment.

Sustainable development requires us to be mindful of the need to safeguard the future in all of our choices, decisions, and actions. Wherever possible we should take opportunities to contribute positively to the local economy and community, reduce waste and utilities consumption and minimise any negative impact on the environment both now and for future generations.

Working in a sustainable way means rethinking a lot of what we do. It affects not only the major strategic decisions we take but also how we go about our daily business.

Getting these decisions right will not only help us save money, eliminate unnecessary waste in the system and reduce our carbon footprint; it demonstrates to partners and the public that the CCG is dedicated to enhancing individuals' well-being through our

work as commissioners of high quality health services, but also by enhancing the wellbeing of the local and global community through taking seriously our corporate responsibilities.

## Travel

We encourage sustainable travel wherever possible. We offer shower facilities and cycle parking where we can. We also promote care closer to home and home working opportunities where possible.

## Waste

We work hard to minimise the creation of waste and have a robust approach to recycling. Paper, cardboard, glass, metal, ink cartridges, batteries, electrical goods and confidential waste are all recycled.

## Workforce development

All of our staff are encouraged to work sustainably, we promote environmental awareness, encourage low carbon travel and facilitate flexible working where possible.

## Utilities usage

The CCG's headquarters is based in The Rivergreen Centre an environmentally sensitive, low impact building that achieved a BREEAM excellent rating and has received many awards including RICS Sustainable Building of the Year 2007.

Heating is provided by two wood pellet burning boilers. As the pellets come from waste timber and timber grown recently, and sourced locally, this makes for a carbon neutral fuel. An optimum start and weather-compensated control system determines when the boilers kick into action and how hot the water needs to be. The system measures the outside temperature and then calculates the flow of temperature necessary to reach a pre-determined ambient room temperature.

Hot water is primarily provided by eight solar panels. Throughout the summer the panels provide the bulk of the heat. In the cooler months the boilers provide back-up. Approximately 60% of hot water requirements are provided 'free'.

Power is provided by the mains distribution grid. The design of the building eliminates the need for power wherever possible eg use of only passive ventilation, light sensors and photo-cells to adjust the light levels.

A computerised building management system monitors the building performance providing a real-time check on a range of variables including ambient temperatures, energy consumption, water consumption and boiler performance.

# Equality, diversity and human rights

North Durham CCG complies with the *Equality Act 2010* and the Public Sector Equality Duty. We have demonstrated our commitment to taking equality and human rights into account in everything we do, whether that is commissioning services, employing people, developing policies, communicating, consulting or involving people in our work. Equality and diversity training is a mandatory requirement for CCG staff.

The work done towards advancing equality of opportunity and meeting the legal requirements has been published on our website, including the equality strategy, the equality delivery system (EDS) and the equality objectives.

## Equality delivery system

The CCG has used the EDS to assist in compliance with legislation. The EDS ensures that those with "protected characteristics" are taken into account in everything we do. It also encourages a more representative workforce, ensuring staff are supported and that those at the highest level are committed to promoting equality. The CCG has used the EDS to shape its equality objectives. The Governing Body has delegated responsibility to the Risk and Audit Committee to oversee the development of policy, strategy and practice and also to ensure the equality objectives are being met.

## Staff gender profiles

The CCG staff gender profile is given in the table below. This reflects our gender representation on the Governing Body, very senior manager (VSM) staff and all CCG staff.

| | Female | Male |
|---|---|---|
| Governing Body | 9 | 9 |
| VSM | 1 | 1 |
| Employees | 33 | 8 |

The CCG can demonstrate fair and equitable recruitment, workforce engagement and employment terms and conditions to ensure levels of pay and related terms and conditions are fairly determined for all posts, with staff doing equal work, and work rated as of equal value, and being entitled to equal pay.

## Promoting equality and diversity

Staff across the CCG have access to an online and paper based copy of a multi-faith diversity calendar for both 2014 and 2015 designed by our equality and diversity manager within the commissioning support unit. This calendar highlights key dates in order to promote the positive work that can be achieved when equality and diversity

principles are embedded within an organisation. We also receive the Diversity Matters newsletter on a quarterly basis to keep all staff up to date on current diversity issues, news and key diary dates.

### Accessibility and communications

The CCG's public buildings are accessible for people with a disability. Information for patients and the general public is available in other languages or formats such as large print or Braille and audio upon request. The CCG has earned the two tick 'positive about disabled people' symbol awarded by Jobcentre Plus which demonstrates our commitment to employ, retain and develop the abilities of disabled staff.

### Staff sickness absence

The table below provides staff sickness absence data for 2014 (with comparative figures for the nine months to December 2013), showing the total number of full time equivalent (FTE) staff days lost to sickness absence and the total number of FTE years available, based on the total number of FTE staff members within the CCG. This equates to an average number of days' sickness per FTE member of staff of 5.2 (4.6 for the nine months to 31 December 2013):

| | 2014<br>Number of days | 2013<br>Number of days |
|---|---|---|
| Total number of days lost to sickness absence | 180.5 | 152.2 |
| Total staff years | 34.9 | 32.8 |
| **Average number of working days lost to sickness absence** | **5.2** | **4.6** |

## Compliance with duties

We certify that the CCG has complied with the statutory duties laid down in the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Dr Neil O'Brien
Accountable Officer
28 May 2015

# Members' report

## Council of Members

The CCG is a membership organisation. The Council of Members comprises of an individual selected by each member practice belonging to one of the CCG's three constituencies. The individual selected has authority to represent the practice's views and to act on its behalf in its dealings between the practice and the CCG.

The Council of Members has three representatives that sit on the Governing Body, representing the views of member practices in each of the three constituencies.

The Council of Members:

- contributes to, changes and approves the CCG's Constitution and any amendments thereafter,
- elects relevant members of the Governing Body,
- reviews and agrees the annual delivery plan,
- contributes to and agrees the commissioning intentions,
- reviews year end performance of the Governing Body,
- holds an Annual General Meeting open to the public.

Member practices are as follows:

**Durham constituency:**

- Belmont and Sherburn Medical Group
- Bowburn Medical Centre
- Brandon Lane Surgery
- Chastleton Medical Group
- Cheveley Park Medical Centre
- Claypath and University Medical Group
- Coxhoe Medical Practice
- Dunelm Medical Practice
- The Medical Group
- West Rainton Surgery

**Chester-le-Street constituency:**

- Bridge End Surgery
- Cestria Health Centre
- Great Lumley Surgery
- Middle Chare Medical Group

- Middle Chare Medical Group – Gardiner Crescent Surgery
- Pelton and Fellrose Medical Group
- Sacriston Surgery

**Derwentside constituency:**
- Annfield Plain Surgery
- Browney House Surgery
- Cedars Medical Group
- Consett Medical Centre
- Craghead Medical Centre
- Dipton Surgery
- Leadgate Surgery
- Oakfields Health Centre
- Park House Surgery
- Queens Road Surgery
- Stanley Medical Group
- Tanfield View Medical Group
- The Haven Surgery
- West Road Surgery

## Governing Body

The Governing Body is responsible for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance.

The Governing Body is also responsible for the CCG's budget of over £330 million, ensuring this is spent as efficiently as possible to provide high quality health care for the local population.

Further details of the governance framework and organisational structure operating within the CCG, including the role of the Governing Body and related committees can be found in the Governance Statement.

The membership of our Governing Body has changed during the year.

- Dr Kate Bidwell was replaced by Dr David Smart as Clinical Chair with effect from 1 October 2014.
- Dr David Smart was replaced by Dr Patrick Wright as Constituency GP Lead for Durham with effect from 1 October 2014.
- Dr Gim Ong was replaced by Dr Chandra Anand as Constituency GP Lead for Derwentside with effect from 1 July 2014.

- Feisal Jassat replaced Verna Fee as Governing Body Lay Member for Patient and Public Involvement with effect from 1 April 2015.

Membership is shown in the table below, along with the membership of all other Committees and details of attendance at relevant meetings throughout the year:

## Governing Body and committee members 2014/15:

| Name | Title | Governing Body Meetings: 8 | Management Executive Meetings: 22 | Risk and Audit Meetings: 5 | Quality Research and Innovation * Meetings: 11 | Finance and Performance Meetings: 10 | Remuneration and Terms of Service Meeting: 1 | Patient, Public and Carer Engagement Committee Meetings: 2 |
|---|---|---|---|---|---|---|---|---|
| Dr Chandra Anand (from 1/7/14) | Constituency GP Lead, Derwentside | M (4) | | | M (8) | M (2)<br>C (5 )<br>(Chair from 1/10/14) | | |
| Nicola Bailey | Chief Operating Officer | M (5) | M (20) | | M<br>(3 of 9)<br>(member until 31/1/15) | M (1) | | |
| Dr Kate Bidwell (until 30/9/14) | Chair | C (4) | | | | | C (1) | |
| Chris Brown | Practice Nurse Representative | M (5) | | | M (10) | | | |
| Nancye Carr | Derwentside Patient Reference Group | | | | | | | M (2) |
| Dr Geoff Crackett | GP Prescribing Lead | | | | M (11) | | | |
| Dr Ian Davidson | Director of Quality and Safety | M (6) | M (16) | | C (10) | | | |
| Ian Doyle | Chester-le-Street Patient Reference Group Representative | | | | | | | M (2) |
| Susan Elsbury (until 31/12/14) | Practice Manager Representative | | | M (2) | | | | |

| Name | Title | Governing Body Meetings: 8 | Management Executive Meetings: 22 | Risk and Audit Meetings: 5 | Quality Research and Innovation * Meetings: 11 | Finance and Performance Meetings: 10 | Remuneration and Terms of Service Meeting: 1 | Patient, Public and Carer Engagement Committee Meetings: 2 |
|---|---|---|---|---|---|---|---|---|
| Verna Fee | Lay Member, Patient and Public Involvement | M (6) | | M (5) | M (6 of 9) (member until 31/1/15) | | M (1) | C (2) |
| Dr Angela Galloway | Secondary Care Clinician | M (7) | | | M (7 of 9) (member until 31/1/15) | | | |
| Dr Barbara Gallwey | Named GP for Safeguarding Adults and Children | | | | M (7) | | | |
| Betty Gibson | Type 3 Member | | | | | | | M (1) |
| Linda Gorman | Practice Manager Representative | | | | M (6) | | | |
| Dr David Graham | Director of Primary Care Development and Innovation | M (3) | M (14) | | M (10) | | | |
| Stephen Hann | Type 3 Member | | | | | | | M (1) |
| Barbara Harker | Finance and Performance Manager | | | | | M (10) | | |
| Richard Henderson | Chief Finance Officer | M (8) | M (21) | | | M (8) | | |
| Dr Liz Herring | Director of Nursing, Quality and Development | M (7) | M (19) | | M (9) | M (6) | | |
| Michael Houghton | Director of Commissioning and Development | M (7) | M (20) | | M (2 of 2) (member from 31/1/15) | M (6) | | |
| Denise Hunter | Practice Manager Representative | | | | | M (8) | | |

| Name | Title | Governing Body Meetings: 8 | Management Executive Meetings: 22 | Risk and Audit Meetings: 5 | Quality Research and Innovation * Meetings: 11 | Finance and Performance Meetings: 10 | Remuneration and Terms of Service Meeting: 1 | Patient, Public and Carer Engagement Committee Meetings: 2 |
|---|---|---|---|---|---|---|---|---|
| Feisal Jassat | North Durham Health Community Alliance Representative | | | | | | | M (2) |
| Maureen Kersley | Practice Manager Representative | M (7) | | | | | | |
| Jo Laverick | Durham Community Action Representative | | | | | | | M (1) |
| Dr Philip Le Dune | Deputy Constituency GP Lead | | | | M (0) (until 31/1/15) | | | |
| Dr Richard Lilly | Constituency GP Lead, Chester-le-Street | M (0) | | | M (11) | M (9) | | |
| Susan Nuttall | Adult Safeguarding Manager | | | | M (6) | | | |
| Dr Neil O'Brien | Clinical Chief Officer | M (5) | C (17) | | | | | |
| Dr Patrick Ojechi | Deputy Constituency GP Lead | (3) (deputy for Richard Lilly) | | | | | | |
| Dr Gim Ong (until 30/6/14) | Constituency GP Lead, Dewentside | M (2) | | | M (2) | M (1) | | |
| Donna Pudwell | Type 3 Member | | | | | | | M (0) |
| Pat Rafferty | Durham Patient Reference Group Representative | | | | | | | M (1) |
| Diane Richardson | Lead Nurse, Safeguarding Children | | | | M (2) | | | |
| Dr David Smart (until 30/09/14) | Constituency GP Lead | M (5) | | M (3) | M (5) | C (4) | M (1) | |

| Name | Title | Governing Body Meetings: 8 | Management Executive Meetings: 22 | Risk and Audit Meetings: 5 | Quality Research and Innovation * Meetings: 11 | Finance and Performance Meetings: 10 | Remuneration and Terms of Service Meeting: 1 | Patient, Public and Carer Engagement Committee Meetings: 2 |
|---|---|---|---|---|---|---|---|---|
| Dr David Smart (from 1/10/14) | Clinical Chair | C (3) | | | | | | M (2) |
| Tom Stevenson | Lay Member, Governance and Audit | M (6) | | C (5) | | M (8) | M (1) | |
| Paul Taylor | HealthWatch Representative | | | | | | | M (2) |
| Lesley Jeavons | Durham County Council Representative (Head of Adult Care) | M (3) | | | | | | |
| Anna Lynch | Director of Public Health, Durham County Council | M (4) | | | | | | |
| Dr Patrick Wright (from 1/10/14) | Constituency GP Lead, Durham | M (3) | | M (2) | M (6) | M (5) | | |

*****The membership of the Quality, Research and Innovation committee was revised in January 2015, which affected the membership of the committee.

**Key:** Member (M) Chair (C)

Further details of the membership of the Remuneration and Terms of Service committee can be found in the Remuneration Report.

# NHS North Durham CCG Governing Body members 2014/15 declarations of interests:

| Name | Title | Declaration detail |
|---|---|---|
| Dr Kate Bidwell | Chair (until 30 September 2014) | GP Partner, Parkhouse Surgery<br>Homeopath - providing NHS and private services<br>Trustee of the NHS County Durham and Darlington Health Improvement Fund<br>Stakeholder representative on the Board of Directors of Investing in Children Community Interest Board<br>Member of the North Durham Primary Care Alliance |
| Dr Chandra Anand | Constituency GP Lead (Derwentside) (from 1 July 2014) | GP Partner, Cedars Medical Group<br>Parent Governor at Cramlington Learning Village<br>Member of the North Durham Primary Care Alliance<br>Clinical Lead for Learning Disabilities |
| Nicola Bailey | Chief Operating Officer | Trustee on the Board of 'In Control' a Charity that works in health, social care and education settings<br>Joint Chief Operating Officer at Durham Dales, Easington and Sedgefield CCG |
| Chris Brown | Practice Nurse Representative | Employed as a nurse practitioner in Drs Lambert and NG, Derwentside<br>Works for a practice that is a member of the North Durham Primary Care Alliance<br>Brother works for Cornforth Partnership as Manager of Durham Voice |
| Dr Ian Davidson | Director of Quality and Safety | GP Partner, Lanchester Medical Centre (formerly Parkhouse Surgery)<br>Member of the North Durham Primary Care Alliance<br>Wife is employed by Stanley Medical Group in North Durham<br>Lanchester Medical Centre has received funding |

| Name | Title | Declaration detail |
|---|---|---|
| | | for research from NHS England and 'Maydon' |
| Verna Fee | Lay Member, Patient and Public Involvement (until 31 March 2015) | Project Officer with Victim Support |
| Dr Angela Galloway | Secondary Care Doctor | Volunteer (unpaid) at St Cuthbert's Hospice, Durham, as an assistant for infection control<br>Trustee at St Cuthbert's Hospice, Durham<br>Appointed as Interim Secondary Care Doctor for Darlington Clinical Commissioning Group in December 2014 |
| Dr David Graham | Director of Primary Care Development and Innovation | GP partner, Queen's Road Surgery<br>Member of the North Durham Primary Care Alliance<br>School Governor, Hexham Middle and Queen Elizabeth School<br>Research Lead at Queen's Road Surgery |
| Richard Henderson | Chief Finance Officer | None |
| Feisal Jassat | Lay Member, Patient and Public Involvement (from 1 April 2015) | Vice-Chair of Age UK, Durham<br>Chair of Chester-le-Street and District Area Action Partnership<br>Trustee of Wheels 2 Work Chester-le-Street<br>Member of the North East Advisory Committee on Clinical Excellence Awards<br>Vice-Chair of Governors of the Hermitage Academy (Chester-le-Street) |
| Liz Herring | Director of Nursing, Quality and Development | None |
| Michael Houghton | Director of Commissioning and Development | None |

| Name | Title | Declaration detail |
|---|---|---|
| Lesley Jeavons | Durham County Council Representative | Employee of Durham County Council<br>Chair of County Durham Safeguarding Adults Board<br>Governor of Tees, Esk and Wear Valley NHS Foundation Trust (appointed) |
| Maureen Kersley | Practice Manager Representative | Employed as Business Manager at Bowburn Medical Centre<br>Member of the North Durham Primary Care Alliance<br>Bowburn Medical Centre is a research practice<br>Trustee of Woodham Christian Centre Ltd |
| Dr Richard Lilly | Constituency GP Lead (Chester-le-Street) | GP Partner, Bridge End Surgery<br>Member of the North Durham Primary Care Alliance<br>Wife is GP Partner in Claypath and University Medical Group<br>Bridge End Surgery is a research practice<br>Mental Health clinical lead for North Durham CCG |
| Anna Lynch | Director of Public Health | Statutory Chief Officer, Durham County Council<br>Chair of the East Durham Domestic Violence Forum<br>Member of Durham Dales, Easington and Sedgefield CCG Governing Body<br>Trustee of NHS County Durham and Darlington Health Improvement Fund |
| Dr Neil O'Brien | Clinical Chief Officer | GP Partner, Cestria Health Centre<br>Surgery provides intermediate level service in ear, nose and throat, dermatology, minor surgery and palpations<br>Member of the North Durham Primary Care Alliance<br>Wife works at County Durham and Darlington NHS Foundation Trust |

| Name | Title | Declaration detail |
|---|---|---|
| Dr David Smart | Constituency GP Lead (Durham) (until 30/9/14)<br><br>Clinical Chair (from 1/10/14) | Member of the North Durham Primary Care Alliance<br><br>GP Partner, Dunelm Medical Practice<br><br>GP Trainer, Northumbria GP training programme<br><br>GP Appraiser, Durham, Darlington and tees Area Team<br><br>Clinical Lead for COPD<br><br>Trustee of the Ferryhill Station, Mainsforth and Bishop Middleham Aid-in-Sickness charity<br><br>CCG member on the Board of Governors for Tees, Esk and Wear Valleys NHS Foundation Trust (representing North Durham CCG, Durham Dales, Easington and Sedgefield CCG and Darlington CCG)<br><br>CCG member on the Board of Governors for County Durham and Darlington NHS Foundation Trust |
| Tom Stevenson | Lay Member, Governance and Audit | None |
| Dr Pat Wright | Constituency GP Lead (Durham) (from 1 October 2014) | Part-time GP Partner at Belmont and Sherburn Medical Group<br><br>GP with a special interest in the management of male sexual dysfunction via an NHS funded clinic<br><br>Committee member for the British Society for Sexual Medicine and Fellow of the European Society of Sexual Medicine<br><br>Lecturer for primary care colleagues regarding assessment and management of male sexual dysfunction and male urological disorders, some of which have been sponsored by pharmaceutical companies |

Where any interests are identified, these are declared by the relevant individual and appropriate action will be agreed, including that the individual concerned withdraws from discussions where appropriate.

# Governing Body member profiles

**Dr Kate Bidwell, Chair (1 April to 30 September 2014)**
Dr Bidwell has been a GP for the last 29 years initially in South Shields, then in Stanley and for the last ten years in Lanchester.

**Dr David Smart, Constituency GP Lead (Durham) (1 April to 30 September 2014) and then Chair (from 1 October 2014)**
Dr Smart studied at the University of Glasgow and became a GP principal at Dunelm Medical Practice in 1985. He was a member of Durham and Chester-le-Street Primary Care Group (and later Primary Care Trust). Dr Smart is a GP trainer and appraiser and is the lead for commissioning within his general practice.

**Dr Neil O'Brien, Clinical Chief Officer**
Dr O'Brien has been a local GP in Chester-le-Street for 15 years. He has been the Accountable Officer and Clinical Lead for the CCG since the organisation was established in April 2013.

**Dr Chandra Anand, Constituency GP Lead (Derwentside) (from 1 July 2014)**
Dr Anand qualified in Medicine from the University of Birmingham Medical School. She gained membership of the Royal College of General Practitioners with Merit in 1999. She has been a GP for 16 years initially in Northumberland and then in Derwentside since 2004. She is a GP Trainer.

**Nicola Bailey, Chief Operating Officer**
Nicola was the acting Chief Executive for Hartlepool Borough Council and has previously held posts such as Director of Child and Adult Services. With over 20 years' managerial and leadership experience in the public sector she has extensive experience in managing and leading organisations through change, developing integrated services and solutions and working at a senior board level.

**Richard Henderson, Chief Finance Officer**
Richard is a qualified accountant (ACA) and brings significant financial experience to the CCG from a broad range of private and public sector organisations. Richard trained as an auditor with Deloitte LLP, working with a variety of organisations, before joining the NHS in a senior finance role at County Durham Primary Care Trust.

**Verna Fee, Lay Member, Patient and Public Involvement**
Verna spent 35 years working in local government and the NHS before taking early retirement in 2010. She has worked extensively in the fields of community development, partnership working and community engagement.

**Tom Stevenson, Lay Member, Governance and Audit**
Tom has 11 years' experience as a Finance Director in the social housing sector for two new large scale voluntary transfer organisations and an arms-length management organisation. He trained as a chartered accountant with Arthur Young, one of the largest accountancy firms in Scotland before moving to Tennent Caledonian Breweries as a retail accountant.

**Dr Liz Herring, Director of Nursing, Quality and Development**
Dr Herring qualified as a registered general nurse in 1990 and has since undertaken NHS management roles following her work as a nurse and clinical nurse specialist. She has worked across the range of acute, community, clinical network and commissioning services.

**Michael Houghton, Director of Commissioning and Development**
Michael brings significant experience from a variety of roles in local government, the NHS, the private and not for profit sector within County Durham and Darlington. Michael has held a number of senior leadership roles in mental health, community and primary care with extensive experience of partnership working, planning commissioning and improving services for patients.

**Dr Ian Davidson, Director of Quality and Safety**
Dr Davidson has been a GP Principal at Park House Surgery in Lanchester since 2003. He currently chairs the County Durham and Darlington Area Prescribing Committee and the Drug and Therapeutic Committee. He is the Accountable Officer for Controlled Drugs for NHS County Durham and Darlington. Dr Davidson was awarded a fellowship of the Royal College of General Practitioners in 2011.

**Dr David Graham, Director of Primary Care Development and Innovation**
Dr Graham began his career in hospital medicine, particularly cardiology. He then moved to a career in General Practice 20 years ago, initially in Hexham before moving seven years ago to Queens Road Surgery, Consett.

**Dr Gim Ong, Constituency GP Lead (Derwentside) (until 30 June 2014)**
Dr Gim Ong has been a Partner at Consett Medical Centre since 2007. Previously he undertook GP Vocational Training Scheme near Warrington and subsequently worked as a GP Locum in the North West, North East and for Her Majesty's Prison Services.

**Dr Richard Lilly, Constituency GP Lead (Chester-le-Street)**
Dr Lilly has been a GP partner at Bridge End Surgery, Chester-le-Street since 1985. He has been involved in GP commissioning for many years and was Chair of Durham and Chester-le-Street Practice Based Commissioning consortium.

**Dr Angela Galloway, Secondary Care Clinician**
Dr Galloway worked as a consultant in St Helens and Knowsley before moving to the North East in 1988 where she held a number of posts in Durham and Newcastle. Prior to her retirement in 2011, Angela worked closely with paediatricians in a number of specialist units (intensive care, bone marrow transplant, infectious diseases and renal).

**Chris Brown, Practice Nurse Representative**
Chris trained as a nurse at Shotley Bridge Hospital, Consett and worked in orthopaedics and out-patients before training as a midwife at University Hospital of North Durham. She has worked as a practice nurse and nurse practitioner.

**Maureen Kersley, Practice Manager Representative**
Maureen Kersley has worked in the NHS since leaving school. She has been a Practice Manager since 1994 with a short two year break when she worked in The County Durham Primary Care Trust. She is currently the Business Manager at Bowburn Medical Centre.

**Anna Lynch, Director of Public Health, Durham County Council**
Anna has been the Director of Public Health for County Durham since 2006. Before that she worked as Director of Public Health for Easington and held various roles in health promotion, the NHS and within local authorities in the North West.

**Lesley Jeavons, Head of Adult Care, Durham County Council**
A nurse by profession, Lesley left the NHS and moved to local government in 1994 where her roles included frontline services, staff development and project management. She took up her current post in 2007 and is responsible for care management, safeguarding and in-house provision.

**Dr Pat Wright, Constituency GP Lead (Durham) (from 1 October 2014)**
Dr Wright has worked as a GP partner at Belmont and Sherburn medical group since 1985 acquiring 30 years of clinical and managerial experience. Apart from his primary role as a GP partner he has considerable experience of clinical research in the field of urology. He provides an NHS commissioned community based clinic in Belmont, as a specialist practitioner in the management of male sexual dysfunction/andrology.

## Disclosure of information to auditors

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

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

Dr Neil O'Brien
Accountable Officer
28 May 2015

# Remuneration report

## Remuneration report

### Remuneration and Terms of Service Committee

The Remuneration and Terms of Service (RATS) Committee was established to advise the Governing Body about pay, other benefits and terms of employment for the Chief Officer and other senior staff. The Committee is made up as follows:

| | |
|---|---|
| Kate Bidwell | CCG Chair and Chair of RATS Committee (from 1 April 2014 to 30 September 2014) |
| Dr David Smart | GP Constituency Lead Representative (from 1 April 2014 to 30 September 2014) and then CCG Chair and Chair of RATS Committee (from 1 October 2014) |
| Verna Fee | Lay Member for Patient and Public Involvement (from 1 April 2014 to 31 March 2015) |
| Feisal Jassat | Lay Member for Patient and Public Involvement (from 1 April 2015) |
| Tom Stevenson | Lay Member for Governance and Audit |
| Dr Patrick Wright | GP Constituency Lead Representative (from 1 October 2014) |

The RATS Committee has delegated authority from the Governing Body to make recommendations on determinations about pay and remuneration for employees of the CCG and people who provide services to the CCG. The committee met once during 2014/15, with all four individuals above present at the meeting.

The remuneration for senior managers for current and future financial years is determined in accordance with relevant guidance, best practice and national policy.

Continuation of employment for all senior managers is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to any senior managers during the year and there are no plans to make such payments in future years. This is in accordance with standard NHS terms and conditions of service and guidance issued by the Department of Health.

Contracts of employment in relation to all senior managers employed by the CCG are permanent in nature and subject to between three and six months' notice of termination by either party. The Constituency GP Leads, practice manager and practice nurse representatives are not directly employed by the CCG, with their services provided through separate agreements between the CCG and the respective GP practices. These agreements run for a fixed term of 24 months.

Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the *NHS Pension Scheme Regulations* for those who are members of the scheme. No awards have been made during the year to past senior managers.

For the purpose of this remuneration report, the definition of 'senior managers' is as per the Manual for Accounts 2014/15 published by the Department of Health:

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

It is considered that the Governing Body members represent the senior managers of the CCG.

Details of the relevant salaries and allowances for all of the senior managers of the CCG can be found in the tables below, both for 2014/15 and also relevant comparative figures for 2013/14.

**Important Note regarding 'All Pension Related Benefits' stated in the tables below:**

Please note the amount included here is the annual increase in pension entitlement expected **over twenty years**. This value has been determined in accordance with the HMRC method of calculation, in accordance with guidance from NHS England. Employee pension contributions made in 2014/15 have been deducted from the total. Pension related benefits shown in the table above relate to the NHS pension scheme members only**. The figure shown is not intended to reflect annual remuneration received by the individual during the financial year.**

## NHS North Durham CCG senior officers' salaries and allowances - 2014/15:

| Name | Title | 2014/15 | | | | | |
|---|---|---|---|---|---|---|---|
| | | Salary and Fees (Bands of £5,000) £000 | Taxable Benefits (Rounded to the nearest £00) £00 | Annual Performance Related Bonuses (Bands of £5,000) £000 | Long-term Performance Related Bonuses (Bands of £5,000) £000 | All Pension Related Benefits (Bands of £2,500) £000 | Total (Bands of £5,000) £000 |
| Dr N O'Brien | Clinical Chief Officer | 90 – 95 | - | - | - | 40 – 42.5 | 130 – 135 |
| N Bailey | Chief Operating Officer | 70 – 75 | 44 | - | - | - | 75 - 80 |
| Dr I Davidson | Director of Quality and Safety | 65 – 70 | - | - | - | - | 65 – 70 |
| Dr D Graham | Director of Primary Care Development and Innovation | 50 – 55 | - | - | - | 2.5 – 5 | 55 – 60 |
| R Henderson | Chief Finance Officer | 90 – 95 | - | - | - | 20 – 22.5 | 110 – 115 |
| Dr L Herring | Director of Nursing, Quality and Development | 80 – 85 | 20 | - | - | 30 – 32.5 | 115 – 120 |
| M Houghton | Director of Commissioning and Development | 80 – 85 | 32 | - | - | 35 – 37.5 | 120 – 125 |
| | | | | | | | |
| Dr K Bidwell | Chair | 30 – 35 | - | - | - | - | 30 – 35 |
| V Fee | Lay Member, Patient and Public Involvement | 5 – 10 | - | - | - | - | 5 – 10 |
| T Stevenson | Lay Member, Governance and Audit | 5 – 10 | - | - | - | - | 5 – 10 |
| Dr A Galloway | Secondary Care Clinician | 5 – 10 | - | - | - | - | 5 – 10 |
| Dr R Lilly | GP Constituency Lead | 35 – 40 | - | - | - | - | 35 – 40 |
| Dr G Ong | GP Constituency Lead (from 1 April 2014 to 30 June 2014) | 5 – 10 | - | - | - | - | 5 – 10 |
| Dr D Smart | GP Constituency Lead (from 1 April 2014 to 30 September 2014) and Chair (from 1 October 2014) | 45 – 50 | - | - | - | - | 45 – 50 |
| Dr C Anand | GP Constituency Lead (from 1 July 2014) | 30 – 35 | - | | | - | 30 – 35 |
| Dr P Wright | GP Constituency Lead (from 1 October 2014) | 15 – 20 | - | | | - | 15 – 20 |
| C Brown | Practice Nurse Representative | 10 – 15 | - | - | - | - | 10 – 15 |
| M Kersley | Practice Manager Representative | 5 – 10 | - | - | - | - | 5 – 10 |
| | | | | | | | |
| A Lynch | Director of Public Health | - | - | - | - | - | - |
| L Jeavons | Durham County Council Representative | - | - | - | - | - | - |

## NHS North Durham CCG senior officers' salaries and allowances - 2013/14 comparative figures:

| Name | Title | 2013/14 | | | | | |
|---|---|---|---|---|---|---|---|
| | | Salary and Fees (Bands of £5,000) £000 | Taxable Benefits (Rounded to the nearest £00) £00 | Annual Performance Related Bonuses (Bands of £5,000) £000 | Long-term Performance Related Bonuses (Bands of £5,000) £000 | All Pension Related Benefits (Bands of £2,500) £000 | Total (Bands of £5,000) £000 |
| Dr N O'Brien | Clinical Chief Officer | 90 - 95 | - | - | - | - | 90 - 95 |
| N Bailey | Chief Operating Officer | 140 - 145 | 84 | - | - | - | 150 - 155 |
| Dr I Davidson | Director of Quality and Safety | 50 - 55 | - | - | - | - | 50 - 55 |
| Dr D Graham | Director of Primary Care Development and Innovation | 50 - 55 | - | - | - | 22.5 - 25 | 75 - 80 |
| R Henderson | Chief Finance Officer | 85 - 90 | - | - | - | 45 - 47.5 | 130 - 135 |
| Dr L Herring | Director of Nursing, Quality and Development | 75 - 80 | 19 | - | - | 70 - 72.5 | 150 - 155 |
| M Houghton | Director of Commissioning and Development | 75 - 80 | 26 | - | - | 67.5 - 70 | 145 - 150 |
| | | | | | | | |
| Dr K Bidwell | Chair | 65 - 70 | - | - | - | 112.5 - 115 | 180 - 185 |
| V Fee | Lay Member, Patient and Public Involvement | 5 - 10 | - | - | - | - | 5 - 10 |
| T Stevenson | Lay Member, Governance and Audit | 5 - 10 | - | - | - | - | 5 - 10 |
| Dr A Galloway | Secondary Care Clinician | 5 - 10 | - | - | - | - | 5 - 10 |
| Dr R Lilly | GP Constituency Lead | 35 - 40 | - | - | - | - | 35 - 40 |
| Dr G Ong | GP Constituency Lead | 35 - 40 | - | - | - | - | 35 - 40 |
| Dr D Smart | GP Constituency Lead | 35 - 40 | - | - | - | - | 35 - 40 |
| C Brown | Practice Nurse Representative | 10 - 15 | - | - | - | - | 10 - 15 |
| M Kersley | Practice Manager Representative | 5 - 10 | - | - | - | - | 5 - 10 |
| | | | | | | | |
| A Lynch | Director of Public Health | - | - | - | - | - | - |
| L Jeavons | Durham County Council Representative | - | - | - | - | - | - |

**Notes:**

The taxable benefits included in the tables above all relate to lease car benefits.

No performance related benefits have been agreed for any senior officers.

No pension related benefits are included for the Chief Operating Officer in either 2014/15 or 2013/14, or for the Clinical Chief Officer in 2013/14, as there was no increase in pension entitlement for those individuals in the respective financial year once employee contributions are removed.

All pension related benefits disclosed in this report relate to 'officer employment' only, i.e. for any general practitioners, the figures exclude any benefits derived from practitioner employment.

The Clinical Chief Officer role involves a total of five sessions per week (0.5 whole time equivalent). The remuneration above for both 2013/14 and 2014/15 reflects the total amount payable for the number of sessions involved.

The following senior officers are not directly employed by the CCG. The amounts disclosed above in both 2013/14 and 2014/15 are paid to the respective GP practice as the employing organisation, to provide the services of the individuals on a sessional basis:

| | |
|---|---|
| Dr R Lilly | Constituency GP Lead |
| Dr G Ong | Constituency GP Lead (from 1 April 2013 to 30 June 2014) |
| Dr D Smart | Constituency GP Lead (from 1 April 2013 to 30 September 2014) and then CCG Chair (from 1 October 2014) |
| Dr C Anand | Constituency GP Lead (from 1 July 2014) |
| Dr P Wright | Constituency GP Lead (from 1 October 2014) |
| C Brown | Practice Nurse Representative |
| M Kersley | Practice Manager Representative |

The following senior officers are not employed by the CCG and receive no remuneration from the CCG for their role as Governing Body members:

| | |
|---|---|
| A Lynch | Director of Public Health |
| L Jeavons | Durham County Council Representative |

The following senior officer has been employed in a joint post shared with Durham Dales, Easington and Sedgefield (DDES) CCG since 1 March 2014:

| | |
|---|---|
| N Bailey | Chief Operating Officer |

No costs were recharged to Durham Dales, Easington and Sedgefield CCG for this post for the month of March 2014 on the grounds of materiality and as a result the

remuneration included above for 2013/14 represents the full amounts earned by the individual for all work across North Durham CCG and Durham Dales, Easington and Sedgefield CCG in that year. From 1 April 2014, the remuneration for this joint post has been apportioned on a 50:50 basis between North Durham CCG and Durham Dales, Easington and Sedgefield CCG, hence the remuneration included above for 2014/15 represents only the share that relates to the North Durham CCG role.

The total remuneration earned by the individual for all work across the two CCGs in 2014/15 is shown below:

| Name | Title | 2014/15 | | |
|---|---|---|---|---|
| | | Salary and Fees (Bands of £5,000) £000 | Taxable Benefits (Rounded to the nearest £00) £00 | Total (Bands of £5,000) £000 |
| N Bailey | Chief Operating Officer | 140 - 145 | 87 | 150 - 155 |

## Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the CCG in the financial year 2014/15 was £90-95k (2013/14: £150–155k). This was 2.6 times (2013/14: 3.76 times) the median remuneration of the workforce, which was £35,536 (2013/14: £40,558).

In 2014/15, one employee (2013/14: one employee) received a full time equivalent remuneration in excess of the highest paid director. Full time equivalent remuneration for employees ranged from £7,822 to £186,020 (2013/14: £7,822 to £186,020).

For the purposes of identifying the highest paid director for this disclosure, it is the cost to the CCG of an individual that is considered, rather than the total of that individual's remuneration. In 2013/14 the highest paid director in the CCG was the Chief Operating Officer. From 1 March 2014 that post became a shared role with Durham Dales, Easington and Sedgefield CCG, with remuneration apportioned between the two CCGs on a 50:50 basis. As a result, it is only the North Durham CCG share of remuneration for that post which is considered in calculating the highest paid director and this is reflected in the reduction in the banded remuneration of the highest paid director compared to 2013/14.

The remuneration of £7,822 relates to the CCG's lay members who receive an annual remuneration for a time-commitment below the CCG's normal contractual hours. As

this represents the annual remuneration for the full required time-commitment, this is considered to represent the full time equivalent remuneration for that role although it relates to a time-commitment significantly below the CCG's normal contractual hours.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. Accordingly the total remuneration figures reflected here exclude the pension related benefits shown in the salaries and allowances table on page 61.

| | 2014/15 | 2013/14 |
|---|---|---|
| | | |
| Band of Highest Paid Director's Total Remuneration (£'000) | 90 – 95 | 150 – 155 |
| | | |
| Median Total Remuneration (£) | 35,536 | 40,558 |
| | | |
| Ratio | 2.60 | 3.76 |

The reduction in the ratio between the median remuneration and the highest paid director largely reflects the reduction in the highest paid directors remuneration following the changes to the Chief Operating Officer role as highlighted above.

There have been no other significant changes to remuneration of other staff within the CCG during the year. Due to the small number of staff employed by the CCG, the median remuneration can be impacted by relatively small changes.

## NHS North Durham CCG senior officers' pension benefits 2014/15:

| Name and Title | Real increase / (reduction) in pension at age 60 (bands of £2,500) £000 | Real increase / (reduction) in Pension Lump Sum at aged 60 (bands of £2,500) £000 | Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £000 | Lump Sum at aged 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000 | Cash Equivalent Transfer Value at 1 April 2014 £000 | Real increase in cash equivalent transfer value £000 | Cash Equivalent Transfer Value at 31 March 2015 £000 | Employer's contribution to stakeholder pension £000 |
|---|---|---|---|---|---|---|---|---|
| Dr N O'Brien<br>Clinical Chief Officer | 0 - 2.5 | 5 - 7.5 | 5 - 10 | 15 - 20 | 57 | 33 | 90 | - |
| N Bailey<br>Chief Operating Officer | 0 - 2.5 | - | 80 - 85 | - | 930 | 29 | 959 | - |
| R Henderson<br>Chief Finance Officer | 0 - 2.5 | - | 5 - 10 | - | 51 | 15 | 67 | - |
| Dr L Herring<br>Director of Nursing, Quality and Development | 0 - 2.5 | 5 - 7.5 | 25 - 30 | 80 - 85 | 411 | 41 | 452 | - |
| M Houghton<br>Director of Commissioning and Development | 0 - 2.5 | 5 - 7.5 | 25 - 30 | 80 - 85 | 431 | 47 | 477 | - |
| Dr D Graham<br>Director of Primary Care Development and Innovation | 0 - 2.5 | 0 - 2.5 | 15 - 20 | 50 - 55 | 293 | 9 | 302 | |
| Dr K Bidwell<br>Clinical Chair (until 30 September 2014) | 0 - 2.5 | 0 - 2.5 | 10 - 15 | 30 - 35 | 196 | N/A | N/A | - |

The table above includes only those senior managers where the CCG makes contributions direct to a pension scheme as an employer.

The figures included above reflect total pension benefits accrued within the NHS Pension Scheme, not just those accrued from employment within the CCG. No lump sum is shown for employees who only have membership in the 2008 section of the NHS Pension Scheme.

Dr K Bidwell retired on 30 September 2014, therefore no cash equivalent transfer value is shown as at 31 March 2015 and all figures included in the table above for Dr K Bidwell reflect only the 6 month period to 30 September 2014.

## Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

## Real increase in cash equivalent transfer values

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

Dr Neil O'Brien
Accountable Officer
18 May 2015

# Statement of the Accountable Officer's responsibilities

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

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

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

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

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

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

Dr Neil O'Brien
Accountable Officer
28 May 2015

# Governance statement

## Governance Statement by Dr Neil O'Brien as the Accountable Officer of NHS North Durham Clinical Commissioning Group

### 1. Introduction and Context

1.1 The clinical commissioning group (CCG) was licenced from 1 April 2013 under provisions enacted in the *Health and Social Care Act 2012*, which amended the *NHS Act 2006*.

1.2 The clinical commissioning group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the CCG taking on its full powers. As at 1 April 2013, the CCG was licensed without conditions and this has remained the case throughout 2014/15.

### 2. Scope of responsibility

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

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

### 3. Compliance with the UK Corporate Governance Code

3.1 Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance with the relevant principles of the Code is considered to be good practice. This Governance Statement is intended to demonstrate how the CCG had regard to the principles set out in Code considered appropriate for CCGs.

3.2 For the financial year ended 31 March 2015, and up to the date of signing this statement, we complied with the provisions set out in the Code, and applied the principles of the Code.

### 4. The Clinical Commissioning Group Governance Framework

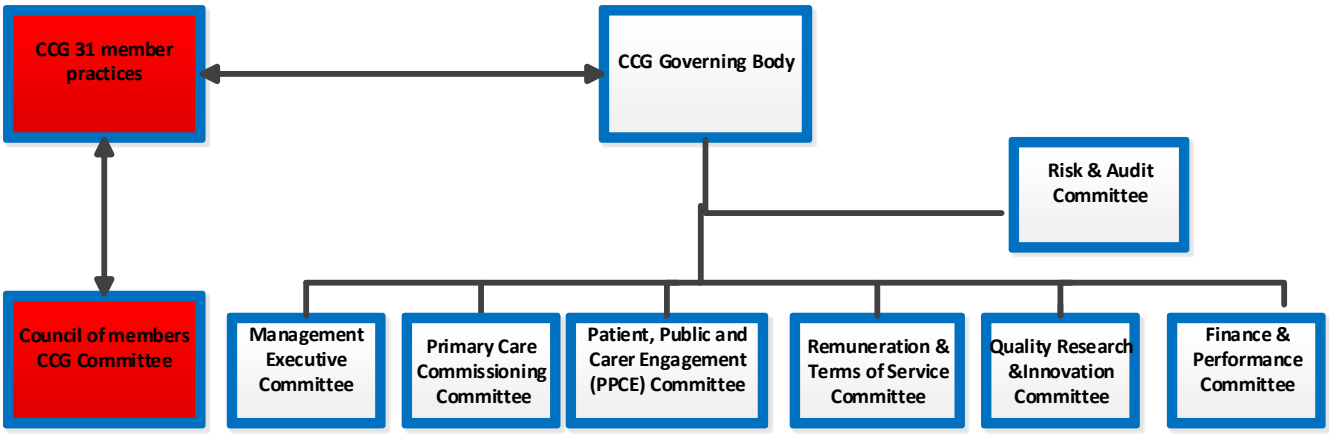
4.1 The National Health Service Act 2006 (as amended), at paragraph 14L(2) (b) states:
*The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted*

*principles of good governance as are relevant to it.*

4.2 The CCG has a Constitution based on the model template published by NHS England, which has been amended and approved to take into account subsequent guidance. Review of the CCG's Constitution confirms that it complies with the elements of the self-certification checklist, including:

- specifying the arrangements made by the CCG for the discharge of its functions,
- specifying the arrangements made by the CCG for the discharge of the functions of the Governing Body,
- the procedures to be followed by the CCG in making decisions,
- the arrangements it has made to secure that individuals to whom health services are being or may be provided pursuant to its commissioning arrangements are involved,
- arrangements made by the CCG for discharging its duties in respect of registers of interests and management of conflicts of interests,
- arrangements made by the CCG for securing that there is transparency about the decisions of the group and the manner in which they are made.

4.3 The CCG has operated since 1 April 2013 with a committee structure which reflects guidance and best practice, including a Remuneration and Terms of Service Committee and a Risk and Audit Committee. Terms of reference have been agreed for all committees which support the organisation in the delivery of effective governance. The terms of reference are included as appendices to the CCG's Constitution which can be found on the CCG's website. The members report section of the Annual Report provides further detail relating to the membership practices, the role of the Council of Members, Governing Body and other committees, including membership and meeting attendance records. The organisational structure including key committees is included in the CCG's Constitution and is set out below;




4.4 The only change to the CCG committee structure during 2014/15 has been the introduction of a Patient, Public and Carer Engagement (PPCE) Committee, reporting in to the CCG Governing Body. Further details of the role of that Committee can be found below.

4.5 With effect from 1 April 2015, NHS England has delegated responsibility to the CCG for the commissioning of certain primary medical care services. This has necessitated the formation of a Primary Care Commissioning Committee from that date, as a Committee of the CCG Governing Body, in accordance with the terms of the delegation from NHS England and in line with relevant national guidance. The role of the Committee will be to carry out the functions of primary care commissioning as per the delegation agreement with NHS England, with all decisions of the Committee being binding on the CCG and NHS England.

4.6 The governance arrangements in place meet the requirements of best practice guidance in respect of risk management and ensure that a strong accountability framework has been established. They reflect the public service values of accountability, probity and openness and specify as Accountable Officer my responsibility for ensuring that these values are met within the Clinical Commissioning Group.

4.7 The Governing Body has an ongoing role in reviewing the CCG's governance arrangements to ensure that these continue to reflect the principles of good governance. The Risk and Audit Committee plays a key role in supporting this by providing assurance to the Governing Body around the risk and governance processes within the CCG.

4.8 During the year 2014/15 the CCG's Governing Body met on eight occasions with all meetings held in public. An annual business cycle is in place, with agendas structured to deal with strategic, performance, quality assurance, risk and governance issues. Highlights of the work performed during the year by the Governing Body within this business cycle include:

- approval of CCG strategic and operational plans, including overall vision, aims and objectives,
- review and approval of CCG budgets for the year,
- agreement of a public and patient engagement plan, including CCG membership model and formation of a PPCE Committee,
- refresh of CCG Constitution for approval by Council of Members,
- review and approval of corporate governance arrangements,
- review and agreement of delegated primary care commissioning arrangements,
- monthly review of progress against plans, financial targets, performance measures, clinical quality standards and significant risks to the CCG.

**4.9 Description of the established Governing Body Committees**

The roles of each of the Governing Body Committees are set out broadly below. The Governing Body Committees have authority under the Scheme of Reservation and Delegation to establish sub-committees or sub-groups to enable them to fulfill their role. Each of the Governing Body Committees has detailed Terms of Reference which are referenced within the CCG's Constitution and are available on the CCG's website. Each committee is authorised by the Governing Body to pursue any activity within its terms of reference and within the Scheme of Reservation and Delegation.

### 4.9.1 Remuneration and Terms of Service Committee

The Committee is established to make recommendations to the Governing Body on pay and remuneration for senior employees of the CCG and people who provide services to the CCG. This includes remuneration for executive officers as well as the Chair and independent lay members and other Governing Body members. The Committee also considers any business cases for early retirement and redundancy.

The Committee met once on 27 August 2014 in order to review all relevant senior managers' remuneration for the year and make relevant recommendations to the Governing Body, with no further meetings required to date.

### 4.9.2 Risk and Audit Committee

The Risk and Audit Committee supports the Governing Body in its main function of ensuring the CCG has made appropriate arrangements to ensure functions are exercised effectively, efficiently and economically and that all relevant principles of good governance are adhered to.

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the Committee provides the CCG with an independent and objective review of systems of internal control, risk and governance processes and arrangements, and compliance with laws, guidance, and regulations governing the NHS. The Committee is a non-executive committee of the Governing Body and has no executive powers.

The Committee's cycle of business includes review of the CCG's risk management processes, including the Assurance Framework and corporate risk register. The Committee considers the work of both internal and external audit, together with other assurance functions including in particular those relating to North of England Commissioning Support (NECS), upon which the CCG is dependent for the majority of commissioning support, to fulfil its role of providing assurance to the Governing Body.

The Risk and Audit Committee, as part of its terms of reference, provides an Annual Report of its work to the Governing Body, as well as providing interim updates as required. The draft report covering the financial year 2014/15 was made available alongside the final Annual Report and Accounts in May 2015 to support the final Governance Statement. The principal purpose of the report is to provide assurance to the Governing Body and to support the Accountable Officer's review of the internal control arrangements. The Risk and Audit Committee has a business cycle which enables the Committee to carry out its key objectives necessary to support its assurances regarding the effectiveness of the organisation's internal controls.

During the year, the Committee has fulfilled this annual business cycle, with key work completed by the Committee including:

- appointment of internal auditors, agreement of the internal audit plan and review of progress against that plan,
- review of risk management processes, including risk management policy,

assurance framework and corporate risk register,
- review and agreement of financial governance arrangements , including standing financial instructions,
- review of assurance processes and reports in respect of outsourced functions,
- review and approval of the annual accounts and Annual Report of the CCG under delegated authority from the Governing Body.

The Committee has undertaken a self-assessment against both the requirements of the NHS Audit Committee Handbook and other areas of best practice. The outcome of this work has been incorporated into the business cycle for the Committee.

### 4.9.3 Management Executive

The Governing Body has delegated the day to day operational management of the CCG to the Management Executive. This includes the implementation and delivery of plans agreed by the Governing Body.

As with all other committees, the Management Executive has an agreed business plan. It usually meets twice per month and has met 22 times. Highlights of the work performed during the year by the Management Executive include:

- detailed review and refresh of CCG strategic and operational plans, including development of a primary care strategy,
- prioritisation of commissioning intentions and agreement of a delivery plan for the year, including monthly review of progress against the delivery plan,
- review of clinical quality indicators and concerns, along with performance against NHS Constitution targets and outcome indicators,
- monthly review of the financial position, together with review and agreement of non-recurring funding schemes in the year,
- monthly review of CCG risk register and detailed review of the assurance framework,
- review and approval of CCG policies and procedures.

### 4.9.4 Finance and Performance Committee

The Finance and Performance Committee supports the CCG to achieve financial balance, including delivery of quality, innovation, productivity and prevention (QIPP) financial targets, and organisational performance objectives, through reviewing performance in-year and implementing any relevant actions as required.

The Finance and Performance Committee met ten times during the year and its work has included:

- development of CCG budgets for the year, followed by monthly review of financial position, including performance against the agreed QIPP plan,
- monthly review of activity and financial performance on major healthcare contracts, with agreement of relevant actions as required including contract management queries and agreement of practice variation reporting,
- monthly review of performance against NHS Constitution targets and outcome

indicators with agreement of mitigating actions as required,
- review and update of relevant finance and performance risks.

### 4.9.5 Quality, Research and Innovation Committee

The duties of the Quality, Research and Innovation Committee are driven by the priorities for the CCG and any associated risks or areas of clinical quality across commissioned services and primary care services. The CCG also has a duty to make the best use of research and innovation to deliver health gain and improve patient safety and experience through services commissioned. A key component of innovation is being aware of existing best practice and seeking to embed it in the CCG's commissioned services. It is also required to benchmark practice against national and local standards to measure the effectiveness of services commissioned.

The Quality, Research and Innovation Committee met eleven times during the year and its work has included:

- monthly review of the clinical quality standards of our health care providers,
- agreement of the annual CQUIN (commissioning quality and innovation) schemes,
- development of a quality improvement scheme to drive up quality in primary care,
- the delivery of a commissioner assurance visit programme and oversight of the improvement actions required for better patient experience,
- a forward plan for clinical audit, measuring the effectiveness of commissioned services,
- clinical agreement of new service specifications and expected clinical outcomes for patients,
- quarterly review and management of clinical quality risks,
- oversight of the programme of clinical research and implications for practice,
- quarterly assurance that we meet statutory safeguarding requirements,
- the integration of Mid Staffordshire recommendations into commissioning processes,
- compliance with the safe management and storage of controlled drugs.

### 4.9.6 Patient, Public and Carer Engagement Committee

The PPCE Committee has been established during the year to provide assurance to the CCG Governing Body in relation to patient, public and carer engagement. The Committee will develop the communications and engagement strategy of the CCG, review, challenge and evaluate CCG engagement processes and provide a two way communication channel between the CCG and patients, public and carers.

The first meeting of the Committee took place on 10 December 2014 and the Committee meets on a bi-monthly basis, with work to date focused on the development of the CCG's communications and engagement strategy.

### 4.9.7 Primary Care Commissioning Committee

The Primary Care Commissioning Committee has been established with effect from 1 April 2015, in accordance with the delegation of responsibility for commissioning certain primary medical care services from NHS England. The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of delegated powers. The terms of reference of the Committee reflect relevant national guidance, with the Committee made up of a majority of non-conflicted members. All meetings of the Committee shall be held in public, with the first meeting due to take place in May 2015.

### 4.9.8 Joint Committees

The CCG has not entered into any formal joint committees with other CCGs or any other organisations. Collaborative working arrangements have been developed with a number of other CCGs, including joint arrangements with the CCGs in the North of England to determine commissioning for health gain policies and to review and approve individual funding requests, including conducting an appeals process. These joint working arrangements do not represent formal joint committees and the CCG retains responsibility for making any relevant decisions in line with the Scheme of Reservation and Delegation.

### 4.10 Review and assessment of board effectiveness and assessment of compliance with The UK Corporate Governance Code (2012)

4.10.1 In reviewing and assessing the effectiveness of the Governing Body, the guidance contained within The UK Corporate Code of Governance (2012) was further developed into a Governing Body "self-assessment" questionnaire. The guidance contained within the Code has enabled a detailed a review of Governing Body effectiveness against the following criteria – leadership, effectiveness, accountability, remuneration and relations with stakeholders on a 'comply or explain' basis. This self-assessment was supported by a dedicated session for the Governing Body to review Governing Body compliance with the Code in March 2014, which has then been used to inform the Governing Body development programme during the year. In particular, having reviewed the effectiveness of the CCG's governance framework and arrangements in relation to The UK Corporate Code of Governance, I consider that the organisation complies with the principles and standards of best practice contained within the guidance on a 'comply or explain' basis.

## 5. The CCG risk management framework

5.1 Our comprehensive approach to risk management employs best practice in compliance with accepted standards. A Risk Management Policy is in place which takes into account current guidance on risk management best practice and incorporates guidance provided by ISO 31000:2009 (formerly AZ/NZ Standard 4360:2004) and the former National Patient Safety Agency in its approach to assessing risk. It is also consistent with NHS England's Risk Management Strategy and Risk Management Policy and Procedure issued in July 2013.

5.2 The Risk Management Policy sets out the CCG's approach to the assessment and management of clinical and non-clinical risk in fulfilment of our overall objective to commission high quality and safe services. This includes the processes and procedures adopted by the CCG to identify, assess and appropriately manage risks and the detailed roles and responsibilities for risk management. It provides guidance for the systematic and effective management of risk. Key elements of the Risk Management Policy include:

- a clear statement of Governing Body and individual accountability for delivery of the policy,
- clear principles, aims and objectives of the risk management process,
- a clearly defined process for delivering the policy including an implementation plan to ensure that the framework and risk management awareness is communicated to all staff,
- details of the approach to be undertaken to assess and report risk,
- an agreed process for reporting, managing, analysing and learning from adverse events supported by a "fair blame" culture and approach,
- confirmation of the arrangements for reporting risk through the risk register.

5.3 Risk is identified and embedded in the organisation via a number of mechanisms including the incident reporting system which identifies the risks that have already (or nearly) occurred from incidents or near misses; through our strategic planning system which ensures that all organisational objectives are rated for risks to achievement of delivery; and in our performance management system which rates all objectives for risk to delivery. In addition all Governing Body reports are assessed for equality impact.

5.4 Our Risk Management Framework is the systematic application of management policies, procedures and practices to the tasks of identifying, monitoring, mitigating and managing risk. All CCG risks are recorded and managed in the electronic Safeguard Incident Risk Management System (SIRMS). Additionally the CCG Assurance Framework enables the Risk and Audit Committee and the Governing Body to ensure effective arrangements are in place for the management of risks to principal strategic objectives and for the sound governance of the organisation.

Our approach to risk management ensures:

- risk management is a cohesive element of the internal control systems within the corporate governance framework supported by robust risk management systems and processes,
- the organisation meets statutory obligations including those relating to health and safety and data protection,
- all stakeholders, staff and partner organisations are assured that the CCG is committed to managing risk appropriately,
- staff can access support and risk management training and development is provided across the organisation,
- updates and guidance reviews are communicated to all staff.

5.5 The Risk Management Policy sets out the CCG's position in respect of risk appetite, being the amount of risk that the organisation is prepared to accept, tolerate or be exposed to at any point in time. The CCG endeavours to reduce risks to the lowest possible level reasonably practicable. Where risks cannot reasonably be avoided, every effort will be made to mitigate the remaining risk. Section 7 below provides further information on how risks are identified and assessed through a comprehensive risk register, including actions taken to manage and mitigate risks. The control mechanisms which help to mitigate risk are set out in further detail as part of the internal control framework below.

5.6 Our Counter Fraud activity plays a key part in deterring risks to the organisation's financial viability and probity. An annual Counter Fraud Plan is agreed by the Risk and Audit Committee which focuses on the deterrence, prevention, detection and investigation of fraud.

5.7 Counter Fraud requirements and regulations have been specifically discussed with both the Governing Body and wider CCG employees during the year to cement their knowledge and understanding of Counter Fraud arrangements, with all employees also required to complete e-learning training.

## 6. The CCG internal control framework

6.1 A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control has been in place in the CCG for the year ended 31 March 2015 and up to the date of approval of the Annual Report and Accounts, with no significant changes to the prior year.

The CCG's system of internal control includes the governance framework and arrangements highlighted in section 4 above, with the Scheme of Reservation and Delegation, Standing Financial Instructions and supporting financial and operational policies. The Risk and Audit Committee plays a key role in reviewing the adequacy of the internal control framework and providing assurance to the Governing Body on the effectiveness of internal control arrangements.

This includes, but is not limited to, reviewing the work of internal audit who evaluate the effectiveness of the design and operation of the CCG's system of internal control.

## 6.2. Information governance

6.2.1 The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to

individuals that personal information is dealt with legally, securely, efficiently and effectively.

6.2.2 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 an Information Governance Framework in place comprising an approved strategy, a suite of approved policies and procedures, a programme of mandatory training, information risk management, incident management and has also adopted and implemented the Health and Social Care Information Centre's (HSCIC), 'Checklist for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation'.

6.2.3 The organisation has in place a standard operating procedure for the reporting of level 2 information governance incidents to the Information Commissioner. This procedure outlines the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach.

6.2.4 There have been no information governance breaches in year requiring disclosure to the Information Commissioner or within the Annual Report.

6.2.5 Information governance processes and arrangements are reviewed by the Risk and Audit Committee, with the Management Executive overseeing the day to day management of systems and processes. The CCG has also appointed a Caldicott Guardian (Ian Davidson) and Senior Information Risk Owner (Nicola Bailey).

6.2.6 The Information governance toolkit has been provided by the HSCIC to support performance monitoring of progress on information governance in the NHS. The CCG has published the HSCIC information governance toolkit and has self-assessed as being 68% overall compliant, which confirms the organisation's rating as overall 'satisfactory' in this regard. In accordance with the agreed internal audit plan for 2014/15 an audit of the information governance toolkit self-assessment was undertaken, the scope of which was to provide on-going assurance that the processes for determining scores against individual requirements was adequate. This audit concluded that significant assurance could be provided over the related controls in place around the information governance toolkit self-assessment.

6.2.7 The CCG complies with its statutory duty to respond to requests for information. During the year the CCG received 227 requests under the *Freedom of Information Act 2000* and one requests under the Data Protection Act 1998. All the requests were responded to within the statutory timescales.

**7. Risk assessment in relation to governance, risk management and internal control**

7.1 Risk is identified and embedded in the organisation via a number of mechanisms including a comprehensive risk register which identifies current and prospective risks to the organisation. As highlighted above, the risk register incorporates the full comprehensive list of all risks facing the organisation at an operational and strategic level, across the five areas of delivery, development and transition, finance, performance and quality.

7.2 The risk register captures details of the assessment of each risk in terms of consequence and likelihood to produce an overall risk score, together with the mitigating action then being taken to manage those risks.

7.3 Each risk is assigned to a responsible director, who maintains overall responsibility for the risk, with each risk also aligned to a Governing Body committee based on the respective delivery area. Finance and performance risks are aligned to the Finance and Performance Committee, quality risks are aligned to the Quality, Research and Innovation Committee, with delivery and development and transition risks being aligned to the Management Executive.

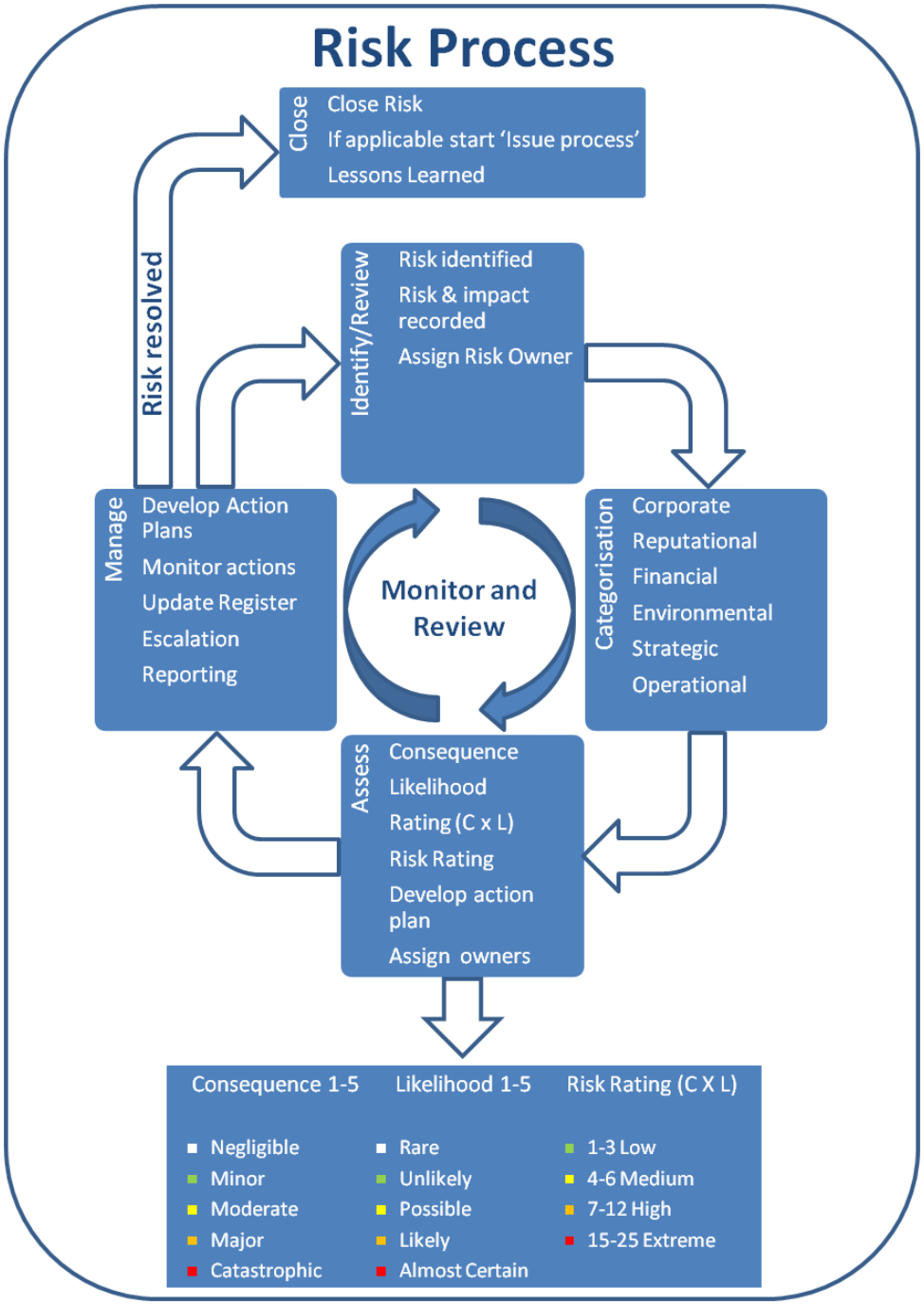
7.4 All risks are reviewed on a monthly basis by the respective aligned committee to ensure that risks are appropriately assessed and that where required action is being taken, with the Management Executive and Governing Body performing an overall review of all risks.

7.5 All corporate red risks, identified as having the potential to have a significant impact on the CCG corporate objectives, are then escalated and specifically reviewed by Governing Body.

7.6 The Risk and Assurance Committee ensures the CCG adheres to a robust risk management assessment process. Active steps are taken to ensure that it is regularly updated. In addition, all CCG policies and reports are assessed for equality impact.

7.8 The process for identifying and assessing risks within the CCG has remained unchanged throughout the year; see diagram 1 below for the CCG risk process.

***Diagram 1 CCG risk process:***




7.9 Risks have continued to be reviewed and managed during the year with a number of new risks identified during the year, together with risks closed as mitigating action is completed and issues are resolved. Details of all of the risks that have faced the CCG during the year can be found in the monthly Governing Body reports which are available on the CCG's website.

7.10 Current risks

A summary of the significant corporate red risks currently facing the CCG are as follows:

| Risk | Actions | Rating |
|---|---|---|
| **Achievement of A&E target:** Pressures on A&E services are impacting on performance against the A&E 4hr wait target by the CCG's main provider CDDFT. There is a risk that the poor performance will continue and the 95% target will not be met. | Strategic Resilience Group in place across County Durham & Darlington to monitor plans and issues and agree remedial actions as required;<br><br>A&E improvement plan agreed with CDDFT containing a range of actions now implemented / underway. This included an external review of systems and processes performed by ECIST, who are recognised specialists in emergency care;<br><br>GP practices across North Durham continue to be open on weekends to add additional capacity in to the system and provide an alternative to A&E attendances;<br><br>Additional capacity commissioned from Gateshead Foundation Trust as part of the trust's new emergency care centre. Divert policy agreed with CDDFT, NEAS and Gateshead to transfer emergency activity to the Queen Elizabeth Hospital when handover delays are greater than 30 minutes or there are other pressures at the UHND site;<br><br>Significant resilience funding invested as part of a whole systems approach to tackling A&E pressures. | **16** |
| **Increased PBR activity in Secondary Care:** There is a continued increasing trend in secondary care PBR activity. If the increasing trend continues it will impact on the demand in future years and result in a financial pressure for the CCG. | Realistic activity baselines and budgets set, incorporating pressures and trend of activity growth seen in previous years;<br><br>Additional resource identified within NECS SLA to support the management of the PbR contract;<br><br>Commissioning intentions agreed including areas such as review of outpatient attendances which will be expected to impact on activity;<br><br>Contingency funding identified within reserves to mitigate potential financial pressures;<br><br>Position monitored through finance and performance committee with a range of other actions underway, including support for practices to identify and manage contract queries, referral guidance systems, impact of primary care outcomes scheme and practice variation work. | **16** |

7.11 Future risks

The current pressures on the health service are substantial, in particular the increasing demands of an ageing and growing population must be met from constrained financial resources. This will increase the pressure on current services and potential risks around delivery of performance targets whilst maintaining quality and ensuring services are safe, within available financial resources. The introduction of the Better Care Fund from 1 April 2015, a single pooled budget across the CCG and local authority, designed to enable transformation in integrated health and social care, will require substantial change in the way services are delivered with an unprecedented shift in activity required away from hospital into community settings.

The CCG has a strategic plan together with a two year operational plan, incorporating the Better Care Fund, which has been refreshed during the year, supported by a financial plan. These plans demonstrate how these pressures will be managed to enable continued achievement of a balanced financial position whilst also delivering on the strategic aims of the CCG. The impact of the Better Care Fund in particular represents a significant challenge. The implementation of these plans and the schemes designed to take activity out of hospital, will require close monitoring to ensure progress is made and financial pressures can be managed.

## 8. Review of economy, efficiency and effectiveness of the use of resources

8.1 The CCG has well developed systems and processes in place for managing its resources. Robust financial governance arrangements have been maintained throughout the year, including the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies incorporated within the CCG Constitution, supplemented by the CCG's Standing Financial Instructions and detailed financial limits, all of which provide the framework through which the CCG discharges its business. This is supported by comprehensive and well established systems of internal control which help to govern the effective use of resources.

8.2 Annual budgets were set by the CCG prior to the start of the financial year, based on the operational and financial plan, which set the basis on which resources will be utilised. The strategic and operational planning process incorporates a review and prioritisation of commissioning intentions and investment decisions to enable the most effective and efficient use of available resource. Annual budgets, and the longer term financial plans, are reviewed and approved by the Governing Body. This includes plans to deliver against the Quality, Innovation, Productivity and Prevention (QIPP) agenda.

8.3 As part of the planning process, a range of benchmarking tools are used, including the commissioning for value packs and CCG outcomes benchmarking support packs published by NHS England. These tools provide comparative information on the CCG's spend and resulting outcomes, allowing the effectiveness of CCG spending to be assessed and incorporated into strategic plans and budgets.

8.4 Both the Management Executive and Finance and Performance Committee play a key role in managing performance and delivery against financial plans, ensuring

appropriate action is taken to address any issues as required and providing assurance to the Governing Body that resources are being utilised in line with plans, and that expected outcomes are being delivered. In addition, monthly reports are also reviewed by the Governing Body, showing both performance against budgets and financial targets, as well as progress against the CCG's delivery plan and performance against health outcome indicators.

8.5 The Risk and Audit Committee also plays a key role in providing assurance to the Governing Body in relation to financial governance arrangements and the effectiveness of systems and processes of internal control. A significant component of this assurance is the work of both the CCG's internal and external auditors.

8.6 Specifically, as part of their annual audit, the CCG's external auditors are required to satisfy themselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources. They do this by examining documentary evidence and through discussions with senior managers. Their audit work is made available to and reviewed by the Risk and Audit Committee. Although the work of the external auditors does not form part of the CCG's internal control environment, their conclusions in respect of this use of resources work, provides further assurance that the processes implemented by the CCG are robust.

## 9. Review of the effectiveness of governance, risk management and internal control

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

### 9.2. Capacity to handle risk

9.2.1 As Accountable Officer I have overall responsibility for:

- ensuring the implementation of an effective Risk Management Policy, including effective risk management systems and internal controls,
- the development of the corporate governance and assurance framework,
- meeting all the statutory requirements and ensuring positive performance towards our strategic objectives.

9.2.2 Each of the directors of the CCG is responsible for;

- co-ordinating operational risk in their specific areas in accordance with the Risk Management Framework,
- ensuring that all areas of risk are assessed appropriately and action taken to implement improvements,
- ensuring that staff under their management are aware of their risk management responsibilities in relation to the Risk Management Framework,
- incorporating risk management as a management technique within the performance management arrangements for the organisation.

9.2.3 All Managers within the CCG are responsible for implementing the risk management strategy within their span of control and for ensuring that staff understand and apply the relevant policy and strategy in relation to risk management. All staff within the CCG are responsible for assisting in the implementation of the Risk Management Policy and for highlighting any areas of risk through the incident reporting procedures, a principal means through which the CCG manages risk and learns lessons.

**9.3. Review of effectiveness**

9.3.1 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 management letter and other reports. 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, Management Executive, the Risk and Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

9.3.2 As part of the CCG's risk management processes, an Assurance Framework has been in place throughout the year which provides a simple yet comprehensive method for the effective and focussed management of the principal risks and assurances to meeting and delivering the CCG's objectives. The Assurance Framework reflects the principal risks associated with the delivery of the CCG's strategic objectives. This includes risks around the delivery of the CCG's strategic aims, financial stability including QIPP delivery, and development of effective corporate governance and risk management.

9.3.3 The Assurance Framework details the key controls and assurances in place against each risk, together with any relevant action being taken to address gaps in controls and assurances where required. This is supplemented by detailed risk registers that record the full comprehensive list of all risks facing the CCG at an operational and strategic level, across the five areas of delivery, development and transition, finance, performance and quality.

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

9.3.5 The previous year was one of significant change for the NHS as a whole, with a transition of commissioning responsibilities to multiple organisations, including the creation of new statutory bodies and abolition of primary care trusts. This inevitably created an increased risk of gaps in internal control systems and governance processes within new statutory organisations, a risk which was largely mitigated through the adoption of well-established risk management and governance processes and systems of internal control from the former primary care trust. 2014/15 has been a relatively stable year in comparison, with no significant changes in those systems and processes, allowing them to be further embedded within the

organisation.

9.3.6 As highlighted above, the Risk and Audit Committee plays a key role in providing assurance to the Governing Body on the effectiveness of the systems of internal control and governance arrangements operated by the CCG. As part of this, the work of both internal and external audit and other sources of assurance are considered. No significant internal control issues have been identified from the work of the Risk and Audit Committee.

9.3.7 The majority of commissioning support services are procured from NECS, including risk and governance expertise, together with the management of the majority of internal control systems and processes, for example in relation to finance systems and controls.

9.3.8 A service auditor reporting process has been implemented to provide assurance over the effectiveness of controls and processes within NECS. For 2013/14 this report only covered the six months from 1 October 2013 to allow a period of relative stability to be reviewed. For 2014/15 the reporting process covers the full year. An interim report covering the period 1 April 2014 to 30 September 2014 was received in December 2014, with a final report covering the remaining period to 31 March 2015 received in May 2015. The detailed findings of the reports and in particular those control objectives which were not achieved for the full period have been reviewed and are not considered to significantly impact on the CCG. Additional controls are in place within the CCG in terms of the review of transactions processed by NECS which mitigate any risk arising from deficiencies in these control objectives.

9.3.9 The CCG also has additional systems of control and review mechanisms internally over the work performed by NECS which provide additional assurance that there have been no significant internal control issues which have impacted on the CCG.

9.3.10 In addition to the majority of commissioning support services which are provided by NECS, the CCG has also outsourced certain other systems and services to third party providers. The national Integrated Single Financial Environment (ISFE) and procurement systems are provided by NHS Shared Business Services and the national Electronic Staff Records (ESR) system is provided by McKesson. Assurance over the relevant control environments in place for these systems has been gained from independent auditor reports for the year ended 31 March 2015, in accordance with ISAE3402. No significant control deficiencies have been identified from these auditor reports.

9.3.11 Payroll services are also received from a third party provider in Northumbria Healthcare NHS Foundation Trust. The CCG's own system of internal controls provides assurance over the operation of payroll, this includes the Scheme of Reservation and Delegation and prime financial policies which govern and set levels of authorisation, together with subsequent monthly payroll reviews. Again no significant issues have been identified from the review of payroll information during the year.

9.3.12 Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit opinion contributes to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the CCG's system of internal control. It concluded that overall significant assurance can be given 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 weakness in the design and inconsistent application of controls put the achievement of particular objectives at risk.

9.3.13 During the year Internal Audit have not issued any audit reports with a conclusion of no assurance. One audit report relating to continuing healthcare had a conclusion of limited assurance, with all other audit reports having a conclusion of significant assurance.

9.3.14 The limited assurance report on continuing healthcare highlighted a number of control deficiencies relating to the approval, reporting and in particular the payment of continuing healthcare cases. Mitigating actions have been implemented during the year to address the issues raised. Review processes have also been in place throughout the year which provide assurance that any control deficiencies have not had a significant impact on the CCG during the year, for example through the payment of ineligible claims.

**9.4. Data quality**

9.4.1The NECS Data Management service have processes and systems in place to assess the quality and completeness of data managed on behalf of the CCG. Data is checked at all stages of processing through CSU systems and finally on publication of reports/analysis. Data is compared against historic and planned levels to provide assurance on completeness as well as with peer organisations in the form of benchmarking analysis.

9.4.2 Processes are in place to raise any data quality issues with providers on a monthly basis – feedback from these challenges is utilised to alter any processing routines as required. The CCG utilises contract levers where necessary to ensure high quality data is captured at source and to minimise any updating of data once received by commissioners. Reconciliation accounts for each contract highlight any discrepancies between provider and commissioner data that are then investigated and resolved.

9.4.3 Significant validations steps are in place in all routine data processing tasks to ensure poor quality data is not made available for analysis and then subsequently used as the basis for commissioning decisions.

**9.5. Business critical models**

9.5.1 The CCG is aware of the quality assurance requirements in respect of business critical models contained within the recommendations in the Macpherson

report and I consider that appropriate arrangements are in place to provide sufficient quality assurance.

9.5.2 Any business critical models identified, together with information relating to the quality assurance processes for those models, will be provided to the Analytical Oversight Committee chaired by the Chief Analyst in the Department of Health, as appropriate.

**9.6 Data security**

9.6.1 The CCG has published the HSCIC Information Governance Toolkit and has self-assessed as being level 2 overall compliant, which confirms the organisation's rating as overall 'satisfactory' in this regard. In accordance with the agreed internal audit plan for 2014/15 an audit of the Information Governance Toolkit self-assessment was undertaken, the scope of which was to provide ongoing assurance that the processes for determining scores against individual requirements was adequate.

9.6.2 There have been no Serious Incidents relating to data security breaches involving the CCG during 2014/15 or up to the date of this statement.

9.6.3 NECS as the provider of IT services to the CCG has a range of controls in place. Control objectives include: physical access, logical access, segregation of duties, data transmissions, data centre environmental controls, IT processing, data integrity and backups, change management procedures, network security measures, problem and incident resolution, system recovery and disaster recovery plans. Assurance is provided to the CCG on the effectiveness of these controls through the AAF01/06 (service auditor) report that Deloitte will produce for the CCG to inform this. The CCG has now received the AAF Report which shows that all IT controls described above are 'operating effectively'.

**9.7. Discharge of statutory functions**

9.7.1 During establishment, the arrangements put in place by the clinical commissioning group and explained within the *Corporate Governance Framework* were developed with extensive expert external legal input, to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the Scheme of Reservation and Delegation.

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

9.7.3 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.

## 10. Conclusion

No significant internal control issues have been identified.

Dr Neil O'Brien
Accountable Officer
28 May 2015

# Financial statements

## NHS North Durham CCG Financial Statements for the year ended 31 March 2015

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**The Primary Statements:**



**Notes to the Accounts**

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

| | Note | 2014/15 £000 | 2013/14 £000 |
|---|---|---|---|
| **Administration costs and programme expenditure** | | | |
| Gross employee benefits | 3.1 | 1,689 | 1,676 |
| Other costs | 4 | 323,590 | 315,896 |
| Other operating revenue | 2 | (50) | (48) |
| **Net operating costs before interest** | | **325,229** | **317,524** |
| | | | |
| Investment Revenue | 7 | - | - |
| Other (gains) / losses | 8 | - | - |
| Finance costs | 9 | - | - |
| **Net operating costs for the financial year** | | **325,229** | **317,524** |
| | | | |
| **Of which:** | | | |
| **Administration costs** | | | |
| Gross employee benefits | 3.1 | 1,501 | 1,519 |
| Other costs | 4 | 4,322 | 4,295 |
| Other operating revenue | 2 | - | - |
| **Net administration costs before interest** | | **5,823** | **5,814** |
| | | | |
| **Programme expenditure** | | | |
| Gross employee benefits | 3.1 | 188 | 157 |
| Other costs | 4 | 319,268 | 311,601 |
| Other operating revenue | 2 | (50) | (48) |
| **Net programme expenditure before interest** | | **319,406** | **311,710** |
| | | | |
| **Total comprehensive net expenditure for the year** | | **325,229** | **317,524** |

## Statement of Financial Position as at 31 March 2015

| | Note | 31 March 2015 £000 | 31 March 2014 £000 |
|---|---|---|---|
| **Current assets:** | | | |
| Trade and other receivables | 11 | 2,527 | 1,498 |
| Cash and cash equivalents | 12 | 54 | 123 |
| **Total current assets** | | **2,581** | **1,621** |
| **Total assets** | | **2,581** | **1,621** |
| **Current liabilities** | | | |
| Trade and other payables | 13 | (18,795) | (17,810) |
| **Total current liabilities** | | **(18,795)** | **(17,810)** |
| **Total assets less current liabilities** | | **(16,214)** | **(16,189)** |
| **Financed by taxpayers' equity** | | | |
| General fund | | (16,214) | (16,189) |
| **Total taxpayers' equity:** | | **(16,214)** | **(16,189)** |

The notes on pages 94 to 113 of annual report form part of this statement

The financial statements on pages 90 to 113 of annual report were approved and authorised for issue by the Risk and Audit Committee on 26 May 2015 and signed on its behalf by:

Dr Neil O'Brien

Accountable Officer

28 May 2015

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

| | General fund £000 | Total reserves £000 |
|---|---|---|
| **Changes in taxpayers' equity for 2014/15:** | | |
| **Balance at 1 April 2014** | (16,189) | **(16,189)** |
| **Changes in CCG taxpayers' equity for 2014/15:** | | |
| Net operating costs for the financial year | (325,229) | **(325,229)** |
| **Net recognised CCG expenditure for the financial year** | **(325,229)** | **(325,229)** |
| Net Parliamentary funding | 325,204 | **325,204** |
| **Balance at 31 March 2015** | **(16,214)** | **(16,214)** |

| | General fund £000 | Total reserves £000 |
|---|---|---|
| **Changes in taxpayers' equity for 2013/14:** | | |
| **Balance at 1 April 2013** | - | **-** |
| **Changes in CCG taxpayers' equity for 2013/14:** | | |
| Net operating costs for the financial year | (317,524) | **(317,524)** |
| **Net recognised CCG expenditure for the financial year** | **(317,524)** | **(317,524)** |
| Net Parliamentary funding | 301,335 | **301,335** |
| **Balance at 31 March 2014** | **(16,189)** | **(16,189)** |

## Statement of Cash Flows for the year ended 31 March 2015

| | Note | 2014/15 £000 | 2013/14 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Net operating costs for the financial year | | (325,229) | (317,524) |
| Increase in trade and other receivables | | (1,029) | (1,498) |
| Increase in trade and other payables | | 985 | 17,810 |
| **Net cash outflow from operating activities** | | **(325,273)** | **(301,212)** |
| **Net cash outflow before financing** | | **(325,273)** | **(301,212)** |
| **Cash flows from financing activities** | | | |
| Net funding received | | 325,204 | 301,335 |
| **Net cash inflow from financing activities** | | **325,204** | **301,335** |
| **Net (decrease) / increase in cash and cash equivalents** | 12 | **(69)** | **123** |
| **Cash and cash equivalents at the beginning of the financial year** | | 123 | - |
| **Cash and cash equivalents (including bank overdrafts) at the end of the financial year** | | **54** | **123** |

## Notes to the financial statements

### 1. Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups (CCGs) shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2014/15* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, 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 CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG 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 CCG 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.

## Notes to the financial statements (continued)

### 1. Accounting Policies (continued)

#### 1.5 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the CCG 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 CCG is in a "jointly controlled operation", the CCG recognises:

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

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

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

#### 1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the CCG'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.

1.6.1 *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 CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- determining whether income and expenditure should be disclosed as either administrative or programme expenditure;
- determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets;
- determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare.

*1.6.2 Key Sources of Estimation Uncertainty*

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

- the assumptions applied in the estimation of activity not yet invoiced, including partially completed treatment spells as at the Statement of Financial Position date; and
- the estimate of potential future liabilities in respect of continuing healthcare services.

#### 1.7 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.

## Notes to the financial statements (continued)

### 1. Accounting Policies (continued)

#### 1.8 Employee Benefits

1.8.1 *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.

1.8.2 *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 CCG 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 CCG commits itself to the retirement, regardless of the method of payment.

#### 1.9 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 CCG has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

#### 1.10 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.

*1.10.1 The CCG as Lessee*

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.

#### 1.11 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 CCG's cash management.

## Notes to the financial statements (continued)

### 1. Accounting Policies (continued)

#### 1.12 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

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

A restructuring provision is recognised when the CCG 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.

#### 1.13 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which the CCG 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 CCG.

#### 1.14 Non-clinical Risk Pooling

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG 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.

#### 1.15 Continuing healthcare risk pooling

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

#### 1.16 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 CCG, 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 CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.

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

## Notes to the financial statements (continued)

### 1. Accounting Policies (continued)

#### 1.17 Financial Assets

Financial assets are recognised when the CCG 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.

All CCG assets have been classified as loans and receivables.

1.17.1 *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 CCG 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.

#### 1.18 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the CCG 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.

1.18.1 *Other Financial Liabilities*

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

## Notes to the financial statements (continued)

### 1. Accounting Policies (continued)

#### 1.19 Value Added Tax

Most of the activities of the CCG 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.

#### 1.20 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 CCG not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

#### 1.21 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

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

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

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

## 2. Other Operating Revenue

| | 2014/15 Admin | 2014/15 Programme | 2014/15 Total | 2013/14 Total |
|---|---|---|---|---|
| | £000 | £000 | £000 | £000 |
| Non-patient care services to other bodies | - | 50 | 50 | 48 |
| **Total other operating revenue** | **-** | **50** | **50** | **48** |

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.

## Notes to the financial statements (continued)

## 3. Employee benefits and staff numbers

### 3.1 Employee benefits

| | 2014/15 | Total | Total | | Admin | | | Programme | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Permanent Employees | Other | Total | Permanent Employees | Other | Total | Permanent Employees | Other |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Employee Benefits** | | | | | | | | | |
| Salaries and wages | 1,403 | 1,290 | 113 | 1,249 | 1,136 | 113 | 154 | 154 | - |
| Social security costs | 122 | 122 | - | 109 | 109 | - | 13 | 13 | - |
| Employer Contributions to NHS Pension scheme | 164 | 164 | - | 143 | 143 | - | 21 | 21 | - |
| **Total employee benefits expenditure** | **1,689** | **1,576** | **113** | **1,501** | **1,388** | **113** | **188** | **188** | **-** |

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the year.

### 3.2 Average number of people employed

| | 2014/15 | | | 2013/14 |
|---|---|---|---|---|
| | Total Number | Permanently employed Number | Other Number | Total Number |
| **Total** | **32** | 30 | 2 | 31 |

None of the above people were engaged on capital projects.

### 3.3 Staff sickness absence and ill health retirements

| | 2014/15 Number | 2013/14 Number |
|---|---|---|
| Total Days Lost | 180 | 152 |
| Total Staff Years | 35 | 33 |
| **Average working Days Lost** | **5.2** | **4.6** |

The staff sickness absence data for 2014/15 is based on the 12 months ended 31 December 2014 (2013/14: 9 month period from April to December 2013).

No staff retired early on ill health grounds during the financial year.

### 3.4 Exit packages agreed in the financial year

No exit packages have been agreed in the financial year

## Notes to the financial statements (continued)

## 3. Employee benefits and staff numbers (continued)

## 3.5 Pension costs

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

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable individual 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 CCG of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be 4 years, with approximate assessments in intervening years". An outline of these follows:

### a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2015, is based on valuation data as at 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

## Notes to the financial statements (continued)

## 3. Employee benefits and staff numbers (continued)

## 3.5 Pension costs (continued)

## b) Full actuarial (funding) valuation

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

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

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

## c) Scheme Provisions

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

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

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

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

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

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

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

## Notes to the financial statements (continued)

## 4. Operating expenses

| | 2014/15 Admin £000 | 2014/15 Programme £000 | 2014/15 Total £000 | 2013/14 Total £000 |
|---|---|---|---|---|
| **Gross employee benefits** | | | | |
| Employee benefits excluding governing body members | 829 | 188 | 1,017 | 943 |
| Executive governing body members | 672 | - | 672 | 733 |
| **Total gross employee benefits** | **1,501** | **188** | **1,689** | **1,676** |
| | | | | |
| **Other costs** | | | | |
| Services from other CCGs and NHS England | 3,557 | 1,533 | 5,090 | 3,754 |
| Services from Foundation Trusts | 32 | 235,753 | 235,785 | 231,190 |
| Services from other NHS Trusts | - | 479 | 479 | 604 |
| Purchase of healthcare from non-NHS bodies | - | 35,467 | 35,467 | 33,862 |
| Chair and Non Executive Members | 273 | - | 273 | 277 |
| Supplies and services – clinical | - | 578 | 578 | 513 |
| Supplies and services – general | 29 | 331 | 360 | 1,100 |
| Consultancy services | 60 | - | 60 | 47 |
| Establishment | 97 | 72 | 169 | 168 |
| Transport | 4 | 1 | 5 | 2 |
| Premises | 24 | 1,180 | 1,204 | 950 |
| Impairments and reversals of receivables | - | - | - | 220 |
| Audit fees | 84 | - | 84 | 85 |
| Other non statutory audit expenditure | | | | |
| · Other services | 1 | - | 1 | - |
| Prescribing costs | - | 43,027 | 43,027 | 42,192 |
| Pharmaceutical services | - | 344 | 344 | 292 |
| GPMS/APMS and PCTMS | - | - | - | 294 |
| Other professional fees excl. audit | 151 | 33 | 184 | 204 |
| Clinical negligence | 5 | - | 5 | 5 |
| Education and training | 5 | 11 | 16 | 137 |
| CHC Risk Pool contributions | - | 459 | 459 | - |
| **Total other costs** | **4,322** | **319,268** | **323,590** | **315,896** |
| | | | | |
| **Total operating expenses** | **5,823** | **319,456** | **325,279** | **317,572** |

## Notes to the financial statements (continued)

### 5.1 Better Payment Practice Code

| Measure of compliance | 2014/15 Number | 2014/15 £000 | 2013/14 Number | 2013/14 £000 |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total non-NHS trade invoices paid in the year | 9,135 | 39,014 | 7,958 | 33,563 |
| Total non-NHS trade invoices paid within target | 8,732 | 38,089 | 7,774 | 32,957 |
| **Percentage of non-NHS trade invoices paid within target** | **95.59%** | **97.63%** | **97.69%** | **98.19%** |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 2,197 | 244,352 | 1,481 | 233,299 |
| Total NHS Trade Invoices Paid within target | 2,183 | 244,139 | 1,474 | 233,181 |
| **Percentage of NHS Trade Invoices paid within target** | **99.36%** | **99.91%** | **99.53%** | **99.95%** |

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

### 5.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no payments made in respect of late payments of commercial debts in 2014/15 (2013/14: none).

### 6. Income Generation Activities

The CCG does not undertake any income generation activities.

### 7. Investment revenue

There was no investment revenue in 2014/15 (2013/14: none).

### 8. Other (gains) and losses

There were no other (gains) and losses in 2014/15 (2013/14: none).

### 9. Finance costs

There were no finance costs in 2014/15 (2013/14: none).

## Notes to the financial statements (continued)

## 10. Operating Leases

### 10.1 As lessee

The CCG has entered into a small number of formal operating lease arrangements, relating to leased cars and the lease of photocopying equipment, none of which are individually significant. Specific lease terms vary by individual arrangement but are based upon standard practice for the type of arrangement involved.

The CCG occupies property owned and managed by NHS Property Services Limited. For 2013/14, a transitional occupancy rent based on annual property cost allocations was agreed. For 2014/15, the charges from NHS Property Services Limited reflect the actual cost of occupancy, or void space, attributable to the CCG. This is reflected in Note 10.1.1.

During the year the CCG agreed a lease with NHS Property Services Limited for the occupation of the Rivergreen Centre. The lease is for a period of 5 years, with effect from 1 April 2013, and includes an annual rental charge of £154k. In respect of all other properties , while our arrangements with NHS Property Services Limited fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note only includes future minimum lease payments for the Rivergreen Centre and not for these other arrangements.

### 10.1.1 Payments recognised as an Expense

| | 2014/15 Buildings £000 | 2014/15 Other £000 | 2014/15 Total £000 | 2013/14 Total £000 |
|---|---|---|---|---|
| **Payments recognised as an expense** | | | | |
| Minimum lease payments | 1,165 | 21 | 1,186 | 891 |
| Contingent rents | - | - | - | - |
| **Total** | **1,165** | **21** | **1,186** | **891** |

### 10.1.2 Future minimum lease payments

| | 2014/15 Buildings £000 | 2014/15 Other £000 | 2014/15 Total £000 | 2013/14 Total £000 |
|---|---|---|---|---|
| **Payable:** | | | | |
| No later than one year | 154 | 18 | 172 | 22 |
| Between one and five years | 308 | 7 | 315 | 15 |
| After five years | - | - | - | - |
| **Total** | **462** | **25** | **487** | **37** |

## Notes to the financial statements (continued)

### 11. Trade and other receivables

| | Current 31 March 2015 £000 | Non-current 31 March 2015 £000 | Current 31 March 2014 £000 | Non-current 31 March 2014 £000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 914 | - | 471 | - |
| NHS prepayments and accrued income | 1,311 | - | 1,005 | - |
| Non-NHS receivables: Revenue | 243 | - | 206 | - |
| Non-NHS prepayments and accrued income | 52 | - | 1 | - |
| Provision for the impairment of receivables | - | - | (220) | - |
| VAT | 7 | - | 23 | - |
| Operating lease receivables | - | - | 12 | - |
| **Total Trade and other receivables** | **2,527** | **-** | **1,498** | **-** |
| **Total current and non current** | **2,527** | | **1,498** | |

The great majority of trade is with other NHS bodies, including other CCGs as commissioners for NHS patient care services. As CCGs are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary.

### 11.1 Receivables past their due date but not impaired

| | 31 March 2015 £000 | 31 March 2014 £000 |
|---|---|---|
| By up to three months | - | 153 |
| By three to six months | 1 | - |
| By more than six months | - | - |
| **Total** | **1** | **153** |

The CCG did not hold any collateral against receivables outstanding at 31 March 2015 (31 March 2014: none).

### 11.2 Provision for impairment of receivables

| | 2014/15 £000 | 2013/14 £000 |
|---|---|---|
| **Balance at 1 April** | (220) | - |
| Decrease / (increase) in receivables impaired | 220 | (220) |
| **Balance at 31 March** | **-** | **(220)** |

The CCG has reviewed all receivables to determine whether an impairment value is required. In determining the recoverability of a receivable, the CCG considers any change in credit quality of the receivable from the date credit was initially granted up to the reporting date. The overall level of credit risk is considered to be relatively low due to the proportion of the customer base which is comprised of NHS bodies.

## Notes to the financial statements (continued)

## 12. Cash and cash equivalents

| | 2014/15 £000 | 2013/14 £000 |
|---|---|---|
| Balance at 1 April | 123 | - |
| Net change in year | (69) | 123 |
| **Balance at 31 March** | **54** | **123** |
| | | |
| **Made up of:** | | |
| Cash with the Government Banking Service | 54 | 123 |
| **Cash and cash equivalents as in Statement of Financial Position** | **54** | **123** |
| | | |
| **Balance at 31 March** | **54** | **123** |

The CCG held £nil cash and cash equivalents at 31 March 2015 on behalf of patients (31 March 2014: £nil).

## 13. Trade and other payables

| | Current 31 March 2015 £000 | Non-current 31 March 2015 £000 | Current 31 March 2014 £000 | Non-current 31 March 2014 £000 |
|---|---|---|---|---|
| NHS payables: revenue | 4,421 | - | 3,487 | - |
| NHS accruals and deferred income | 3,535 | - | 3,287 | - |
| Non-NHS payables: revenue | 31 | - | 531 | - |
| Non-NHS accruals and deferred income | 10,521 | - | 10,346 | - |
| Social security costs | 22 | - | - | - |
| Tax | 24 | - | - | - |
| Other payables | 241 | - | 159 | - |
| **Total Trade and Other Payables** | **18,795** | **-** | **17,810** | **-** |
| | | | | |
| **Total current and non-current** | **18,795** | | **17,810** | |

At 31 March 2015, the CCG had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2014: none).

Other payables include £31k in respect of outstanding pension contributions at 31 March 2015 (31 March 2014: £nil).

## 14. Provisions

There were no provisions to recognise in the financial statements at 31 March 2015 (31 March 2014: none).

## 15. Contingencies

There were no contingent assets or liabilities at 31 March 2015 (31 March 2014: none).

## Notes to the financial statements (continued)

## 16. Commitments

There were no contracted or non-cancellable contracts entered into by the CCG at 31 March 2015 which are not otherwise included in these financial statements (31 March 2014: none).

## 17. Financial instruments

### 17.1 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.

As the CCG 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 CCG 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 CCG in undertaking its activities.

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

#### 17.1.1 Currency risk

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

#### 17.1.2 Interest rate risk

The CCG has no borrowings and has only limited powers to borrow funds from government for capital expenditure, subject to affordability as confirmed by NHS England. The CCG therefore has low exposure to interest rate fluctuations.

#### 17.1.3 Credit risk

Because the majority of the CCG's revenue comes from parliamentary funding, the CCG 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.

#### 17.1.4 Liquidity risk

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

## Notes to the financial statements (continued)

## 17. Financial instruments (continued)

### 17.2 Financial assets

| | Loans and Receivables 31 March 2015 £000 | Total 31 March 2015 £000 | Loans and Receivables 31 March 2014 £000 | Total 31 March 2014 £000 |
|---|---|---|---|---|
| Receivables: | | | | |
| · NHS | 1,759 | 1,759 | 1,256 | 1,256 |
| · Non-NHS | 250 | 250 | 229 | 229 |
| Cash at bank and in hand | 54 | 54 | 123 | 123 |
| **Total at 31 March** | **2,063** | **2,063** | **1,608** | **1,608** |

### 17.3 Financial liabilities

| | Other 31 March 2015 £000 | Total 31 March 2015 £000 | Other 31 March 2014 £000 | Total 31 March 2014 £000 |
|---|---|---|---|---|
| Payables: | | | | |
| · NHS | 7,956 | 7,956 | 6,774 | 6,774 |
| · Non-NHS | 10,839 | 10,839 | 11,036 | 11,036 |
| **Total at 31 March** | **18,795** | **18,795** | **17,810** | **17,810** |

## 18. Operating segments

The CCG has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the CCG's Governing Body, considered to be the 'chief operating decision maker' of the CCG, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the CCG relates to its role as a commissioner of healthcare for its relevant population. As a result, the CCG considers that it has only one operating segment, being the commissioning of healthcare services.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the statement of comprehensive net expenditure and statement of financial position respectively.

## 19. Pooled budgets

The CCG was not party to any pooled budget arrangements during 2014/15 (2013/14: none).

The CCG has subsequently entered into a pooled budget arrangement with Durham County Council, with effect from 1 April 2015, in respect of the Better Care Fund.

## Notes to the financial statements (continued)

### 20. Intra-government and other balances

| | Current Receivables 31 March 2015 £000 | Non-current Receivables 31 March 2015 £000 | Current Payables 31 March 2015 £000 | Non-current Payables 31 March 2015 £000 |
|---|---|---|---|---|
| **Balances with:** | | | | |
| · Other Central Government bodies | 7 | - | 472 | - |
| · Local Authorities | 119 | - | 103 | - |
| **Balances with NHS bodies:** | | | | |
| · NHS bodies outside the Departmental Group | 1,499 | - | 3,043 | - |
| · NHS Trusts and Foundation Trusts | 726 | - | 4,913 | - |
| **Total of balances with NHS bodies:** | **2,225** | **-** | **7,956** | **-** |
| · Public corporations and trading funds | - | - | - | - |
| · Bodies external to Government | 176 | - | 10,264 | - |
| **Total balances at 31 March 2015** | **2,527** | **-** | **18,795** | **-** |

| | Current Receivables 31 March 2014 £000 | Non-current Receivables 31 March 2014 £000 | Current Payables 31 March 2014 £000 | Non-current Payables 31 March 2014 £000 |
|---|---|---|---|---|
| **Balances with:** | | | | |
| · Other Central Government bodies | 22 | - | - | - |
| · Local Authorities | 6 | - | 584 | - |
| **Balances with NHS bodies:** | | | | |
| · NHS bodies outside the Departmental Group | 1,208 | - | 3,298 | - |
| · NHS Trusts and Foundation Trusts | 48 | - | 3,476 | - |
| **Total of balances with NHS bodies:** | **1,256** | **-** | **6,774** | **-** |
| · Public corporations and trading funds | - | - | - | - |
| · Bodies external to Government | 214 | - | 10,452 | - |
| **Total balances at 31 March 2014** | **1,498** | **-** | **17,810** | **-** |

### 21. 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 CCG.

### 22. Losses and special payments

There were no losses or special payments identified in 2014/15 (2013/14: none).

## Notes to the financial statements (continued)

## 23. Related party transactions

During the year the CCG has undertaken transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

| CCG Governing Body member | Possible Related Party | Payments to Related Party £000 | Receipts from Related Party £000 | Amounts owed to Related Party £000 | Amounts due from Related Party £000 |
|---|---|---|---|---|---|
| Dr K Bidwell<br>Chair | Parkhouse Surgery / Lanchester Medical Centre | 121 | | 6 | |
| | Investing in Children | 32 | | | |
| N Bailey<br>Chief Operating Officer | Durham Dales, Easington & Sedgefield CCG | 1 | | 2,955 | 1,113 |
| C Brown<br>Practice Nurse | Drs Lambert and NG | 151 | | 2 | |
| Dr I Davidson | Parkhouse Surgery / Lanchester Medical Centre | 121 | | 6 | |
| Director of Quality and Safety | Stanley Medical Group | 245 | | 15 | |
| Dr A Galloway | St Cuthberts Hospice | 675 | | | |
| Secondary Care Clinician | Darlington CCG | | | | 223 |
| Dr D Graham<br>Director of Primary Care Development and Innovation | Queen's Road Surgery | 277 | 2 | | 2 |
| L Jeavons | Durham County Council | 5,602 | | 103 | 119 |
| Durham County Council Representative | Tees Esk and Wear Valley (TEWV) NHS Foundation Trust | 36,257 | | 82 | |
| M Kersley<br>Practice Manager | Bowburn Medical Centre | 113 | | 8 | 2 |
| Dr R Lilly | Bridge End Surgery | 298 | 1 | 27 | |
| GP Constituency Lead | Claypath Medical Group | 635 | | 23 | |
| A Lynch | Durham County Council | 5,602 | | 103 | 119 |
| Director of Public Health | Durham Dales, Easington & Sedgefield CCG | 1 | | 2,955 | 1,113 |
| | Cestria Health Centre | 476 | | 31 | |
| Dr N O'Brien | County Durham and Darlington | | | | |
| Chief Clinical Officer | NHS Foundation Trust | 149,780 | | 2,231 | 465 |
| Dr G Ong<br>GP Constituency Lead | Consett Medical Practice | 271 | | 4 | |
| | Dunelm Medical Practice | 317 | 5 | 19 | |
| Dr D Smart | TEWV NHS Foundation Trust | 36,257 | | 82 | |
| GP Constituency Lead / Chair | County Durham and Darlington NHS Foundation Trust | 149,780 | | 2,231 | 465 |
| Dr C Anand<br>GP Constituency Lead | Cedars Medical Group | 151 | | 13 | |
| Dr P Wright<br>GP Constituency Lead | Belmont and Sherburn Medical Group | 317 | 2 | 24 | 1 |

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

## Notes to the financial statements (continued)

## 23. Related party transactions (continued)

The Department of Health is regarded as a related party. During the year the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the CCG 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 Durham County Council.

### 2013/14 comparative figures:

During 2013/14 the CCG undertook transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

| CCG Governing Body member | Possible Related Party | Payments to Related Party £000 | Receipts from Related Party £000 | Amounts owed to Related Party £000 | Amounts due from Related Party £000 |
|---|---|---|---|---|---|
| Dr K Bidwell | Parkhouse Surgery | 118 | | 18 | |
| Chair | Investing in Children | 39 | | | |
| N Bailey | Durham Dales, Easington & | | | | |
| Chief Operating Officer | Sedgefield CCG | 1 | 192 | 2,985 | 908 |
| C Brown | | | | | |
| Practice Nurse | Drs Lambert and NG | 92 | | 6 | |
| Dr I Davidson | | | | | |
| Director of Quality and Safety | Parkhouse Surgery | 118 | | 18 | |
| Dr A Galloway | | | | | |
| Secondary Care Clinician | St Cuthberts Hospice | 644 | | | |
| Dr D Graham | | | | | |
| Director of Primary Care | | | | | |
| Development and Innovation | Queen's Road Surgery | 156 | | | |
| L Jeavons | Durham County Council | 6,822 | 116 | 584 | 6 |
| Durham County Council | Tees Esk and Wear Valley NHS | | | | |
| Representative | Foundation Trust | 35,892 | | 43 | |
| M Kersley | | | | | |
| Practice Manager | Bowburn Medical Centre | 78 | | | |
| Dr R Lilly | Bridge End Surgery | 165 | | | |
| GP Constituency Lead | Claypath Medical Group | 347 | | | 1 |
| A Lynch | Durham County Council | 6,822 | 116 | 584 | 6 |
| Director of Public Health | Durham Dales, Easington & | | | | |
| | Sedgefield CCG | 1 | 192 | 2,985 | 908 |
| Dr N O'Brien | | | | | |
| Chief Clinical Officer | Cestria Health Centre | 326 | | 9 | |
| Dr G Ong | | | | | |
| GP Constituency Lead | Consett Medical Practice | 139 | | | |
| Dr D Smart | | | | | |
| GP Constituency Lead | Dunelm Medical Practice | 205 | | | |

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

## Notes to the financial statements (continued)

## 24. Financial performance targets

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

The CCG's performance against those duties was as follows:

| | 2014/15 Target £000 | 2014/15 Performance £000 | 2013/14 Target £000 | 2013/14 Performance £000 |
|---|---|---|---|---|
| Expenditure not to exceed income | 332,979 | 325,229 | 322,525 | 317,524 |
| Capital resource use does not exceed the amount specified in Directions | - | - | - | - |
| Revenue resource use does not exceed the amount specified in Directions | 332,979 | 325,229 | 322,525 | 317,524 |
| Capital resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | - | - |
| Revenue resource use on specified matter(s) does not exceed the amount specified in Directions | - | - | - | - |
| Revenue administration resource use does not exceed the amount specified in Directions | 6,572 | 5,823 | 6,070 | 5,814 |

The CCG received no capital resource during 2014/15 and incurred no capital expenditure (2013/14: none).

Performance against the revenue expenditure duties is further analysed below:

| | 2014/15 Programme Resource £000 | 2014/15 Administration Resource £000 | 2014/15 Total £000 |
|---|---|---|---|
| Revenue resource | 326,407 | 6,572 | **332,979** |
| Net operating cost for the financial year | 319,406 | 5,823 | **325,229** |
| Underspend against revenue resource | **7,001** | **749** | **7,750** |

| | 2013/14 Programme Resource £000 | 2013/14 Administration Resource £000 | 2013/14 Total £000 |
|---|---|---|---|
| Revenue resource | 316,455 | 6,070 | 322,525 |
| Net operating cost for the financial year | 311,710 | 5,814 | 317,524 |
| Underspend against revenue resource | **4,745** | **256** | **5,001** |

# Independent auditor's report

## INDEPENDENT AUDITORS' REPORT TO THE MEMBERS OF NORTH DURHAM CLINICAL COMMISSIONING GROUP

We have audited the financial statements of North Durham Clinical Commissioning Group (the CCG) for the year ended 31 March 2015 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 24. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England.

*We have also audited the information in the Remuneration Report that is subject to audit, being:*

- the table of salaries and allowances of senior managers and related narrative notes on page 61 to 63;
- the table of pension benefits of senior managers and related narrative notes on page 66 and 67; and
- the table of pay multiples and related narrative notes on page 64 and 65.

This report is made solely to the members of North Durham CCG in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. Our audit work has been undertaken so that we might state to the CCG 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 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 the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

### Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Accountable Officer; and
- the overall presentation of the financial statements.

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

any apparent material misstatements or inconsistencies we consider the implications for our report.

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

**Opinion on regularity**

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

**Opinion on the financial statements**

In our opinion the financial statements:

- give a true and fair view of the financial position of North Durham CCG as at 31 March 2015 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

**Opinion on other matters**

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we report by exception**

We report to you if:

- in our opinion the governance statement does not comply with NHS England's guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

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

### Respective responsibilities of the CCG and auditor

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission in October 2014.

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

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

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

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

The Audit Commission determined these two criteria as those necessary for us to consider under its 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 2015.

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.

### Conclusion

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

**Certificate**

We certify that we have completed the audit of the accounts of North Durham CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Paul Thomson (Engagement Lead)
for and on behalf of Deloitte LLP
Appointed Auditor
Newcastle Upon Tyne, United Kingdom
28 May 2015