Welcome to the third annual report of NHS Cumbria Clinical Commissioning Group (CCG).

In last year’s report we described the progress we were making to address the significant financial and quality challenges facing health services across Cumbria. These challenges have not gone away but neither has our commitment to find the solutions we need.

Building strong partnerships has continued to be a key theme of the past year, whether this has been with local people and the communities we serve, with partners in local health and social care organisations, or with other commissioning organisations. We believe these partnerships are vital as we create a strong foundation upon which to build sustainable health services for the future.

It is now just over a year since we were awarded national Vanguard status for our work on the Better Care Together programme with partners across the Morecambe Bay health system. Over the last 12 months we have seen progress with integrating health and care services, and also with the redesign of urgent care services at Furness General Hospital. As we write we are awaiting the final green light for the development of a new Health and Care Centre in central Barrow, on the site of the old Alfred Barrow School – this will house a number of GP services along with other health and social care services.

We have developed a new commissioning partnership with our neighbouring Lancashire North CCG. This has arisen through our work together on the Vanguard programme. In order to have a single approach to commissioning and developing services for the residents of the Morecambe Bay area we are formalising this partnership, and will be creating a single commissioning team for south Cumbria and north Lancashire.

In June 2015 it was announced that north Cumbria was to be part of the national Success Regime – a slightly misleading name as only those areas with deep-seated quality and financial challenges have been given this status. In September Sir Neil McKay was appointed to chair this programme, previously Sir Neil spent time as acting Chief Executive of the NHS, and has worked in a number of other high profile roles in the health service. Over the past 6 months significant work has taken place to develop proposals for health and social care in north Cumbria and it is expected a number of options for reshaping services in the north of the county will be consulted on during the summer and early autumn of 2016.

In September 2015 we received a visit from the current NHS England Chief Executive, Simon Stevens. Simon spent time looking at primary care services in Workington, visiting the new West Cumberland Hospital in Whitehaven, and then travelling by coach from Whitehaven to the Cumberland Infirmary in Carlisle. It was an opportunity for Simon and his team to see first-hand the challenges created by the remoteness of many of our towns along the west coast of Cumbria.

The new £90 million West Cumberland Hospital opened its doors on 5 October 2015 and is the single biggest investment into the healthcare of West Cumbria since the original hospital opened half a century ago. The new hospital has a strong emphasis on improved privacy and dignity with private ‘patient and staff only’ corridors meaning most patients can be taken between departments without going into public areas.

Open days were held in September giving members of the public the chance to see what the new single en-suite patient rooms looked like as well as some departments such as the new A&E department, Outpatients and Maternity.

The new hospital includes an integrated emergency floor which will provide one of the most advanced and joined up emergency care services in the NHS. The hospital also has seven state-of-the-art main operating theatres all located together on one surgical floor providing the latest techniques in laser and key-hole surgery.

This past year has also seen the CCG focus much more on our responsibility for supporting quality improvement in general practice. In many ways our general practices are the strength of the NHS in Cumbria. Certainly the Care Quality Commission seems to think so with a far higher proportion of
practices across Cumbria being rated outstanding or good than the national average. However as with parts of the health service GP practices are struggling to recruit new doctors, while workload is climbing and stress levels increasing. We have developed an Improvement Plan with local practices and are now implementing it – strong and sustainable general practices are an essential element of both clinical strategies in the north and south of Cumbria.

Finally we could not end without acknowledging the tremendous work by health and care professionals, the voluntary sector and literally thousands of volunteers, in supporting individuals and families whose lives were devastated by the floods that wreaked havoc in many parts of Cumbria this last winter. Our thoughts go out to those still having to cope with the impact of this disaster.

Over the following pages you will find further accounts of improvements and innovation taking place across our county. These successes are down to the dedication and skill of those who work both within the CCG and also across the wider health and social care system. In order to move faster and deliver a wider range of improvements we need to harness the energy and expertise of many more people across our local communities. We hope you will join us and will take encouragement from what you read in this report.

Dr Geoff Jolliffe
Interim Clinical Chair

Dr Hugh Reeve
Interim Chief Clinical Officer
Part 1
Performance Report
1.1 Introduction

The NHS Constitution sets out a range of standards of care that all citizens and service users should expect to receive by right. Those standards are primarily described as maximum waiting times for different types of care, including urgent care in our Accident and Emergency Departments, Referral to Treatment for elective care, Diagnostic and subsequent treatment for Cancer, and as a major step forward in relation to parity of esteem maximum waiting times for some Mental Health interventions.

Across Cumbria, many of those standards have not been reliably delivered over the last year, and indeed there have been deep seated challenges in delivering some of those standards over a longer period. NHS Cumbria CCG is deeply committed to enabling and supporting our local NHS Provider Organisations to address this position. This involves the way that we commission services and the range of services we commission, as well as working directly with those provider organisations to find solutions and where appropriate to use performance management approaches. Increasingly, we recognise that the delivery of those standards is a challenge for our whole Health and Social Care system, and we need to work as collaboratively as possible across all partner organisations.

The following section provides an overview of the achievement of the standards over the last twelve months, and the actions that the CCG and broader system have taken. We will continue to have a clear focus on improving the achievement of the standards over the next 12 months, and to improving the timeliness and quality of care our population access.

It is one component of NHS Cumbria CCG’s Annual Report and Accounts 2015/16: a copy of the full annual report and accounts can be obtained from: www.cumbriaccg.nhs.uk

Hugh Reeve

Interim Chief Clinical Officer (Accountable Officer)
26 May 2016

1.2. NHS Cumbria Clinical Commissioning Group (CCG)

NHS Cumbria Clinical Commissioning Group (CCG) has a population of 522,063, which includes patients who are resident in Scotland, Northumberland, North Yorkshire and Lancashire, but are registered with a Cumbria Practice. The CCG is co-terminus with Cumbria County Council, other than the Bentham Practice in North Yorkshire.

NHS Cumbria CCG covers a geographical area of 2,600 square miles, and is the second largest CCG in land mass. Cumbria is a primarily rural county with 51% of the population living in rural communities, compared to 19% of the population in England and Wales. Population density is therefore very low. Eden Valley has the lowest population density of any Local Authority in England, just 24 people per square km, compared to Islington with 13,875 people per square km. Our west coast hosts geographically isolated and economically deprived small towns and villages. This presents major challenges for service delivery.

The CCG has a total of 77 member Practices, serving populations between just over 700 – over 25,000 registered patients. Out of hours General practice is provided by Cumbria Health on Call (CHOC).

Cumbria is served by four main NHS Trusts:

- **Cumbria Partnership NHS Foundation Trust (CPFT)**; which delivers physical health community services, including community hospitals, mental health and learning disability services, and some specialist services including neurology and diabetes

- **University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)**; which provides physical health secondary care services from Furness General Hospital, Royal Lancaster Infirmary, and Westmorland General Hospital

- **North Cumbria University Hospitals NHS Trust (NCUHT)**; which provides physical health secondary care services from Cumberland Infirmary Carlisle and West Cumberland Hospital, as well as some outpatient services delivered in community hospitals and the home birthing unit at Penrith Community Hospital
• North West Ambulance Service NHS Trust (NWAS); which delivers Paramedic Emergency Services, Patient Transport Services, and 111.

For the north Cumbria population there are significant patient flows to a number of Trusts in the North East, particularly Newcastle Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust, and Gateshead Health NHS Foundation Trust.

Similarly, there are significant patient flows to Trusts in the North West, particularly Lancashire Teaching Hospitals, Blackpool Teaching Hospitals NHS Foundation Trust, and Wrightington, Wigan and Leigh NHS Foundation Trust.

1.3 Our Vision, Objectives and Principles

We are here to make a real difference to people’s lives. Firstly this is about making a difference by improving the health and well-being of individuals and their families. In particular it is about taking serious action to reduce the inequalities that exist between different communities across Cumbria. We want to add years to people’s lives and quality of life to those years.

Making a difference to people’s lives also includes improving the day to day experiences of patients and those working to deliver better healthcare. Working for the health service in Cumbria should be a source of pride. We want this to be true for all our colleagues, as we recognise that quite simply people who are happy in their jobs provide better care.

To achieve our vision we are committed to:
- Deliver standards of care as enjoyed by most of England
- Return the local NHS system to a sustainable financial balance
- Embed continuous service improvement methods across the system, empowering front line clinicians and practitioners.
- Working flexibly to enable changing, where necessary, which organisation delivers services, where is delivered and how it is paid for.
- Putting ahead of each organisation’s interests and professional interests patients and the health system interests first

1.4 Our Strategic Plan

In 2014/15, working with our local partners, the CCG led the development of a five year plan for the Cumbria healthcare system. Collectively, the partner organisations have made good progress on some of the commitments made through that plan, but clearly there is much more to do.

The 2014/15 five year plan has now been superceded, and will be taken forward through our key local strategies:

- The West, North and East Cumbria Success Regime (Success Regime)
- The Better Care Together Vanguard, covering the Morecambe Bay geographical area inclusive of south Cumbria
- Better Mental Health for all, covering the whole of Cumbria

Additionally, NHS England and NHS Improvement, have required each local health system to produce a new five year Sustainability and Transformation Plan. In most parts of England those plans will cover a population between one and two million people.

Cumbria will be covered by two Sustainability and Transformation Plan areas:
- West, North and East Cumbria, which will build on the work of the Success Regime
• Lancashire and South Cumbria, which will include specific work from Better Care Together

Those plans will be completed in 2016/17, and will further set out the longer term vision for health and care services in those areas.

1.5 Working in Partnership: The Cumbria Health and Wellbeing Board

The Health and Wellbeing Board exists to provide a strategic platform for partners to work better together to deliver against agreed outcomes to ensure that everyone in Cumbria is able to benefit from improvements in health and well-being.

The Health and Wellbeing Board is conscious that, in order for the Joint Health and Wellbeing Strategy to have the desired impact, an effective delivery plan is necessary.

However, the Health and Wellbeing Board has no decision making power outside its statutory functions. Therefore, whilst the Board works towards ensuring delivery of the Joint Health and Wellbeing Strategy, the Board does not formally agree to the activities contained in the Delivery Plan. Rather, the delivery plan notes the activities agreed by members of the health and wellbeing system, through the aligned formal governance arrangements i.e. Better Care Together and the Success Regime and their constituent organisations.

However, as systems leader and as part of its duty to improve performance, the Board will receive quarterly performance updates to assure itself that the actions designed by the system to address the priorities contained in the Joint Health and Wellbeing Strategy are being undertaken and are having the desired effect.

The Joint Health and Wellbeing Strategy identifies four priorities:

• Tackle population health issues where Cumbria is performing poorly
• Tackle health inequalities
• Improve the quality of health and care provision
• Create a health and wellbeing system fit for the future

In order to address these priorities, five outcomes and 15 Key areas of activity were identified. The delivery plan sets out 40 metrics against which these activities will be measured.

The delivery plan was constructed to ensure effective performance monitoring of the system’s ability to deliver the changes required in the Strategy, without increasing information gathering requirements on individual organisations. Therefore, system partners will still be responsible for overall performance management of their respective activities and will have their own performance management arrangements in place.

As set out in the Joint Health and Wellbeing Strategy, it is recognised that there are a number of other strategies which also contribute to achieving its priorities. Therefore, the actions set out in the Delivery Plan should not be seen to be exhaustive and it should not be taken that if an activity in not in the Plan it is not taking place.

It is the intention of the Board to review the Delivery Plan on an annual basis and also to review the impact of other plans and strategies on the health and wellbeing on the people of Cumbria.

1.6 Cumbria Joint Strategic Needs Assessment

The production of a Joint Strategic Needs Assessment (JSNA) for Cumbria is a statutory duty of the county’s Health & Wellbeing Board (HWB) along with a Pharmaceutical Needs Assessment (PNA). The purpose of the JSNA and the Joint Health and Wellbeing Strategy (JHWS) is to improve the health and wellbeing outcomes of the local community and reduce inequalities for all ages.

The JSNA is essential to developing strategy and priorities for Cumbria and therefore it is important that plans for the JSNA process are robust and well considered. The JSNA brings together a wide range of information about health and wellbeing in the county and can be viewed via the link below with the latest Cumbria in Numbers:

www.cumbriaobservatory.org.uk
The JSNA highlights a wide variation in health outcomes across and within Cumbria. Overall, life expectancy of males and females is lower in Cumbria than the English average.

The gap in life expectancy levels between the most and least deprived areas in Cumbria is 9.5 years for men and 7.3 years for women. Those gaps are not decreasing.

The JSNA additionally identifies a broad range of outcomes in Cumbria which are significantly poorer than the England average:

- Mothers smoking at time of delivery in Cumbria is significantly higher and a significantly smaller proportion of mothers breastfeed.

- 25.1% of reception children in Cumbria are overweight compared to 22.5% nationally.

- Hospital admissions for 0 – 14 year olds are higher for unintentional and deliberate injuries than they are nationally.

- The rate of hospital admissions for substance misuse for 15 to 24 year olds is higher than the English average.

- Cumbria has a higher rate of children in need than the national average – 413.9 compared to 346.4 per 10,000 and there is a higher rate of children looked after than the national average – 71 compared to 60 per 10,000.

- Only 4.6% adults with learning disabilities in Cumbria are in employment compared to 6% in England.

- Hospital admission for self-harm in those aged 10 – 24 years in 2013/14 was almost 15% higher in Cumbria than rest of England.

- Cumbria has a significantly higher rate of suicide than England, and the excess death in those under 75 with serious mental illness is almost 30% higher than the English average.

- Almost half of people who use social care services report that they did not have as much social contact as they would like – for carers this increases to almost 60%.

The JSNA identifies the wider determinants of health that contribute to those poorer outcomes, including:

- Cumbria ranks 86th nationally for overall deprivation (out of 152 upper tier local authorities, where 1 is the most deprived). Of Cumbria’s districts, Barrow-in-Furness has the highest level of overall deprivation falling within the 10% most deprived nationally for overall deprivation and is the fifth most deprived district nationally for health deprivation and disability.

- In 2012, 11.6% of households were considered to be living in fuel poverty compared to 10.4% nationally with wide variations between districts.

- There are 10 wards in Cumbria which fall within the bottom 10% nationally for levels of child poverty.

- Excessive weight is known to lead to conditions such as type 2 diabetes, coronary heart disease, stroke and some types of cancer. In 2013, the proportion of inactive adults in Cumbria was 31.3% compared to 28.9% in England – with an upward trend.

- In 2014, 56.8% of children in Cumbria obtained five or more Key Stage 4 exams (GCSE) with grades A* – C including English and Mathematics. However, there are significant variations across the county with just 211% of children living in the ward of Upperby in Carlisle compared to 91.7% of children living in the ward of Ulverston West in South Lakeland.

The CCG commissions health services for the population based on the JSNA, an example of this is the focus on developing clearer frailty pathways to support the growing super-ageing population.

The CCG has also commissioned services that support nurses to provide case management of vulnerable housebound patients and improved access to services for people living in residential care.

The mental health transformation programme focuses on reducing gaps in service to support the most vulnerable. Part of the transformation programme includes engages with service users and their carer’s to fully inform the new strategy.

Reducing health inequalities is embedded in the strategic vision and is fundamental to all of the clinical strategies. The Health and Social Wellbeing system is the emerging model of health prevention/early intervention work in Cumbria.
1.7 NHS Cumbria CCG Assurance

NHS England undertakes a quarterly assurance process with all Clinical Commissioning Groups. The assurance process is based on the five following domains:

- **Well led organisation;** strong leadership and good governance
- **Delegated functions;** which relates to the co-commissioning of General Practice
- **Finance;** financial performance, controls and governance
- **Performance;** delivery of NHS Constitution Commitments and outcomes for patients
- **Planning;** having an assured annual plan and a long term plan to implement the five year forward view

The assurance position for NHS Cumbria CCG for Quarter 2 (the most recently published position) is shown below.

<table>
<thead>
<tr>
<th>Domain</th>
<th>NHS England Assessment</th>
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<tbody>
<tr>
<td>1. Well led organisation</td>
<td>GOOD</td>
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<tr>
<td>2. Delegated functions</td>
<td>GOOD</td>
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<tr>
<td>3. Finance</td>
<td>Financial Performance – Limited Assurance</td>
</tr>
<tr>
<td>4. Performance</td>
<td>LIMITED ASSURANCE</td>
</tr>
<tr>
<td>5. Planning</td>
<td>GOOD</td>
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</tbody>
</table>

NHS Cumbria CCG is working to deliver significant improvements to the domains where the CCG assurance is less than good. In most cases, those domains reflect not just the CCG position, but the position of the whole health economy. For example, the performance domain relates to the achievement of NHS Constitution Standards within our whole system.

In 2016/17 the assurance domains will change to the following four domains:

- **Better Health**
- **Better Care**
- **Sustainability**
- **Leadership**
1.8 Performance Analysis

One of the primary aims of the NHS Constitution is to set out clearly what patients, the public and staff can expect from the NHS. The CCG aims to ensure compliance with the constitution in the services it commissions from providers such as hospitals, community services and ambulance.

At the end of March 2016 the CCG had achieved the standards in only seven of the 21 Expected Rights and Pledges. This remains below the performance that the CCG would wish to achieve but is a slightly improved picture compared to 2014–15 when only five of the standards were achieved.

Diagrams 1 and 2, below, indicate how well the CCG is achieving the standards set out in the NHS Constitution Rights and Pledges for 2015/16.
Areas for improvement and what the CCG is doing about them:

The NHS Constitution Rights and Pledges measure specific points on three main patient care pathways:

- Cancer care pathways
- Urgent and emergency care pathways
- Elective care pathways

Even if only some of the measures in the pathway are failing, it indicates that there are problems that could impact across the whole pathway and need addressing. All three of the above pathways have several standards that are underperforming in Cumbria and are being addressed by the CCG, The Trust Development Authority, Monitor, NHS England (Cumbria and the North East) and in the West, North and East of Cumbria the Success Regime.

Cancer Care pathways, particularly in the North of Cumbria have consistently not achieved the required standards. University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) has been inconsistent in their achievement of the cancer standards although in March 2016 all the standards were achieved.
NHS Cumbria CCG, together with Lancashire North CCG and UHMBT have set up a cancer group developing and implementing plans to address the causes of the variation and to continue to achieve the standards consistently in the future. The task and finish group has for example developed timed pathways for Prostate, Lower GI, Breast and Respiratory cancer. The CCG has also set up a Cancer working group for the North of Cumbria with North Cumbria University Hospitals NHS Trust (NCUHT) which is chaired by a GP. NCUHT has an internal action plan to improve cancer services and the working group is also supporting the Trust with additional actions to improve the cancer pathway. One aim, for example, is to reduce time to first outpatient appointment for those on a fast-track cancer pathway to below 10 days from referral and to reduce time to diagnostics from referral to below 25 days. Medical staff vacancies have impacted on ability to meet performance at both UHMBT and NCUHT.

Urgent and Emergency care has struggled across the whole country and Cumbria has been no exception with increasing numbers of patients admitted urgently or as emergencies. Many of these patients are increasingly frail and elderly, requiring significant rehabilitation and support following discharge back into the community. Capacity in the community, particularly for nursing home beds, homes specialising in care of patients with dementia, and home care packages in rural areas remains limited and this leads to prolonged stays in hospital awaiting appropriate services for discharge. This in turn leads to a lack of beds to admit patients into, resulting in failure to achieve the 95% admitted from A&E within four hours standard, as well as to ambulance handover delays. Historically North West Ambulance Service had been able to deliver their response time standards. However, the increase in numbers of ambulance call outs, together with the increase in ambulance handover delays at hospitals, has led to them failing the 8 minute and 19 minute standards in 2015/16.

Work is underway in both North and South Cumbria to address the challenges being experienced in urgent care services to:

- Prevent admissions that can be managed outside hospital
- Speed up discharge out of hospital once the patient is medically fit
- Ensure the pathways within hospitals are appropriate with early access to diagnostics for example.

An ambulatory care unit was set up at NCUHT for example which enables rapid tests and treatment and discharge out of hospital with appropriate support within a day where possible. This unit is extremely successful and is planned to expand to enable more patients to be treated in this way. Nationally there is strong evidence that elderly patients lose 2-5% of their muscle power within 24 hours of admission to hospital. Ten days in a hospital bed (acute or community) leads to the equivalent of ten years ageing in the muscles of people over 80. The aim of reducing admissions to hospital is therefore not just to improve capacity within hospitals but also to maximise for elderly patients their opportunity to remain at home for as long as possible, rather than to require residential care.

Although NCUHT has not achieved the A&E standard it is to be noted that the latest national A&E benchmarking data published by NHS England shows that North Cumbria University Hospitals Trust has been performing above the national average. The data for March 2016 ranks the Cumberland Infirmary in Carlisle and West Cumberland Hospital in Whitehaven, as 63rd out of 138 Trusts with a major A&E department in England.

A higher proportion than is acceptable of elective care pathways have not been completed within the 18 week timeframe at NCUHT throughout the year though the Trust was successfully reducing the numbers waiting over this time period. UHMBT were achieving this standard during 2015/16 until January 2016. Unfortunately the December 2015 floods led to large numbers of cancellations of both outpatient appointments and surgery. The Junior doctor strikes have led to further cancellations and both these events have resulted in a deterioration in performance from which the Trusts are now trying to recover. Both Trusts have plans in place to reduce numbers of patients waiting over 18 weeks, where necessary using capacity at alternative locations outside of Cumbria. Better Care Together in the south of Cumbria has redesigned the pathway for ophthalmology surgery and will also be redesigning the orthopaedic (musculoskeletal) pathway.
1.9 Strategic Programmes

1.9.1 Better Care Fund (BCF)

The Cumbria Better Care Fund (BCF) plan 2015/16 described how a single pooled budget, agreed between Cumbria County Council and Clinical Commissioning Group, would be used to support joint working and planning to deliver integrated health and social care services across Cumbria.

Whilst the BCF is not the prime driver of integration it provides funding flexibilities, governed through a Section 75 agreement (NHS Act 2016), which facilitate the delivery of shared county wide objectives.

The Cumbria Health and Wellbeing Board, with a statutory duty to promote integration, oversees delivery of the BCF but the delivery of the transformation described is primarily the responsibility of the two main programmes of work in north and south Cumbria – Success Regime and Better Care Together respectively.

The 2015/16 BCF plan addressed a number of national expectations, including the delivery of improved data-sharing across health and social care organisations and systems to improve: the safety and quality of care provided to patients; timeliness of care and be more effective and efficient. Significant progress has been made over the last twelve months which has led to wide scale Health and Social Care record sharing across the county. It is anticipated that this will be fully comprehensive by early in 2017.

Other schemes identified in the Cumbria BCF plan are:

- Sustaining adult social care: To ensure access to quality social care provision and enable maintenance of a preventative focus.
- Rapid response, re-ablement and clinical co-ordination.
- The establishment of an enhanced Psychiatric Liaison service, and
- The introduction of Integrated Care Communities which focus on the delivery of personalised care plans in the right setting.

1.9.2 Better Care Together

The CCG is part of the Better Care Together (BCT) partnership, which published its strategy for the future of healthcare across the Morecambe Bay area in February 2015. The aim is to deliver a better future for our health and wellbeing, enabling our communities to be as healthy as they can be.

Promoting wellbeing and preventing ill-health will be our prime purpose with women’s, mental health, children’s, and older people’s services receiving equal priority with all other areas of care.

The Better Care Together vision is for community based services to be the first port of call for most people so that hospitals can concentrate on those patients who need specialist treatment or emergency care. Hospitals across south Cumbria and north Lancashire will be able to focus on providing excellent care to fewer patients who really need it. This also means the NHS can use its resources – such as staff and funding – in the right way and where they are needed the most.

The aim is to improve the integration of services across the Morecambe Bay area, for example improving how health services work with social care services and strengthening the links between primary care, secondary and community care.

The Five Year Forward View published by NHS England echoes our proposals for integrated out of hospital care. In 2015 BCT were named as one of only 50 Vanguards across the country and received £4.29m of additional funding to support the plans. These include people being supported to make lifestyle choices that will keep them healthy for longer and to help manage their long term conditions e.g. diabetes and asthma. Staff working in and out of hospitals will play an important part in making this strategy a reality. With the assistance of NHS, social care and voluntary organisations, local communities will be encouraged to develop and establish ideas and plans to make their communities happy and healthy places to live.

The health and care system will move further and faster with Better Care Together improvement plans in the coming year. Since the publication of the strategy a huge amount of work has been undertaken to establish some of the changes we want to put in place to improve health across the area.
For more information on Better Care Together please visit: www.bettercaretogether.co.uk

1. In Millom, there have been a number of successes in ensuring that the community play an important part in planning the services they receive. In the early part of 2016 we implemented a telemedicine link between the GP surgery in Millom and Furness General Hospital to allow expert advice to be sought and given, with the aim of preventing some travel and keeping people well in their community.

2. In Barrow there are plans for a new surgery, housing three existing GP practices alongside North West Ambulance Service, community services such as community and specialist nursing, mental health, physiotherapy, podiatry, diabetes, retinal screening), Integrated Children’s Services, a pharmacy and occupational health services for BAE Systems.

3. Also in Barrow, testing on a new way of working for urgent care is taking place, to ensure patients receive the most appropriate care possible, and not use Accident and Emergency as the first port of call.

4. And a locally-developed system for GPs across the Morecambe Bay area to seek Advice and Guidance from hospital specialists such as consultants has seen successes, with up to 35% of conversations resulting in a patient not being referred for an outpatient appointment when they otherwise would have been, avoiding travel and wasted time.

1.9.3 Success Regime

This Members’ report complies with the disclosure Health and care services in north Cumbria have faced significant and long-standing quality challenges, with North Cumbria University Hospitals NHS Trust remaining in Special Measures and major financial and workforce problems across the whole system. West, North & East Cumbria was identified in June 2015 as one of three sites across in England to be placed in the Success Regime, which is a national initiative to improve health and care services in the most challenged parts of the country. The Success Regime was formally launched in September 2015 under the leadership of Sir Neil McKay.

The CCG has worked with the county’s health providers and other stakeholders as part of the Success Regime to develop a clinical strategy to deliver services which are both safer and more affordable in the long-term, and which meet the healthcare needs of local people. The Success Regime has engaged local people and NHS staff in the development of our thinking with drop in sessions held before Christmas in Whitehaven, Workington, Penrith and Carlisle. Between January and March 2016 the “Healthwatch Chatty Van” visited more than 40 locations and spoken to almost 2,000 people. There have been meetings with interested community groups too.

A public progress report was published on 1 March 2016, setting out the initial ideas which had emerged through the early work on the strategy. This included an emphasis on the development on Integrated Care Communities (ICC), bringing together General Practice, social care, community services and community assets to provide co-ordinated care and better approaches to improving population health. The report also highlighted the changes that might be necessary to address the fragility of acute medicine, maternity and paediatric services at West Cumberland Hospital and possible options for changing the role of community hospitals.

The Success Regime submitted a response on 31 March 2016 to the Care Quality Commission’s concerns about acute hospital services, setting out proposed measures to stabilise those services alongside the development of the wider clinical strategy.
The plan is to finalise the clinical strategy in spring 2016, with an expectation that the CCG will undertake public consultation on any proposed changes from the end of June 2016.

For further information on the West, North and East Cumbria Success Regime, please visit: www.successregimecumbria.nhs.uk

There are seven ICCs planned for West, North and East Cumbria:

- Carlisle Rural
- Carlisle Urban
- Cockermouth and Maryport
- Copeland
- Eden
- Keswick and Solway
- Workington

1.10 General Practice

General Practice nationally and locally is undergoing the most significant changes it has seen since the inception of the NHS.

In Cumbria we are seeing plans to develop change across the whole health and care system. Across the County the two strategic programmes (Better Care Together and the Success Regime) are looking to integrate health and social care, with General Practice at the heart of this development.

In the Spring of 2015 the CCG began the General Practice development programme, designed together with CCG member practices through workshops, surveys, small meetings and the first General Practice Conference, with over 250 attendees (now to be established as an annual event) involving hundreds of GPs, practice nurses, practice managers and other practice staff.

The GP Development Plan is about creating a robust General Practice system across Cumbria that can provide the foundation for a new approach to integrated health and social care. The major challenges have been distilled into seven main areas of work and for each there are a set of activities that will both deliver quickly; helping practices to address problems in the short term, as well as activities that may take longer.
Each element of the programme addresses significant problems facing General Practice now but together they build a supportive programme addressing what we need to do together to ensure that General Practice continues to be the high quality service for the residents of Cumbria, with the same core values and service that are valued by the population.

Some practices will want to move forward with aspects of this work more quickly than others to alleviate existing challenges. The CCG are supporting individual practices and groups of practices in taking the work forward, working alongside NHS England, the Local Medical Committee and the local GP Federations to make sure there is a co-ordinated approach.

Across the county we are taking forward initiatives that focus on:

- workforce including attracting more GPs to work and train locally
- the education and further development of our GPs, nurses and other practice staff
- developing a clear focus on improving the health outcomes for the population through improvement programmes organised around common goals.

1.11 Children and Family Services

Children and Family services are an integral part of both the Better Care Together and Success Regime programmes. The focus of these programmes is to have services that are better integrated around the needs of the child and family, and reduce the number of children and young people admitted to hospital by:

- integrating services in community settings
- implementing clear care pathways
- providing alternatives to admission
- improving care for children and young people at risk of being admitted to hospital in need of a psychosocial assessment

Work to achieve these aims continues with a focus on the integration of Children’s Nursing both North and South Cumbria, and the piloting of specific alternatives to admission within Better Care Together. We have been using the model of ‘every child’, in our case Sam, and how services support Sam’s House.

The continued development of Child Adolescent Mental Health Service (CAMHS) remains a priority and is challenging as a result of the continued rise in the numbers of children and young people in need of specialist mental health services. A priority is the continued development, with partners, of the whole system approach. This includes a new investment in CAMHS Tier 2 services, made jointly by the CCG and Cumbria County Council.

The Cumbria Transformation Plan has been assured by NHS England and has secured significant additional funding which will be used on the priorities of developing community Eating Disorder services and services for Children and Young People experiencing a mental health crisis.

Safeguarding and services for Children Looked After continue to be developed and the partnership between the health system and Children’s Services in Cumbria County Council continues to strengthen as new systems and practice embed across the multi-agency landscape.
1.12 Morecambe Bay Maternity Investigation

The report, following the Morecambe Bay Maternity Investigation, was published in March 2015 with 44 recommendations for the University Hospitals of Morecambe Bay NHS Foundation Trust and the wider NHS. The review was established by the Secretary of State for Health in September 2013 following concerns over standards of care in the maternity department at Furness General Hospital between 1 January 2004 and 30 June 2013.

The report concludes that the maternity unit at Furness General Hospital was dysfunctional with serious failures of clinical care leading to unnecessary deaths of mothers and babies. Although pregnancies at other maternity units run by the Trust were reviewed, the investigation found serious concerns over clinical practice were confined to the unit at Barrow.

The report concludes that significant progress is being made at Furness General Hospital with the recommendations intended to ensure this continues. In response the University Hospitals of Morecambe Bay NHS Foundation Trust immediately issued an unreserved apology to all the families concerned.

An action plan was developed with substantial progress being made following Kirkup’s recommendations. These include:

- increased training for staff
- plans for a new maternity unit at FGH – this has been developed with families involved in the investigation and the community
- work has started to develop a Strategic Clinical Partnership with both Central Manchester University Hospitals NHS Foundation Trust and Lancashire Teaching Hospitals NHS Foundation Trust.

1.13 Better Mental Health For All

There has been recognition that we need to strengthen mental health commissioning capacity, and we agreed to create a new joint post to sit across two organisations – the CCG and Cumbria County Council.

The Mental Health Partnership has agreed the following approach:

- A vision document which describes the direction of travel, in line with national and local policy;
- A model of care document which would describe what the future system would look like; and
- An integrated commissioning strategy showing how the vision and model of care will be delivered.

A Transformation Programme has been designed with support from the North East Commissioning Support Unit and a Programme Office has been created to ensure effective oversight of progress with projects and the realisation of benefits and improved outcomes.

A workshop event was held on 5 January 2016 to engage stakeholders and the Mental Health Partnership Group in the design of the model of care. A Clinical Leadership Group, including lead GPs, Psychiatrists, Social Work and other professionals, is now being planned to oversee the development of the model of care using the framework below.
Once the model of care is agreed in outline, an **integrated commissioning strategy** will be developed for North and South Cumbria, aligned with transformation activities.

A Crisis Concordat Delivery Group was formed and this group has overseen the development of a proposal to test out a multi-agency mental health urgent care centre, as an alternative to attending Accident and Emergency departments. The proposal successfully secured £3.3 million from the Home Office’s Police Innovation Fund to fund a two year ‘proof of concept’ pilot on the Cumberland Infirmary site. The Police and Crime Commissioner fully supports the bid and has already committed approximately £336,000 (over two years) to introduce a ‘blue light’ telephone triage system.

Other developments include:

- Cumbria Dementia Partnership has developed a community orientated dementia pathway
- The development of mental health in primary care is now a priority area for action and will be one of the first items for discussion by the Mental Health Clinical Leadership Group.

### 1.14 Learning Disabilities

Cumbria is part of the North East and Cumbria Transformation Programme, which is part of the national Learning Disability Fast Track.

There are a number of Cumbrian residents currently living in ‘special/complex’ packages of care in and out of the county. Some of these people are living in hospital care and the CCG are reviewing these packages in line with delivering the transforming care agenda.

The CCG has a robust **Care and Treatment (CTR) process** in place and are meeting all of the trajectories, which are submitted to NHS England on a weekly basis.

The North East & Cumbria Fast Track plan was submitted to NHS England on 7 September 2015 and the transformation programme aims include:

- Less reliance on in-patient admissions
- Developing community support and alternatives to inpatient admission
- Prevention, early identification and early intervention
- Avoidance of crisis and better management of crisis when it happens
- Better more fulfilled lives.

The plan was split into five key areas:

- Mobilise the area
- Understand where you are
- Develop your vision
- Define your model of care
- Plan for success

Notification was received from NHS England on 5 October 2015 that the North East and Cumbria had been successful in securing £2,055,000 to support the transformation programme.

The CCG and Cumbria County Council have a joint Transforming Care Partnership, which reports into the Cumbria Joint Commissioning Board and in 2015/2016 we have laid the foundations for our local Transforming Care Partnership to lead an extensive engagement process, which will take place in the coming months to develop our local strategy for Learning Disabilities in Cumbria.
1.15 Locality Focus

1.15.1 Allerdale & Copeland

The team in west Cumbria have been involved in a number of projects to improve experience of the health system for patients. These include:

**Frail elderly schemes:** Supporting better management of frail older people and improving patient and staff experience and reducing non-elective admissions. Specialist nurses are supporting vulnerable older people in their own homes and residents in care homes in Cockermouth, Keswick and Workington. A case manager is working with Solway residents who are at risk of admission; a frail elderly assessment clinic, supported by a ‘remote’ geriatrician has been set up in Maryport and an enhanced falls service supported by GPs and AHPs is providing prompt treatment and rehabilitation of patients who have fallen or are at risk of falling in Keswick.

**Care coordinators:** In Copeland, non-clinical care coordinators, based in GP practices, manage holistic support plans for individuals aged 75 and over who are assessed as being mild or moderately frail. The care coordinators put together a holistic support plan containing a range of activities designed to improve the health and wellbeing of the patient, with clinical input being provided by the GP.

**Workington Primary Care Centre:** The CCG has worked closely with the five GP practices in Workington to develop the Primary Care Centre offering ‘same day’ GP appointments and a walk-in minor injury service 8am – 8pm, seven days per week. Funded through the Prime Minister’s Challenge fund the provision has meant improved access to general practice and has stimulated innovative ways of providing primary care services in the town.

In 2015:

- More than 44,000 consultations undertaken.
- Around 1,000 patients a week seen.
- Patient feedback has been overwhelmingly positive.
- Links have been developed with North West Ambulance Service (NWAS) and a community paramedic based at the Primary Care Centre has helped avoid ambulance journeys and A&E attendances.

1.15.2 Carlisle and Eden

The Carlisle and Eden network has been heavily involved in developing new ways of working through the Success Regime and the emerging development around Integrated Care Communities (ICC).

The focus has been to develop a structured programme to demonstrate tangible ways of working to ensure better co-ordination of community based services and prevention of unscheduled hospital admissions.

Going forward, the Carlisle and Eden network are committed to working with the Success Regime to address the challenges particularly around our ageing population and moving forward with our frailty pathway to provide greater capacity and flexibility to support patients alongside addressing workforce issues to design and deliver improved models of care while maintaining financial balance.

This year we have been very involved in work led by Dr Colin Patterson in the improvement and development of more effective cancer pathways for our community.

Dr Rachel Preston is leading a significant amount of work around frailty and keeping people who do not need acute care out of hospital and supporting new schemes like Home First. The team has also been heavily involved in the Emergency Care Improvement Programme (ECIP) at the Cumberland Infirmary in Carlisle.

1.15.3 Furness and South Lakes

The teams in South Lakes and Furness had a busy year working as part of Better Care Together.

- Seven Integrated Care Communities (ICC) in South Cumbria (five more in Lancashire North)
- Each ICC has been shaped in consultation with service providers and local groups and wraps around a collection of general practices
- The size of the ICC varies from around 11,000 to 36,000 and aims to make sense to these community and service members.
The network have tested some new concepts of care in an ICC this past year and the CCG invested funding of over £1million to explore new ways of providing and improving care within an integrated care system. At the same time the CCG funded additional support into rapid access services in the community and also a series of test cycles to understand the connection with urgent care and care of the frail older person.

We now have clarity on a new model of care for the frail older person that starts in an ICC and follows the individual in and out of care settings as quickly and safely as possible. In the next year we will continue to evolve care models and create a frailty team in each ICC and ensure that connections with well-being, preventative and home care are made to reduce duplication, improve experience and get a much better approach to frailty that is supported at home.

We also have a new model of urgent care based around Accident and Emergency departments and what started out as a Furness General hospital initiative has created the blueprint for building relationships and care pathways across the system and has tested models of working differently to improve care and experience in the emergency setting.

The Millom Experience

- Developing more in the community including ‘Around the Combe’ a local newsletter created by the community and to share knowledge and include information on managing ill health.
- Millom also created a support group called ‘2s R Us’ a diabetes group.
- Millom community members shared their experience at the inaugural Kendal community meeting.

1.16 Quality

NHS Cumbria Clinical Commissioning Group continues to develop and expand a number of its quality assurance systems and processes, including information and intelligence systems, executive level quality assurance systems and early warning systems.

The intelligence systems are based upon the providers of care, which are commissioned by the CCG, examining and reporting the quality of care issues that commissioned services deliver.

These include serious incidents requiring investigation, complaints, patient experience and the application of NICE recommendations. These aspects are always checked against the CCG’s own intelligence systems which are based upon:

- information received from external organisations such as the Care Quality Commission (CQC), NHS England (NHSE) and Healthwatch Cumbria
- the Strategic Executive Information Systems (STEIS), which is the national system for NHS organisations to report serious incidents
- concerns raised by GPs including through our SIRMS electronic system
- feedback the CCG receives from patient experience data including ‘I Want Great Care’, General Practice and CCG localities
- complaints received from patients, members of the public, and elected leaders including Members of Parliament.
Individual and collective aspects are addressed directly with the providers by the CCG’s Quality and Safety Team.

The North of England Commissioning Support Unit (NECS) provide support to the CCG by monitoring these systems and providing intelligence, reporting and personal involvement in the Quality and Safety team to support CCG decision making. NECS is able to draw on wider knowledge of systems across the North of England as well as Cumbria and we are increasingly able to use this to benchmark our organisations against their peers.

Throughout the year a new joint approach with Lancashire North CCG has been established to enable the two CCGs to have one Quality surveillance system for University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) with influence over the contracting process. In the past these commissioners have worked separately. Increasingly these systems are bearing relevance to the Better Care Together programmes of work. NECS is supporting the CCGs (and its partner CSU) with joint reporting and joint hospital assurance visit programmes.

From this intelligence the CCG holds the providers to account at monthly Quality Review Groups held with each provider and representatives from the CCG.

In addition to this monthly monitoring, the CCG Quality Team is fully involved in the commissioning process and the information is used for all commissioning reviews, plans or developments. The Quality Team also ensure that the actions providers state they have undertaken to address a concern in the quality of care are directly checked and scrutinised using a regular system of CCG hospital assurance visits to all provider sites over the course of each year.

Each visit always involves a medical professional, nursing professional and Lay Member/Governing Body representative from the CCG. They are provided with all the information on the quality concerns that have occurred on the respective visit site(s). This ensures that the CCG can provide assurance to the Governing Body and the population of Cumbria that care quality concerns are progressed to a positive resolution.

The CCG recognises that there are significant quality concerns with providers across Cumbria and we have not at this stage, secured continuous improvement in the quality of services provided to individuals for, or in connection with the prevention, diagnosis or treatment of illness. Although we note that UHMBFT has successfully been taken out of ‘Special Measures’ by the CQC during the last year.

In addition the CCG recognises that at times, constitutional standards are not being met by some providers, in particular with regard to some waiting times and 12 hour breaches although these are all reported and addressed through the systems outlined above.

Looking forward to the coming year 16 – 17 the CCG are reviewing QRG processes currently to ensure that they are more robust and a Quality Improvement Board has been established for NCUHT which is chaired by NHSE supported by CCG and other stakeholders. In addition the CCG is engaged in clinical strategy development as part of Success Regime and Better Care Together. Following the retirement of the CCG’s Lead Nurse for Quality a new Director of Nursing and Quality has been appointed to the CCG and will be taking up the role in May 2016 who will then take the lead for reviewing and addressing the quality of care provided and the assurance systems presently in place in the CCG.
1.17 Safeguarding

We have systems and processes in place to fulfil our specific duties of co-operation and best practice in relation to safeguarding vulnerable people.

The CCG has in place effective governance and accountability arrangements to fulfil our statutory duties of cooperation and best practice in relation to safeguarding. This includes regular reporting to the Governing Body and updates and exceptions reports to the Quality and Outcomes Assurance Committee.

The CCG makes a significant contribution to the work of the Local Safeguarding Children’s Board and Cumbria Adult Safeguarding Board. The statutory Health and Wellbeing board with responsibility for safeguarding has Executive CCG representation.

In its role in coordinating and driving improvements across the health system, the CCG has chaired a health systems group with executives, senior managers and safeguarding leads from across all providers. The CCG Safeguarding Strategy outlines the key priorities for children and adults and these plans are reviewed by this group and driven by the Local Safeguarding Children’s Board (LSCB) Health Group for children, with a similar group in development for adults.

There is a CCG safeguarding audit and assurance programme in place with our providers. All CCG contracts for commissioned services include a requirement to report annually against a set of safeguarding children and adult safeguarding standards. The CCG has the opportunity to monitor and challenge actions such as training compliance and progress against the outcomes of serious incidents to ensure learning has been embedded.

The County Lead GPs for Safeguarding Children and Adults, with the Locality Named GPs, have provided ongoing leadership and support to the CCG in its duty to make improvements in the quality of primary care.
1.18 Regulatory Intervention

In 2015 the following Care Quality Commission conducted a follow up inspection at North Cumbria University Hospitals NHS Trust (report published 8 September 2015) and University Hospitals of Morecambe bay NHS FT (report published 3 December 2015). This followed earlier inspections which had resulted in both Trusts being placed in special measures. In late 2015 the Care Quality Commission undertook the first full inspection of Cumbria Partnership NHS FT (report published 23 March 2016).

The Care Quality Commission inspects all services against the following domains:

- Is it Safe?
- Is it Effective?
- Is it Caring?
- Is it Responsive to patients needs?
- Is it Well led?

For each domain the Care Quality Commission makes a judgement of:

- Inadequate
- Requires Improvement
- Good
- Outstanding

The outcome of each of the inspections is summarised in the table below. Further information on each of the inspections can be found at www.cqc.org.uk

<table>
<thead>
<tr>
<th></th>
<th>Cumbria Partnership NHS FT</th>
<th>North Cumbria University Hospitals NHS Trust</th>
<th>University Hospitals of Morecambe Bay NHS FT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
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<tr>
<td>Effective</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Caring</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Responsive</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Well Led</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Overall</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>

Following those inspections each Trust was required to agree an improvement plan, which addressed the detailed findings of each inspection.

At the end of March 2016 the Care Quality Commission had conducted inspections of 34 General Practices in Cumbria.

A summary of the overall findings for those Practices is shown below. The percentage equals the percentage of the 34 inspected practices in each category. This demonstrates that although General Practices in Cumbria are facing considerable challenges, overall they have performed very well in the inspection regime compared to the national position.

<table>
<thead>
<tr>
<th></th>
<th>Outstanding</th>
<th>Good</th>
<th>Requires Improvement</th>
<th>Inadequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Practices</td>
<td>6</td>
<td>27</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>% of Practices</td>
<td>17.6%</td>
<td>79.4%</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>National</td>
<td>4%</td>
<td>81%</td>
<td>11%</td>
<td>4%</td>
</tr>
</tbody>
</table>
1.19 Cumbria Learning and Improvement Collaborative (CLIC)

Over the last 12 months, CLIC has continued to drive a positive transformation in health and care, focusing our efforts on learning from and with each other, practicing continuous improvement, and developing leadership skills. In the spirit of ‘just do it’, the team have supported individuals and teams with their ideas, while aligning resources with the priorities of the Success Regime and Better Care Together programmes. As a result, the principle that ‘we all have two jobs’ (to do our job and to improve our job) is beginning to spread, with more and more health and care staff across Cumbria and the Morecambe Bay area working to change the way we do things around here.

CLIC was awarded £557,000 by Health Education North West (HENW), which has funded the Clinical Nursing Skills Programme. The team was in place from May and June 2015. Since then, working closely with the University of Cumbria, more than 130 workshops were facilitated bringing together nurses from across organisations.

**Reached:**
- delivered to over 1,400 registered nurses
- 20 follow-ups completed in the workplace in order to embed learning

**Benefits:**
- nurses’ increasing confidence in reflective practice
- active engagement in their Continuing Professional Development
- building of networks across organisations
- £212,000 has been granted by Health Education North West to deliver more training to support workers across health and social care
- Cumbria Production System (CPS) Toolkit launched in June 2015
- Collection of useful, evidence-based improvement methods on-line

- 34 CPS workshops have been delivered
- Facilitated more than 25 improvement sessions
- Reached more than 900 staff in Cumbria and the Morecambe Bay area

**Leadership support:**
- A successful bid was made to the North West Leadership Academy in August to build capability and capacity in the local system and develop a coaching culture. In addition to the 4 leaders who will be trained in coaching principles. A grant of £3,000 received will facilitate the sharing of learning amongst their senior colleagues, enabling individuals to lead by example, cascading these behaviours and practices throughout the entire workforce.

1.20 North of England Commissioning Support (NECS)

We continue to commission support functions from North of England Commissioning Support (NECS) including, service planning and reform, clinical quality, financial support and medicine optimisation to help achieve our commissioning goals.

NECS is one of the leading commissioning support organisations in the country and is included on NHS England’s lead provider framework. In partnership they help us deliver life changing improvements across health and social care. NECS work with more than 40 Clinical Commissioning Groups in England as well as local authorities, hospitals and clinical networks. NECS prides itself on quality, cost effective and innovative solutions to commissioning challenges.
1.21 Enquiries and Complaints

The North of England Commissioning support Unit (NECS) supports the CCG with the management of complaints that relate to the services we commission.

The CCG aims to improve the health and well-being of all people in Cumbria by ensuring that our patients receive the highest standards of healthcare possible. When mistakes happen, we ensure that lessons are learned to help avoid a similar incident occurring again.

The views and opinions of our patients and families help us to understand when the NHS is doing things well and when it could do something better. Complaints are an essential source of information about the services the CCG commissions and believe that all complaints provide an opportunity to learn and a chance to put things right. We do this by reflecting the Parliamentary and Health Service Ombudsman’s Principles for Remedy:

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

All healthcare providers must provide a complaint service within the requirements of the Complaint Regulations 2009 and any complaint you make about NHS services is to be acknowledged within three working days and properly investigated.

A complaint handler is allocated to a case and a plan detailing how the CCG proposes to investigate the concerns and within what time period, is created.

The CCG aims to resolve complaints quickly and easily with those directly involved; this is called local resolution. Local resolution can also provide a more formal process if necessary.

Complaints should be made within 12 months of the occurrence or from the time you become aware of the matter. Complaints brought later than this are to be investigated if there are good reasons for the delay and it is still possible to carry out the investigation.

If you are not satisfied with the way your complaint has been handled by the NHS, you have the right to take your complaint to the independent Parliamentary and Health Service Ombudsman.
There are two concerns not contained in this report which were originally handled by the Complaints Department but are outside of the team’s usual remit. These were in relation to a staff complaint and a complaint which was later deemed as an MP enquiry.

There have been 30 formal complaints over the year and seventeen of these have been regarding Continuing Healthcare restitution funding decisions. The majority of these are challenging the procedure in the absence of an appeals process.

1.22 Emergency Preparedness

The CCG has a Business Continuity Plan in place. The CCG is a Category 2 responder under the Civil Contingencies Act 2004 and must respond to reasonable requests to assist and cooperate during an emergency, and ensure that contracts with its provider organisations contain relevant emergency preparedness, resilience and response elements. Overall responsibility for emergency preparedness lies with NHS England, Cumbria, and North East (CNE) Area Team and is therefore responsible for co-ordination of the health response in the event of a major incident. The CCG therefore utilises the Major Incident Plan developed by the Area Team and would work with them in the event of a major incident. Regular test events take place across all Category 1 and 2 responders to ensure preparedness in the event of an incident and the CCG takes part in these events.

The CCG continues to have a 24 hour on call presence at Director level to ensure availability of expertise for urgent commissioning decisions, to support very high levels of emergency activity and when necessary, to provide support to the Area Team and other Category 1 responders in the event of a major incident.

1.23 Managing Finances

The Annual Accounts have been prepared in accordance with the Government Financial Reporting Manual, taking account of the application guidance contained in the Department of Health Group Manual for Accounts, as directed by the NHS Commissioning Board.

Financial stability is important to achieve our plans and we are pleased that the financial year was successful in terms of overall financial performance, meeting all of our key financial responsibilities to:

- Achieve operational financial balance
- Remain within cash financing limits
- Pay 95% of creditors within 30 days of receipt of invoice

The CCG’s 2015-16 Financial Plan recognised the financial pressures it faced and targeted the delivery of a £5 million surplus. However, in July 2015 Monitor announced a Local Price Modification to the national “payment by results” tariff for services provided by the University Hospitals of Morecambe Bay NHS Foundation Trust. Consequently this resulted in the CCG having to pay the trust in excess of £12 million pounds, and, in agreement with NHS England, the CCG revised its target surplus to a break-even position. The CCG achieved this revised target of 2015/16 generating a small surplus of around £50,000 for the year. Nevertheless, this remained a very challenging target and the CCG was able to benefit from a number of non-recurring contingencies that will not be available during 2016/17.
2015/16

The Accounts have been prepared under a direction from NHS England, under the NHS Act 2006 (as amended). The chart below shows how the CCG’s revenue resources of £729 million were spent in 2015 – 16. This expenditure reflects that during 2015 –16, in addition to the CCG’s on-going funding allocation, the CCG received £11.6 million additional central funding for the Better Care Fund that had previously been routed directly to Cumbria County Council.

A full breakdown of our annual accounts is included as Part 3.

The on-going system-wide financial pressures, along with issues of quality and clinical sustainability, have long been recognised in the North of Cumbria. Therefore, Cumbria CCG is part of West, North and East Cumbria Success regime (see section 1.9.3) that has been tasked with delivering a sustainable clinical strategy for the overall health system. Similarly, the Better Care Together strategy for the Morecambe Bay geographical area incorporates South Cumbria and endeavours to provide a sustainable financial position for the whole of health services in the area. Both patches are required to deliver system wide “Sustainability and Transformation” plans (STPs) to show how services can be delivered within available resources in June 2016. The South Cumbria plan will be incorporated into the wider “Lancashire & South Cumbria STP”.
2.1 Member’s Report Introduction

This members’ report complies with the disclosure requirements of Chapter 5 of Part 15 the Companies Act (2006) and Schedule 7 of SI 2008 no.140. It is one component of NHS Cumbria CCG’s Annual Report and Accounts 2014/15: a copy of the full annual report and accounts can be obtained from:

www.cumbriaccg.nhs.uk

All 76 GP practices in Cumbria and 1 practice in Bentham, North Yorkshire, are members of NHS Cumbria CCG Membership Body. The full list of members is available at:

www.cumbriaccg.nhs.uk/about-us/how-we-make-decisions/constitution.aspx

2.2 Governing Body

The Governing Body ensures that NHS Cumbria Clinical Commissioning Group (CCG) has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with clearly established principles of good governance.

It ensures that the CCG stays true to its vision and values and in particular:

- As a membership organisation it actively engages its members in decision making and delivery of its overall vision and objectives
- Puts patients and communities at the heart of everything it does, assessing their needs, building on their experiences and involving them in the design of health services and delivery of better outcomes
- Develops constructive and meaningful relationships with its partners and stakeholders in order to deliver high quality, continuously improving service.

Members of the public are welcome to attend to observe the meetings. Details of meetings are available on the CCG’s website.

A full copy of NHS Cumbria CCGs Annual Governance Statement containing: committee structures, roles and responsibilities, membership attendance record and an overview of the year’s work coverage can be found in the Annual Accounts.
Les Hanley – Lay Member
Health Improvement
Les is a director at Age UK and worked at a senior level in the nuclear industry. Les chairs the Outcomes & Quality Assurance Committee and is also a Member of the Remuneration, Audit and Finance & Performance Committees.

Ruth Gildert – Nurse Member
Ruth spent 40 years in nursing and senior management in the NHS and has retired back to Cumbria. She is a member of Remuneration, Finance & Performance and the Outcomes & Quality Assurance Committees.

Anthony Woodyer – Consultant Member
Anthony’s career has included taking the role of clinical lead for surgery; managing the Day Case/Endoscopy Unit, Associate Medical Director, and Trust Medical Director. Anthony is a member of Outcomes and Quality Assurance Committee, Finance and Performance Committee, Remuneration and Audit Committee, Serious Incident Review Group and Individual Funding Review Group at NHS Cumbria CCG and a Partner Governor with the University Hospitals of Morecambe Bay NHS Foundation Trust.

Dr Geoff Jolliffe
Dr Jolliffe is the lead GP for Furness and is also undertaking the role of Interim Clinical Chair. He is part of the Risedale Surgery in Barrow and has special interests in respiratory disease and palliative care. He is currently the Chair of Furness Locality Executive, the Governing Body, Clinical Leads Group and Finance & Performance Committee.

Dr Rachel Preston
Dr Preston is part of the Lakes Medical Practice in Penrith and represents the North Cumbria GP membership at the Governing Body. She is the Lead GP for Eden locality and chairs the Eden Locality Executive.

Dr Hugh Reeve
Dr Reeve is the CCG’s Interim Chief Clinical Officer. He is a senior partner in the Nutwood Surgery in Grange over Sands. He is a Member of the Clinical Leads Group, the Finance & Performance Committee, the Better Care Together Programme

Dr David Rogers
Dr Rogers is the CCG’s Medical Director and the Clinical Lead for serious incidents. He continues to do a small amount of General Practice at Fellview Practice in Cleator Moor. He is a member of the Clinical Leads Group and chairs several other groups on behalf of the CCG.
Jon Rush – Lay Member
Patient Engagement
Jon was a Chief Superintendent with Greater Manchester Police after spending 24 years working for Cumbria Constabulary where he became Deputy Commander. Jon is a member of the Outcomes and Quality Assurance Committee, Remuneration Committee, Audit Committee and Finance and Performance Committee.

Peter Scott – Lay Member
Finance and Governance
Peter has more than 30 years’ experience in the NHS holding Director of Finance posts at local, regional and national level. He is Vice-Chair of the Governing Body, chairs the Audit and Remuneration Committees and is a Member of the Finance & Performance Committee.

Charles Welbourn
Charles is the CCG’s Chief Finance Officer. He is a Member of the Clinical Leads Group and Finance & Performance Committee.

Nigel Maguire – Chief Officer
Nigel was the Chief Officer for the CCG and left in September 2015. He was a member of the Governing Body, Clinical Leads Group and Finance & Performance Committee.
2.4 Locality Lead GPs

Dr Jim Hacking
Dr Hacking is the lead GP for South Lakes. He is part of the Park View Surgery.

Dr Helen Horton
Dr Horton is the lead GP for Copeland. She is part of Distington Surgery.

Dr Geoff Jolliffe
Dr Jolliffe is the lead GP for Furness. He is part of the Risedale Surgery in Barrow and has special interests in respiratory disease and palliative care.

Dr Niall McGreevy
Dr McGreevy is Lead GP for Allerdale and chair of the Allerdale Locality Executive. Dr McGreevy is a GP at James Street Surgery in Workington.

Dr Colin Patterson
Dr Patterson is the Lead GP for Carlisle and chairs the Carlisle Locality Executive. Dr Patterson is a GP at Brunswick House Surgery in Carlisle.

Dr Rachel Preston
Dr Preston is the lead GP for Eden. She is part of the Lakes Medical Practice in Penrith.
2.5 Clinical Leads

**Dr Amanda Boardman**
Dr Boardman is the Clinical GP Lead for Children and Safeguarding. Her role is to support GPs to enable effective safeguarding and provide clinical leadership in developing high quality children’s services.

**Dr William Lumb**
Dr Lumb is Chief Clinical Information Officer and provides both technical and informatics support to NHS Cumbria CCG. He works with key stakeholders across Cumbria and with the CCG’s Executive to shape overall informatics strategy.

**Dr Neela Shabde**
Dr Shabde is the Clinical Director for Children and Families. She brings paediatric and safeguarding expertise. She works with multi-agency partnerships to improve outcomes for children and young people. Dr Shabde retired on 31 March 2016.

2.6 Senior Management Team

**Laura Carr**
Laura is Lead Nurse for Quality and Safety and Clinical Director for Mental Health and Learning Disabilities. Laura is a member of the Clinical Leads Group and Outcomes and Quality Assurance Committee. Laura retired on 10 April 2016.

**Anthony Gardner**
Anthony is the lead director for South Cumbria. Anthony is a member of the Clinical Leads Group, Better Care Together Programme Board, South Lakes and Furness Locality Executive meetings.

**Eleanor Hodgson**
Eleanor is the Director for Children and Families and is a member of the Clinical Leads Group.

**Caroline Rea**
Caroline is the Director of Primary Care and is a member of the Clinical Leads group, and Outcomes and Quality Assurance Committee.

**Peter Rooney**
Peter is the CCG’s Interim Chief Operating Officer. He is a member of the Finance & Performance Committee and Clinical Leads Group.
The Senior Management team also includes:

- Dr Hugh Reeve
- Dr David Rogers
- Charles Welbourn

The CCG’s staffing structure as of 31 March 2016 is available at:

www.cumbriaccg.nhs.uk/about-us/who-we-are/ccg-structure.aspx

*Each director knows of no information which would be relevant to auditors for the purposes of their report, and of which the auditors are not aware, and; has taken “all the steps that he or she ought to have taken” to make himself/herself aware of any such information and to establish that the auditors are aware of it.

2.7 Register of Interests

The CCG’S Register of Interests is set out below. However, the CCG has determined that there are no material declarations of interests of conflicts.

The CCG’s register of interests is available at:


2.8 Equality and Diversity

Section 149 of the Equality Act places an additional set of requirements upon public bodies, known as the Public Sector Equality Duty (PSED). The specific duty requires public authorities to publish annually information on the effects of their services and employment on people who share a protected characteristic and to put in place Equality Objectives:

- ensure equality is everyone’s business
- improve health and well-being of the local community
- deliver services that improve patient experience

The Equality Report for 2016 is available on the CCG website and shows how NHS Cumbria CCG is meeting its commitment to Equality Legislation and how we are making progress towards our Equality Objectives.

NHS England Five Year Forward View looks to a future of a health system with a new relationship with patients and communities and sets out a series of commitments in relation to empowering people, supporting carers, promoting volunteering and engaging the voluntary sector and communities.

The CCG is committed to making sure that equality and diversity is a priority when planning and commissioning local health care. The Success Regime and Better Care Together are starting to describe very different models of health care provision, with an increasing focus on General Practice and other community services, and the need to reduce reliance on hospital based care.

This year saw the establishment of a Public Sector Equality Steering Group, which will be looking to develop a county wide Equality Strategy leading to shared Equality Objectives.

2.9 Meeting Statutory Human Rights Requirements

The Human Rights Act 1998 sets out a range of rights which have implications for the way the CCG commissions services and manages their workforce. The CCG, like all public authorities, has a positive obligation (Human Rights Act 2000) to respect, protect and promote human rights.

Human rights values such as Fairness, Respect, Equality, Dignity and Autonomy (FREDA) underpin the public service ethos, the NHS Constitution and NHS professional codes of conduct.

By putting human rights at the heart of health services we can not only comply with the law but also improve the quality of health care. To help achieve this, the CCG has embedded the human rights based approach into its Equality Impact Analysis process.
2.10 Staff Development

The CCG promotes and supports staff learning and development across the organisation in a number of ways. Personal development needs are established through the appraisal review process which informs a rolling skills, learning and development programme.

Several members of staff are being supported to undertake nationally accredited educational leadership programmes via the NHS Leadership Academy including the Elizabeth Garrett Anderson and Nye Bevan.

NHS Cumbria CCG works closely with CLIC (Cumbria Learning & Improvement Collaboration) to scope and deliver learning opportunities for the CCG and wider Cumbria health economy. A range of programmes are offered in 3 key learning areas including Leadership, Improvement Tools and Education & Learning. Other senior leads have taken part in leadership programmes offered by neighbouring NHS organisations, NECS and Northumbria Healthcare.

In house training supports staff in specific roles and is developed and delivered in accordance with business needs i.e. Senior Leaders Development Programme, HR Training, Emergency Planning. This forms part of individual’s core development and links with wider development programmes.

Staff Development Events are also held 3 times a year, these allow staff an opportunity to collectively develop and learn together.

NHS Cumbria CCG took part in the NHS Staff Survey for the first time this year. There was a good take up among staff and an action plan is being developed with Director level support to tackle areas giving concern.

This year:
- 95% of appraisals have been completed
- 97% of mandatory training has been completed
- 85% of staff members have chosen to complete some additional learning over the past 12 months
2.11 Staff Sickness

The CCG recognises the contribution of its employees and is committed to providing good working conditions and to ensuring that health and safety standards are met.

Processes are in place to ensure managers address sickness absence issues, both short and long-term, in a fair, consistent and equitable manner.

In dealing with any sickness absence cases, CCG managers are mindful of obligations that they and the organisation may have under the Equality Act 2010.

Managers are fully trained in policies and procedures relating to absence and are supported, where required, by a dedicated HR Business Partner from North of England Commissioning Support, who the CCG commissions the HR service from. Where appropriate advice is sought from appropriate medical professionals though the Occupation Health service. All new starters are made aware of the relevant policies and procedures during their induction.

NHS Cumbria CCG’s Human Resources policies are available at www.cumbriaccg.nhs.uk

The absence rate for the CCG (1 January to 31 December 2015) was:

<table>
<thead>
<tr>
<th>Average of 12 months Absence (% of FTE)</th>
<th>Average FTE 2015</th>
<th>Total FTE Days Available</th>
<th>Total FTE days Lost to sickness absence</th>
<th>Average Sick Days per FTE</th>
<th>Estimated Cost of Sickness Absence</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.31%</td>
<td>100.38</td>
<td>22,584.69</td>
<td>747.55</td>
<td>7.45</td>
<td>£218,461.24</td>
</tr>
</tbody>
</table>

2.12 Communication and Engagement

The activity in the Communications and Engagement Team has centred around the main programmes of work – Success Regime and Better Care Together and the GP Development programme.

Freedom of Information Requests (FOIs)

The Freedom of Information Act gives the right to all individuals to request access to information held by NHS Cumbria CCG with a response within 20 working days. There have been 274 FOI requests received since April 2015 (up until March 29th 2016). Key themes are finance, contracting, prescribing and medications. This year has shown an increasing number of FOI requests from drug companies and IT companies.
Accountability Report - Part 2

MP Letters

During the current year there has been 64 MP letters (up until March 29th 2016), which the CCG aim to respond to within ten working days. A number of the letters relate to individuals, either their treatment or medications. Other themes include continuing health care and transport.

Parliamentary Enquiries

Parliamentary enquiries come from the Senior Briefing Officer at NHS England in response to questions raised by local MPs in the House of Commons. They are usually at short notice with a quick turn-around time. Since October 2015 (when a formal logging system for these requests was introduced) the Communications and Engagement Team have received 13 covering a range of issues including West Cumberland Hospital, the Success Regime, maternity services and travel issues.

Press Releases & Media Enquiries

Since September last year (when the updated logging process was introduced) the Communications Office has received approximately 38 media enquiries and produced around 48 press releases.

Social Media is an important way of sharing key messages and health information. In April 2014 we had 7,056 followers which has grown to 8,051. Facebook is an area we are trying to grow and will continue to focus on in the year ahead.

Social media proved to be particularly helpful during Storm Desmond and were able to update the public and media organisations in real time as the events unfolded. An appeal for doctors to help CHOC had more 32,000 impressions and 193 retweets. It was also a key way of communicating with staff.

The NHS Cumbria CCG website is also being updated and improved and a new intranet is due to go live in Summer 2016.

Publications

We have established several regular newsletters. GP News is produced every two weeks to GPs and Practice Managers providing updates on the quality and performance, clinical and service updates and event and training opportunities. Staff News is produced every two weeks and bringing together a wide range of useful information for staff. This includes updates on the key programmes of the Success Regime, Better Care Together and Mental Health. From Hugh is a regular communication briefing from the Interim Chief Clinical Officer to staff providing updates on key developments within the organisation.

Engagement Activity

Engagement is a key part of the work carried out by NHS Cumbria CCG. In 2015/2016 the CCG have played an active and regular role in the West Cumbria Community Forum, which brings a wide range of individuals together who represent groups with an interest in health services in the area. The information gathered through this and through similar sessions is fed back into the CCG commissioning team, who are responsible for developing services.

The Communications and Engagement team also supported a countywide, month long, engagement in November 2015 around ‘what a good Maternity Service looks like’, working with partners including Healthwatch Cumbria and the county’s Maternity Liaison Services Committees.
The team also works with the county’s transformation programmes – Better care Together, West, North and East Success Regime and Mental Health Services. The feedback is gathered and fed directly into the workstreams focusing on the relevant areas.

Other areas of engagement work have included:

• supporting the development of patient forums and integrated care communities;
• working with GPs on the GP development programme, and
• an exhibition and open day in Barrow about the primary care centre planned for the Alfred Barrow School site.

2.13 Health and Safety

The CCG has legal and statutory obligations under the Health and Safety at Work Act 1974 and subsequent regulations to ensure the Health, Safety and Welfare of its employees and those visiting its premises.

North of England Commissioning Support (NECS) are contracted to provide Health and Safety/Fire and Security Services to NHS Cumbria CCG therefore NECS are responsible for Health and Safety/Fire and Security and the CCG as an employer are accountable.

Over the last 36 months there has been a considerable amount of work undertaken to meet and deliver its legal obligations around Health and Safety/Fire. Cumbria CCG continues to strive for continued improvement and performance around Health and Safety and to minimise incidents in relation to Health and Safety ensuring a safe working environment for its staff and visitors to its premises.

To ensure compliance with Health and Safety/Fire and Security the CCG have undertaken the following work:

1. Developed and agreed Health and Safety Strategy which sets out the framework for Health and Safety within the organisation.
2. Annual Health and Safety Audits to ensure compliance against all legislation relevant to the CCG.
3. Annual work plans to ensure work around strategy is taken place and completed.
4. Regular Governance meeting around work plan.
5. Policies and Procedures in place details the organisations requirements around legislation which also details individual’s responsibilities and also detail around gaining assurance on the requirements.

2.14 Fraud

The CCG is committed to reducing fraud, bribery and corruption within the NHS in line with this national strategy. The CCG will investigate genuine and reasonable concerns expressed by employees, will seek appropriate disciplinary, regulatory, civil and criminal sanctions against fraudsters and, where possible, will seek to recover any losses.

The CCG has in place a Local Counter Fraud, Bribery and Corruption policy. The overall principles of the policy are:

• improve the knowledge and understanding of everyone in NHS Cumbria CCG irrespective of their position, about the risk of fraud, bribery and corruption within the CCG and its unacceptability;
• assist in promoting a climate of openness and a culture and environment where staff feel able to raise concerns sensibly and responsibly, and to provide details of how to raise any such concerns;
• set out NHS Cumbria CCG’s responsibilities in terms of the deterrence, prevention, detection and investigation of fraud, corruption and bribery;
• ensure that appropriate sanctions are considered following an investigation.

This Policy applies to all those employed by the CCG, irrespective of position held, on all sites. This includes temporary staff, students, volunteers, consultants, contractors, vendors, lay members and/or any external organisations that have a business relationship with the CCG.

2.15 Cost Allocation and Setting of Charges for Information

The CCG certifies that it has complied with HM Treasury’s guidance on cost allocation and the setting of charges for information.
2.16 Audit Services

The external auditor appointed by the CCG is:
Grant Thornton UK LLP, 4 Hardman Square, Spinningfields, MANCHESTER M3 3EB

Services commissioned for 2015/16 were for external audit services for NHS Cumbria CCG at a cost of £85,000.

2.17 Compliance with National Health Service Act 2006

The CCG certifies that it has complied with the statutory duties laid down in the National Health Service Act 2006.

Details of how the CCG has discharged its duties can be accessed in the Annual Governance Statement.

2.18 Statement of Accountable Officer’s Responsibilities

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

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

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

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

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

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

I also confirm that:

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

Dr Hugh Reeve
Interim Chief Clinical Officer (Accountable Officer)
26th May 2016
2.19 Annual Governance Statement by the Accountable Officer

Introduction & Context

The core purpose of the CCG is “to commission the majority of healthcare safely, to discharge responsibly their stewardship of the majority of the NHS budget and exercise their functions in relation to improving quality, reducing inequality and being efficient, and hence delivering better outcomes within their resource”.

The Annual Report details the CCG’s core functions and strategic programmes.

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

As at 1 April 2015, the CCG was licensed without conditions.

Scope of Responsibility

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

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

Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, the CCG considers that compliance is good practice and strives through its leadership and governance arrangements to ensure it meets the main principles of the Code.

This has been demonstrated by:

- **Leadership** - ensuring the principles of effective leadership have been embedded during 2015/16. Lay/Clinical Members have continued to constructively challenge and help develop proposals on strategies, ensuring conflicts of interests are managed along with everyday working practices of the CCG. In particular it has ensured that any business cases proposed in relation to General Practice Development schemes have been scrutinised and approved by the Governing Body.

- **Effectiveness** - continuing to review the terms of reference for the CCG’s committees to ensure that they have an appropriate balance of skills, experience, and independence. During 2015/16 the CCG has continued to hold development sessions for the Governing Body to ensure that there is sufficient knowledge within the decision making body to enable them to discharge their responsibilities effectively. In addition the CCG has developed a formal, rigorous and transparent procedure for the appointment to individual roles of the Governing Body.

- **Accountability** - The Governing Body receives regular updates to enable it to have an understandable assessment of the CCG’s position and prospects. Alongside of this the CCG’s risk assurance framework has continued to be maintained and updated to provide the Governing Body with a clear understanding of its main risks to achieving its strategic objectives.

- **Remuneration** - The CCG works within the Agenda for Change framework for the remuneration of its employees. For Very Senior Officers (VSM) the Remuneration Committee ensures it has a formal and transparent process for determining the remuneration packages of these officers. This includes evaluating the requirements of the post and undertaking comparisons with like for like organisations to ensure that the CCG retains professional, high quality officers.

- **Relations with Stakeholders** - During 2015/16 there have been major developments in the way the CCG works with its stakeholders. Closer working relationships have been developed and as a result the CCG has amended its Constitution in order to enable the Governing Body to set up joint committees with other CCGs/organisations.
The Clinical Commissioning Group Governance Framework

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

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

As Accountable Officer I have continued throughout 2015/16 to work with the Membership, Governing Body, CCG Officers and other stakeholders to ensure that the CCG’s Constitution remains relevant and consistent with the CCG’s vision to commission safe, secure, high quality services across Cumbria and reduce inequalities across the whole health care system.

In 2015/16 the CCG has reviewed its Constitution, Standing Orders, Reservation and Delegation of Powers and Prime Financial Regulations to enable the CCG to establish joint committees which will help to develop greater working relationships with partner organisations. These were approved by the Full Council of Members on 20 April 2016 and will be submitted to NHS England for ratification.

An Internal Audit has been undertaken by Audit North on the CCG’s Governance and Risk Management Systems. The conclusion of this report was that a rating of ‘significant assurance’ was issued. Audit North’s summary to the report stated:

“The governance structures and Risk Management put in place by Cumbria CCG closely reflect those recommended by NHS England and, as such are based on accepted best practice for CCGs. The committee structure is appropriate to the size and nature of the organisation, a risk management process is in place and risk mitigation is regularly addressed by senior management. The CCG has a number of high risk issues articulated on its Board Assurance Framework and Risk Register which it must continue to monitor and mitigate as far as it can. Although a number of committees and groups discuss risks and mitigating actions, we were unable to obtain evidence to demonstrate the full extent of the discussions of these key risks and associated actions to provide a comprehensive audit trail of monitoring arrangements in place.”

Key findings for management attention

In general, we found that the design of the controls and the overall governance structure in Cumbria CCG was sound. The committee structure was operating effectively and in accordance with NHS England guidance. Similarly, the CCG has adopted a risk management framework which provides for a structure appropriate to the size and nature of the organisation and the Governing Body regularly reviews issues associated with the key risks. However, we did identify a number of areas where the CCG had inconsistently applied its own constitution, in particular:

• whilst the terms of reference of key committees closely followed NHS England guidance, the copies provided to us showed no evidence of them having been reviewed at the appropriate time as required by the CCG constitution;
• although there is an agreed and understood timetable for submission of papers to key committees, this is not documented and could thus be open to challenge;
• the constitution requires that a lay member be appointed to represent the third sector, however this position remains unfilled;
• information regarding key meetings was out of date on the CCG website at the time it was reviewed;
• there is no evidence that either the Finance and Performance Group or the Directors Group have reviewed the risk register in the last year as required by the RM framework adopted by the Governing Body; and
• the Governing Body have reviewed the Assurance Framework/Risk Register twice in the last year rather than quarterly as detailed in the framework

The CCG has taken on board the comments listed above and procedures are in the process of being put in place to address the issues raised.

In addition to the above, NHS England have requested that Pricewaterhouse Cooper (pwc) undertake a number of reviews on governance processes and financial management at a selection of CCG’s across the Country, one of which is NHS Cumbria CCG. This review is currently underway and due to report back at the end of April 2016.
The CCG remains accountable to its 77 (reduced from 82 due to practice mergers) Member Practices which are responsible for ensuring that it carries out its functions and general duties. It is the responsibility of all CCG employees, Member Practices, the Governing Body, its committees, sub-committees and anyone else acting on behalf of the Group to ensure compliance with the Constitution, Standing Orders, Reservation & Delegation of Powers and Prime Financial Policies. Despite the severe financial challenges across the Cumbrian health economy, the CCG remains committed to working within its resources to commission care in the most appropriate setting and with the aim of ensuring our patients have the best experience and clinical outcomes from the services commissioned.

On 19 November 2015 the Full Council of Members met to receive an overview of the Cumbrian Health System, consider how the CCG works with its Membership and agree the Cumbria General Practice Plan. As part of the overview of the Cumbrian Health System, Members were advised of the Success Regime (north of the County) and Better Care Together (south of the County) programmes and how this could result in different ways of working for the CCG. Pending further development of these programmes the Membership approved the extension of the contracts of the three Lay Members and the Governing Body Registered Nurse until April 2017.

A further meeting was held on the 20 April 2016 to provide Members with updates on the following programmes:

- General Practice Development
- the Success Regime; and
- Better Care Together

Members were also advised on how the CCG would need to refocus its resources in order to meet the changing requirements within the Cumbrian health economy in the light of the above programmes. With these possible changes in mind the Membership also approved changes to its governance arrangements to allow for joint committees to be formed with other CCGs. It also agreed that the Governing Body be responsible for approving changes to the CCG’s Standing Orders, Reservation and Delegation of Powers and Prime Financial Regulations.

### Attendance at the Full Council of Members 2015/16:

<table>
<thead>
<tr>
<th>Total Membership</th>
<th>Total of Number of Formal Meetings Held</th>
<th>% Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>2</td>
<td>59</td>
</tr>
</tbody>
</table>
The Governing Body

The prime focus of the Governing Body is to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG’s principles of good governance whilst remaining true to its vision and values. In particular:

- As a membership organisation it actively engages its members in decision making and delivery of its overall vision and objectives;
- Puts patients and communities at the heart of everything it does, assessing their needs, building on their experiences and involving them in the design of health services and the delivery of better outcomes;
- Develops constructive and meaningful relationships with its partners and stakeholders in order to deliver high quality, continuously improving services

The Governing Body also provides assurance that the CCG is compliant with its statutory duties and that it meets key national requirements for governance in order to be a public organisation. It also has oversight of all the CCG’s committees and ensures that the key functions of the CCG are delivered. The Governing Body is responsible for:

- Approving the vision and values of the CCG
- Approving the CCG’s commissioning plans
- Providing assurance (through its Outcomes & Quality Assurance Committee) that quality and outcomes are improving and that health inequalities are reducing
- Approving the financial strategy and annual budget
- Providing assurance that safeguarding, (for both Adults & Childrens) arrangements are effective
- Creating and maintaining a culture of openness and transparency, values and behaviours which support continuous improvements in clinical effectiveness, safety and experience of the services which are commissioned
- Assuring the wider CCG, patients and communities that performance is in line with plans and local needs and that recovery action plans are in place where necessary
- Ensuring that a register of interests is maintained and reviewed regularly and updated as necessary
- Providing assurance that strategic risk is being effectively managed
- Providing formal resolution of disputes between Localities, including recommendations to the Full Council of Members where appropriate
- Determining recommendations from the Remuneration Committee on the terms and conditions for all posts above the top threshold of the National Agenda for Change (AfC) pay-scale, including off-payroll appointments

The membership of the Governing Body consists of:

I. The Clinical Chair of the CCG (appointed through election by the elected GP’s)
II. Six non-offer members (appointed by the Chair of the CCG) including:
   - Four Lay Members (Finance & Governance Lead; Public Engagement Lead; Health Improvement Lead and a Third Sector Organisations Lead)
   - a registered nurse (Clinical Member)
   - a secondary care specialist doctor (Clinical Member)
III. Five officer members including:
   - the Chief Officer
   - two elected locality Lead GPs
   - the Chief Finance Officer
   - the Medical Director

However the fourth Lay Member for Third Sector organisations has not yet been appointed. This is due to the fact that the CCG is currently reviewing its working arrangements in light of the Success Regime and Better Care Together programmes.

2015/16 has again seen some major challenges in the Cumbria health system which the Governing Body has been monitoring closely. Assurance in support of these pressures and the above responsibilities has been regularly presented to the Governing Body as follows:
• Quality Reports identifying issues in provision of services and detailing actions to mitigate risk (these reports are scrutinised in detail at the Outcomes & Quality Assurance Committee prior to onward submission to the Governing Body)

• Performance reports including highlighting risks in key performance areas where they are occurring and forming action plans which, once operational, will mitigate these risks

• Monthly finance reports which detail expenditure to date, areas of concern and action being taken to mitigate risks, including detailed updates on the Local Price Modification at the University Hospital of Morecambe Bay NHS Hospital Trust (UHMB) and the CCG’s Cost Improvement Plan. As appropriate this report also details progress on contract negotiations

• Update reports on the development of the Cumbrian Mental Health Strategy

• Reports on potential conflicts of interest e.g. pathway schemes developed and approved by the Locality Executive which recommend payments to GP practices which are considered and signed off by the Governing Body

• Safeguarding Annual Reports and update reports

• Royal College of Obstetricians & Gynaecologists Report Maternity Review November 2014 (jointly commissioned with NHS Lancashire North CCG [LNCCG]) and the National Review on Maternity Services

• Better Care Together programme - developing facilities to improve access to service in the South of the County

• Success Regime - developing facilities to improve access to services in the North of the County

• Joint working with NHS Lancashire North CCG

• Implementation of the NHS 111 services

• Cumbria Learning Improvement Collaborative Annual Report and update reports

• Communications and Engagement updates which detailed engagement events which have taken place, details on MP enquiries, Freedom of Information requests and complaints made to the CCG

• Better Care Fund

• NHS Cumbria CCG Stakeholder Survey

• Constitutional Changes

In addition to the formal Governing Body meetings Members also receive more detailed briefings in development sessions. These have included:

• Children’s Services update report
• Maternity Review progress
• Success Regime
• Better Care Together Programme
• Working with Lancashire North
• Visions, Values & Objectives
• University of Central Lancashire (UCLan) presentation
• Cumbria Health Deal

There has also been two joint development sessions between NHS Cumbria and NHS Lancashire North CCG’s Governing Bodies to explore the possibility of joint commissioning of services in the South of the County via the establishment of a joint committee. Further development on this will continue into 2016/17 and Constitutional changes have been agreed by the Full Council of Members to enable the establishment of joint committees.

<table>
<thead>
<tr>
<th>Attendance at the Governing Body</th>
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<tbody>
<tr>
<td>Total Membership</td>
</tr>
<tr>
<td>10*</td>
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</tbody>
</table>

*Please note that for the purpose of the calculation below the Lay Member for Third Sector Organisations has not been counted as the post has not yet been filled*
Committees of the Governing Body

Clinical Leads Group

The Clinical Leads Group is the committee where all the Localities come together to give each other advice, reflect on plans and performance, give each other support and have informal, constructive challenge.

The Clinical Leads Group helps co-ordinate and support activity across localities, develop county-wide standards and ensure delivery of the service redesign or pathway work which is commissioned on a county-wide basis. The Clinical Leads Group will also support the Governing Body, manage county-wide strategic risks, and provide a forum for strategic engagement with other county-wide partners and for clinical relationships with NHS England. In addition there is also a role for clinical leaders to informally arbitrate on disputes between localities prior to the formal resolution at the Governing Body or Full Council of Members. The Clinical Leads Group’s primary functions are:

- Providing a forum for the CCG Clinical Leaders to determine clinical strategies and advise the Governing Body
- Providing clinical oversight to major strategic programmes, e.g. Primary Care, Cancer
- Enabling appropriate peer challenge, support and joint problem solving and learning between localities
- Ensuring a formal peer review system is developed and implemented

The Clinical Leads Group responsibilities are:

- Leading the clinical input to the development of the County-wide vision, strategy, clinical policies and standards from a commissioning perspective
- Tackling health inequalities across Cumbria and assessing the extent to which inequalities are being reduced and quality and outcomes are improving
- Overseeing service and pathway redesign where this takes place across the County or a number of localities
- Managing the continuing care budget and other County-wide risk budgets on behalf of the localities
- Responding to decisions on Specialised Commissioning made by NHS England

The Clinical Leads Group consists of the following members:

- Clinical Chair
- Clinical Directors
- Chief Officer
- Director of Clinical Innovation
- Lead Nurse (Quality and Safety)
- Six Locality Lead GPs
- Medical Director

Items considered during 2015/16 include:

- Royal College of Obstetricians & Gynaecologists Report Maternity Review November 2014 (jointly commissioned with NHS Lancashire North CCG) and the National Review on Maternity Services
- Cumbria’s Mental Health Strategy
- CCG Vision, Strategy and Structure
- Joint working with NHS Lancashire North CCG
- Financial updates
- Cost Improvement Plan updates
- Full Council of Members update
- Cumbria Health on Call (CHOC) and NHS 111 Service
- NHS Cumbria CCG Stakeholder Survey

The Clinical Leads Group has also reviewed its Terms of Reference and agreed to meet bi-monthly rather than monthly.
The CCG has six Locality Executives: Allerdale, Carlisle, Copeland, Eden, Furness and South Lakes. Each Locality Executive is responsible for setting the Locality vision and strategy, developing Locality commissioning plans, driving improvements in quality and outcome and reducing inequalities. A key area for the Localities is engaging with patients, communities, third sector organisations and maintaining effective relationships with partners, providers and key stakeholders in the Locality.

It is anticipated that as the CCG refocuses its resources in light of the Success Regime and Better Care Together Programme outcomes there will be a need to review how the Localities function. Therefore the review of the Terms of Reference for the Locality Executives has not been undertaken pending a clearer vision of what will be required in the coming months.

Each Locality has determined the number of GPs it feels most appropriate for local circumstances. There are five elected GPs in Carlisle, Eden, South Lakes and Furness, nine in Copeland and six in Allerdale.

### Locality Executives

#### Allerdale:
- Chair (Elected by the five sub-localities from amongst their number to represent the Locality at the CCG Executive)
- A GP representative from each sub-locality
- Network Director and/or Network lead
- Allerdale Locality Senior Commissioner
- Primary Care Development Lead
- Business, Finance & Performance Lead
- Sub-locality Commissioning Leads
- Lay Representative

#### Carlisle:
- Chair (elected from the twelve practices within the Locality. The Chair of the Carlisle Locality Executive is a role undertaken by one of the five elected GPs and the Chair represents the Locality at the CCG Executive)
- A Practice Manager
- A Practice Nurse
- Network Director and/or Network Lead
- Carlisle Locality Senior Commissioning Manager
- Primary Care Development Lead
- Business, Finance and Performance Lead
- Two Lay Representatives

### Attendance at the Clinical Leads Group 2015/16:

<table>
<thead>
<tr>
<th>Total Membership</th>
<th>Total of Number of Formal Meetings Held</th>
<th>% Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>9</td>
<td>72</td>
</tr>
</tbody>
</table>
Accountability Report - Part 2

Copeland:

- Chair (elected by the nine practices from amongst their number to represent the Locality at the CCG Executive)
- A GP representative from every GP practice in the Locality
- Network Lead
- Copeland Locality Senior Commissioning Manager
- Primary Care Development Lead
- Business, Finance & Performance Lead
- Locality Lead within Adult Social Care
- Lay Representative

Eden:

- Chair (elected by the ten practices from amongst their number to represent the Locality at the CCG Executive)
- A representative from every GP practice in the Locality (this may be a GP, Practice Nurse or Practice Manager)
- Network Director and/or a Network Lead
- Eden Locality Senior Commissioning Manager
- Primary Care Development Lead
- Business, Finance & Performance Lead
- Lay Representative
Furness:
- Chair (elected by the GPs working within the fifteen practices from amongst their number)
- GPs elected by the 15 practices from amongst their number
- A Practice Manager
- Network Director
- Network Lead
- Furness Locality Senior Commissioning Manager
- Primary Care Development Lead
- Business, Finance & Performance Lead
- Lay Representative

South Lakes:
- Five elected GPs
- Practice Manager Representative
- Network Director
- Network Lead
- South Lakes Locality Senior Commissioning Manager
- Primary Care Development Lead
- Business, Finance & Performance Lead
- Lay Representative

The Governing Body receives assurance of work being undertaken by the Localities through the receipt of the Locality minutes.

The coverage of work by the Localities is covered in more detail in the CCG’s Annual Report.

<table>
<thead>
<tr>
<th>Attendance at Locality Executive Meetings 2015/16:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Total Membership</td>
</tr>
<tr>
<td>Total number of meetings held</td>
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<tr>
<td>% attendance</td>
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</tbody>
</table>
Audit Committee

The Audit Committee provides the Governing Body with an independent and objective view of the CCG’s financial systems, financial information and compliance with statute, regulations and directions governing the CCG in finance. It also reviews the effectiveness of the system of governance including the Standing Orders, Reservation and Delegation of Powers and Prime Financial Policies, CCG Policies, risk management and internal control, incorporating the arrangements made by the CCG for managing conflicts of interest, whistleblowing and fraud (both clinical and non-clinical).

The Membership consists of:

- Lay Member for Finance & Governance (Chair)
- Lay Member for Public Patient Engagement
- Lay Member for Health Improvement

In support of the membership the following officers are in attendance: Chief Finance Officer, Head of Internal Audit and officers of the CCG’s External Auditors (Grant Thornton).

During 2015/16 and with the support of Audit North, the Audit Committee developed a Business Plan which enabled the Committee to assess its responsibilities and what assurance it needed to meet those responsibilities.

This process provided a high level of confidence to the Committee that the work programme covered had provided it with the assurance it needed. However it did identify a small number of areas where further assurance was required and this has been factored into the 2016/17 work programme for the Committee. This will also help evaluate any training needs for Members of the Committee.

Members also requested that a Business Plan be established for each of the Committees as part of the annual review of Committee performance/review of Terms of Reference.

Items considered during 2015/16 include:

- Final accounts & Annual Report 2014/15
- Register of Interests
- 2014/15 Annual Report Benchmarking Review
- Audit Panel Requirements
- Board Assurance Framework & Risk Register
- Internal & External Audit Plans
- Internal & External Audit report
- Counter Fraud Issues
- Losses & Special Payments

The Governing Body receives assurance of work being undertaken by the Committee through the receipt of its minutes.

<table>
<thead>
<tr>
<th>Attendance at the Audit Committee 2015/16:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Membership</strong></td>
</tr>
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<td>3</td>
</tr>
</tbody>
</table>
Auditor Panel

From 2017/18 CCG’s will be responsible for appointing their own external auditor and directly managing the resultant contract and the relationship. Therefore there was a requirement for the CCG to establish an Auditor Panel in line with the Local Audit and Accountability Act, 2014. This was supported by guidance produced by the Department of Health and the Healthcare Financial Management Association (hfma) entitled “Auditor Panels – Guidance to help Health Bodies meet their Statutory Duties, September 2015”. The establishment of the Auditor Panel was approved at the Governing Body on 3 February 2016 and will be included in the CCG’s Constitution as a Committee of the Governing Body.

A key function of the Auditor Panel will be to advise the CCG’s Governing Body on the appointment of the external auditor, which needs to be completed by 31 December 2016.

The Membership will consist of:

- Lay Member for Finance & Governance (Chair)
- Lay Member for Public Patient Engagement
- Lay Member for Health Improvement

The Panel shall operate in line with the appointment process detailed in the guidance (specified above) issued by the Financial Reporting Council, the independent regulator responsible for promoting high quality financial reporting and governance.

In particular, the Panel will:

- Advise the CCG on the selection, appointment and removal of the CCG’s external auditor and to ensure that the proposed contractual arrangements are appropriate
- Advise the CCG on any proposal by the external auditor to enter into a liability limitation agreement
- Advise the CCG on the purchase of any ‘non-audit’ services from the external auditors (e.g. consultancy and project management)

To date the Panel has not met.
Remuneration Committee

In September 2015 the Remuneration Committee reviewed its Terms of Reference to read as follows:

The Remuneration Committee considers and makes recommendations to the Governing Body on the appropriate remuneration and terms of service for all posts above the top threshold of the National Agenda for Change (AfC) pay-scale, including off-payroll appointments, including:

- All aspects of salary (including performance-related elements/bonuses)
- Provisions for other benefits e.g. car allowances
- Severance payments for those specified above taking into account any legal relevant national guidance as is appropriate and overseeing appropriate contractual arrangements for such staff
- Disciplinary arrangements where the Chief Officer is an employee or member of another CCG

The Committee discharges its functions in accordance with legal and NHS requirements, national guidance and good governance practice.

The Membership consists of:

- Lay Member for Finance & Governance (Chair)
- Lay Member for Public Engagement
- Lay Member for Health Improvement
- Lay Member for Third Sector Organisation
- Governing Body Registered Nurse
- Governing Body Secondary Care Doctor

In support of this Committee the following officers are in attendance: Head of Human Resources (North of England Commissioning Support) and Clinical Chair.

Work coverage for 2015/16 has included the following: Chief Officer Resignation Report, review of VSM payments and the remuneration for the Designated Doctor and the Consultant Psychiatrist Support posts.

*Please note that for the purpose of the above calculation the Lay Member for third Sector Organisations has not be counted as the post has not yet been filled.

The Governing Body receives assurance of work being undertaken by the Committee through the receipt of its minutes.

<table>
<thead>
<tr>
<th>Attendance at the Remuneration Committee 2015/16:</th>
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<tbody>
<tr>
<td>Total Membership</td>
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<tr>
<td>5</td>
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</table>
Outcomes & Quality Assurance Committee

This Committee examines, in detail, the areas of concerns in the quality of care provided to Cumbrian patients. It works closely with the Quality & Safety team to ensure that the assurance provided to the Governing Body is robust and demonstrates that quality assurance systems and processes are in place.

In February 2016 the Terms of Reference were reviewed and the Membership amended to consist of:

- Lay Member for Health Improvement (Chair)
- Lay Member for Public Engagement
- Governing Body Registered Nurse
- Governing Body Secondary Care Doctor
- Medical Director
- Lead Nurse (Quality & Safety)
- Clinical Quality Safety Manager
- Representative from the Communications team

Work coverage includes scrutinising, on a bi-monthly basis, a detailed Quality Report to ensure progress and improvements are being made in the provision of health care across Cumbria. This report is then redacted to remove patient identifiable information and presented to the Governing Body. In addition to this Members of this Committee are actively involved in undertaking CCG site visits to all providers to ensure that quality concerns are progressed to a positive resolution (further details regarding site visits are included in the Quality section in the Annual Report). Other items considered include:

- Safeguarding (Adults & Children) Annual Report & updates
- Adult Safeguarding Accountability Framework
- Pressure Ulcers
- Unexplained deaths
- Approval of Clinical Policies
- Mental Health Strategy
- Maternity services
- Childrens services
- Nursing/Residential Homes

The Governing Body receives assurance of work being undertaken by the Committee through the receipt of its minutes.

A Business Plan is being developed for this Committee and will be presented to it in May 2016 from which a 2016/17 work programme will be established.

### Attendance at the Outcomes & Quality Assurance Committee 2015/16:

<table>
<thead>
<tr>
<th>Total Membership</th>
<th>Total of Number of Meetings Held</th>
<th>% Attendance</th>
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</thead>
<tbody>
<tr>
<td>8</td>
<td>6</td>
<td>71</td>
</tr>
</tbody>
</table>
Finance & Performance Committee

The Finance & Performance Committee provides the Governing Body with assurance on the CCG’s finances and performance issues. Its remit and responsibilities:

- Overview the annual planning process in accordance with the agreed timetable to ensure the delivery by the CCG of the following milestones:
  - Strategic and Annual Operating Plans in accordance with NHS England’s requirements
  - Financial Plan (i.e. the Annual Budget, including cost improvement plans)
  - Contracts with NHS and Non-NHS partners in line with the agreed contract strategy
  - Overview the annual planning cycle for performance targets in accordance with mandated NHS standards and the CCG’s objectives (e.g. integrated Performance Measures)
  - Ensure that the Corporate Risk Register and associated assurance framework is managed effectively in accordance with the CCG’s objectives
  - Review the monthly Finance and Performance Management reports
  - Review and monitor the NHS Cumbria CCG infrastructure plans, including Information Management & Technology (IM&T) and estate issues
  - Review, approve and monitor implementation and outcomes of business cases
  - Review and approve CCG operational policies

In February 2016 the Committee reviewed its Terms of Reference and added the following responsibilities:

- Ensure that the CCG’s responsible officer has an integrated approach to the management standards of health, safety and welfare and also undertakes responsibility for Fire under the Regulatory Reform (Fire Safety) Order (2005) in keeping with legal requirements and in accordance with locally agreed policies

- Overview of Human Resources policies and practices

The Membership of the Committee was also amended to consist of:

- Clinical Chair
- Chief Officer
- Chief Finance Officer
- Network Director - North
- Lay Member for Finance & Governance (Vice-chair)
- Lay Member for Public Engagement
- Lay Member for Health Improvement
- Governing Body Registered Nurse
- Governing Body Secondary Care Doctor

Due to the remit of this Committee, Members considered it important that the Chief Finance Officer and the Responsible Director for Performance (or nominated deputies) were present at all meetings. Therefore the section on Quorum was amended to read as follows:
The following are required to ensure a meeting is Quorate:

- **Officer Members:**
  - The Chief Finance Officer or nominated deputy
  - Responsible Director for Performance or nominated deputy

- **Two Lay Members**

Items considered during 2015/16:

- Approval of Corporate Strategies/Polices/Plans (including Health & Safety, Domestic Violence & the work place and Childrens Safeguarding Supervision)
- Performance Reports
- Finance Report
- UHMB Tarrif Modification
- Financial Plan 2015/16
- Cost Improvement Programme
- CCG Running Costs
- GP Out of Hours Services
- Management Structures
- Better Care Fund
- Business Cases (including Locality/Network Investments, Persistent Pain Services, and Home Oxygen Procurement)
- NHS 111 Services

### Attendance at the Finance & Performance Committee 2015/16:

<table>
<thead>
<tr>
<th>Total Membership</th>
<th>Total of Number of Meetings Held</th>
<th>% Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>10</td>
<td>87</td>
</tr>
</tbody>
</table>
Better Care Fund Governance Arrangements

In 2014, the Cumbria Health and Wellbeing Board formally requested that the Local Government Association undertake a review of the current governance arrangements for the commissioning and strategic planning of integrated care.

The review addressed the future role, remit, and support arrangements for the Board to strengthen its capacity to meet its statutory and locally agreed responsibilities. The review resulted in:

- A re-constituted Health and Wellbeing Board, with reduced membership focussed on strategic decision makers with County Wide leadership roles. The Board is chaired by the Leader of Cumbria County Council

- A new Public Health Alliance, which will focus on prevention, early intervention, and public health facing interventions. This will report to the Health and Wellbeing Board, with overlapping membership including the Director of Public Health

- A further formalising of the Joint Commissioning Board - being established as a working group of the Health and Wellbeing Board - focussed on its performance management and co-ordination role for the delivery of the Better Care Fund. The Board is jointly chaired by NHS Cumbria CCG’s Chief Operating Officer and Cumbria County Council’s Corporate Director of Health and Care Services.

A Better Care Fund coordination group is attended by the Cumbria County Council, the CCG and representatives from the North of England Commissioning Support Unit. This group focuses on performance monitoring. It meets monthly to coordinate and produce the monthly and quarterly reports, which are then reported to and considered by the Joint Commissioning Board at its monthly meetings.

As part of this performance management arrangement, the Health and Wellbeing Board receives and signs off the Better Care Fund quarterly returns.

In addition, the Health and Wellbeing Board has held a number of development sessions which have included the provider trusts. These sessions are supplemented by regular informal meetings between the Chairs and Chief Executives (or equivalent) of the CCGs, County Council and the provider trusts.

These arrangements are being used to fulfil the Health and Wellbeing Board’s statutory duty to promote integration and have primarily discussed organisational form arrangements across partners.
Annex 1 below illustrates the integrated system of governance:

**Cumbria Better Care Fund Integrated System Governance**

The Governing Body will receive regular update reports on the Better Care Fund and these have been programmed into the Governing Body’s work programme.
Senior Management Arrangements

Due to the long term sickness absence of the Chief Officer (Accountable Officer) the CCG sought, and was granted, approval from National Health Service England (NHSE) for the following interim senior management arrangements:

- Interim Chief Clinical Officer (Accountable Officer)
- Interim Clinical Chair
- Interim Chief Operating Officer

In September 2015 the Chief Officer resigned and the CCG is in the process of advertising the post. In the meantime approval has been granted by NHSE for the interim arrangements to be extended from 31 March 2016 and will remain in place until the new Chief Officer is in post.

The key relationships between the constitutional committees are demonstrated below:
General

The CCG continuously reviews its governance arrangements to ensure they are fit for purpose and supports the delivery of the CCG’s objectives. The reviews for 2015/16 have seen the introduction of Business Plans to help formulate robust work programmes for 2016/17. These in turn will be utilised to establish what training requirements the members of each committee will require to enable informed decision making within the CCG.

The Annual Report provides details of the Success Regime and Better Care Together Programmes. It is envisaged that as a result the CCG will be working in greater alignment with NHS Lancashire North CCG and other partner organisations and may require the establishment of joint committees. At the Full Council of Members meeting on 20 April 2016 Members approved the amendments to the CCG’s Constitution to include the NHS England model wording for the establishment of joint committees.

At the aforementioned meeting the following amendments were also approved:

- Changes to the Constitution:
  - Provision was made for Members of the Group to be able to participate in meetings of the Full Council of Members by telephone, by the use of video conferencing and/or webcam, where such facilities are available
  - Provision was made for practice representatives to submit votes by post, email or other electronic means in advance of a Full Council of Members meeting
  - The Governing Body be delegated authority to amend the Constitution:
    - to reflect the establishment of any joint committees it approves
    - make minor technical changes for example as and when practices names and addresses change or where practices merge

- Changes to the Standing Orders, Scheme of Reservation and Delegation and Prime Financial Policies:
  - The Scheme of Delegation be amended to delegate to the Governing Body all matters relating to committee administration including the terms of reference, membership and the overarching scheme of reservation and delegation, Standing Orders and Prime Financial Polices.
  - The process for the appointment to individual roles of the Governing Body be inserted into the Standing Orders under Section 6 ‘The Governing Body’

- The Terms of Reference for the following Committees were also approved:
  - Audit Committee
  - Auditor Panel
  - Clinical Leads Group
  - Finance & Performance Committee
  - Outcomes & Quality Assurance Committee; and
  - Remuneration Committee

Once the full impact of the two programmes is established the CCG will realign its priorities and allocate its resources accordingly. This will include the Locality Executives reviewing their Terms of Reference.

The approved changes to the Constitution, Standing Orders, Scheme of Delegation and Prime Financial Regulations will be updated in line with the requirements of NHS England and will be submitted to them for approval in line with the required deadlines. These documents can be found by following the link below (please note that the above changes will not appear in the above documents until approval has been granted by NHS England):

www.cumbriaccg.nhs.uk/about-us/how-we-make-decisions/constitution.aspx
On the 4 May 2016 the Governing Body utilised its development session to review its effectiveness and consider its Business Plan and Work Programme 2016/17. Overall the Governing Body felt that the assurance received during the course of 2015/16 was effective. In particular the development Business Plans for the Governing Body and its Committees has enabled the Members to focus on where they required additional information/reports. This will support the Governing Body’s primary responsibility to provide assurance that the CCG is compliant with its statutory duties and that it meets key national requirements for governance in order to be a public organisation. These, in turn, have then been used to produce work programmes for 2016/17.

The Governing Body will formally receive its schedule of meetings and work programme for approval on 1 June 2016.

The Clinical Commissioning Group Governance Framework

Corporate Governance is the system by which the Governing Body directs and controls the organisation at the most senior level in order to achieve its objectives and meet the necessary standards of accountability and probity.

The CCG wherever possible will prevent risk arising by the application of policies and procedures for staff and contractors to follow the CCG Constitution, Standing Orders, Reservation and Delegation of Powers and Prime Financial Policies, the use of technical support external to the CCG e.g. through legal, Information Governance, HR advice and internal and external audit.

The risk management strategy applies to all risks, whether these are financial, quality, performance, governance etc.

During 2015/16 the CCG has undertaken a lot of work to improve its Risk Management Framework. The Risk Champions are more confident in undertaking equality impact assessments on potential risk areas and feel empowered to escalate any areas of concern to the Director Group. The CCG has continued to provide its staff with support both through the CCG’s General Manager and the North East Commissioning Services (NECS) on the approach to risk management and the updating of the corporate risk register which is maintained electronically in the Safeguard Incident Risk Management System (SIRMS). This remains underpinned by the six Localities, the Childrens and Mental Health/Learning Disabilities team individual risk registers.

As per the Risk Management Framework, strategic risks with a residual risk score of 15 or above for an operation risk that has the potential to impact across the organisation are escalated and reported to Director Group for review.

The Risk Champions for each Directorate recognise that there are still a number of risks that cut across more than one Locality (e.g. the ongoing issues of recruitment both for Clinical staff in the Trusts and GPs in primary care) and again work will be ongoing during 2015/16 to review the risks currently in place and remove duplication across the system.

It is also acknowledged that risks may be shared with other organisations that the CCG works with jointly to deliver services and these are identified and fed into the system.

In response to mitigating risks such as those mentioned above, the CCG has actively sought to support its partner organisations/stakeholders. Recruitment drives have been held across Cumbria which has included the three Trusts, Healthwatch and other businesses in Cumbria.

Further work on this is planned for 2016/17 including working with one of Cumbria’s major employers to promote working and living in Cumbria. In addition the CCG’s General Practice Development Plan seeks to support its Membership and NHSE (responsible for the commissioning of primary care services) in securing funding, resolving premises issues and recruitment.
The following details are recorded for each risk on the register:

- Risk category
- Risk description
- Inherent risk
- Existing controls/assurance
- Risk grading with controls
- Gaps in controls/assurance
- Actions to reduce the risk to an acceptable level

An internal audit has been undertaken by Audit North on the CCG’s Governance and Risk Management Systems. The conclusion report was that a rating of ‘significant assurance’ was issued (further details on the ‘key findings for management attention’ can be found in the ‘The Clinical Commissioning Group Governance Framework’ on pages 2 and 3). The CCG has taken on board the comments listed in the key findings for management attention and procedures are in the process of being put in place to address the issues raised.

The CCG will annually review its framework and regular updates will be provided to the Governing Body on a regular basis.

The diagram below illustrates the governance structure and control mechanisms which have been established:
Risk Assessment in Relation to Governance, Risk Management & Internal Control

Throughout 2015/16 the Director Group, Finance & Performance Committee and the Governing Body has received regular updates on the CCG’s Assurance Framework which has been managed through the process detailed in the Risk Management Framework of this statement. The CCG, on its inception in 2013, inherited a number of risks from the former NHS Cumbria Primary Care Trust (PCT) which still remain very relevant today. These include:

- University Hospital of Morecambe Bay NHS Foundation Trust (UHMB) is unable to continue to provide clinically and financially sustainable services that are accessible to the population of Cumbria
- North Cumbria University Hospital Trust (NCUHT) is unable to provide clinically and financially sustainable services that are accessible to the population of Cumbria

Throughout 2015/16 the CCG has continued to work with NHS England, the Care Quality Commission (CQC) and Monitor to ensure effective support mechanisms are put in place for both Trusts to secure good quality care which is accessible to the Cumbrian population. Alongside of this the CCG is working collaboratively with partner organisations to develop various models of care through both the Success Regime in the north and the Better Care Together Programme in the south. These programmes are fundamental to the supporting the mitigation of the risks identified above.
A summary of the major risks identified, during 2015/16 in the CCG’s Assurance Framework is set out below:

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Existing Controls</th>
<th>Further Actions to Mitigate</th>
</tr>
</thead>
</table>
| University Hospital of Morecambe Bay NHS Foundation Trust (UHMB) is unable to continue to provide clinically and financially sustainable services that are accessible to the population of Cumbria | • The CCG is working collaboratively with UHMB & LNCCG and other partners under the Better Care Together Programme. This has led to development of the BCT Clinical Strategy & Delivery Plan.  
• Outline Business case being prepared for NHSE & Monitor and subject to external assurance by NHSE & Monitor  
• BCT has made a successful ‘Vanguard’ application to deliver a new care model for an Accountable Care System (ACS). Process is subject to scrutiny through national Vanguard process  
• UHMB application for local price modification has been accepted by Monitor; work underway with NHSE to assess commissioner implications (see financial risk below).  
• There are a number of formal ways the CCG assesses on-going clinical quality, including: joint Assuring Quality meetings with LNCCG & UHMB; Morecambe Bay QSG with NHSE; RCOG and Kirkup meeting. | • The CCG is working “Better Care Together” programme established with clear governance structure and risk process  
• The CCG is working Vanguard ‘value proposition’ to accelerate delivery for BCT plan and go further with ACS proposals (including capitated budget)  
• The CCG is working Alignment of local investments through Better Care Fund to early delivery of BCT Out of Hospital Model  
• The CCG is working Work on a Maternity Strategy/Plan as part of RCOG and Kirkup delivery plans |
### Risk Description

<table>
<thead>
<tr>
<th>North Cumbria University Hospital Trust (NCUHT) is unable to provide clinically and financially sustainable services that are accessible to the population of Cumbria</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CCG is not delivering key NHS constitution targets</td>
</tr>
</tbody>
</table>

### Existing Controls

- CCG is participating in the Success Regime Programme in North Cumbria to develop a sustainable clinical and financial strategy for North Cumbria
- Monthly review of all performance targets across providers
- Providers monitored by regulators on achievement of targets

### Further Actions to Mitigate

- A response to CQC has been submitted and feedback is awaited from them
- Work on Pre-Consultation Business Case is underway
- Action Plan agreed by regulator and CCG for underperforming standards
- System Resilience Groups established (North & South Cumbria) to co-ordinate management of non-elective patient flows to improve A&E waiting times. Urgent Care Sub-group leads and co-ordinates Urgent Care Action Plan. Cancer and Elective Care sub-groups also in place to support recovery
- National Emergency Care Improvement Programme supporting North Cumbria recovery of urgent care.
- North Cumbria Success regime escalation includes delivery of current constitutional standards
<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Existing Controls</th>
<th>Further Actions to Mitigate</th>
</tr>
</thead>
</table>
| Risk of failure to ensure that robust safeguarding systems and appropriate services are in place for children and young people (including Children looked after) across our providers and the wider partnership. There is risk of failing our statutory duties and preventing harm | • CCG Functions that check and deliver:  
• CCG Organisational Development Plan to include safeguarding competence levels for all CCG Staff  
• Paediatricians with responsibility for Child Death Review (north and south of County)  
• Contracts for childrens services that require providers to adopt ways of working that deliver safeguarding (NICE guidance, partnership working, clinical leadership) with annual audit and self-assessment declaration  
• CCG monitoring of annual audit tool (three main provider contracts + CHOC+ Primary Care GP practices)  
• CCG Safeguarding policies & procedures  
• Leadership delivering on safeguarding policies (adults and children) with active use of robust systems and processes challenging management behaviours and holding managers to account  
• Executive lead for safeguarding  
• Safeguarding Practice Lead GPs in all GP practices  
• Designated professionals for Childrens safeguarding  
• Director leadership – safeguarding  
• Named GP Safeguarding Lead per Locality and County Lead GP for Safeguarding Children | • Lead Nurse who will be responsible for leading work on quality and safeguarding  
• On-going development of CCG governance arrangements as part of wider system of safeguarding and engaging with partner organisations to address identified risks and system issues  
• CCG representation on Safeguarding Improvement Board and LSCB and relevant sub-groups  
• Support around the delivery of safeguarding training to Independent Contractors  
• Developing GP Safeguarding Practice Leads’ knowledge  
• System of exception reporting via internal quality governance arrangements and contracting processes |
<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Existing Controls</th>
<th>Further Actions to Mitigate</th>
</tr>
</thead>
</table>
| Risk that Commissioners do not transform patient management outside the Acute sector to appropriately reduce demand on hospital services and activity increases above the contracted levels | • The CCG’s contract with NCUHT reflects planned activity reductions as the result of changes in out of hospital activity  
• Contract with UHMB reverted to PbR in 2015/16 as uncertainties of UHMB financial position precluded an ‘Assured Contract’  
• Contingency through BCF fund and BCT OoH plans in place to deliver activity reductions – linked to CQUIN schemes as additional support for non-achievement  
• The CCG has a programme of work in primary care for reducing unwanted clinical variation in the following areas – prescribing, procedures of low clinical value and elective referrals | • CCG has approved formal list of procedures of limited clinical benefit and practices supported by CCG infrastructure & SIMS  
• The CCG identified a series of planned changes in out of hospital care through the “Better Care Fund” (BCF)  
• CCG has approved formal list of procedures of limited clinical benefit and practices supported by CCG infrastructure & SIMS  
• E-referral processes being implemented incorporating referral guidelines |
| Risk that the CCG is unable to produce a credible 5-year strategic plan, that is clinically sustainable and financially viable for the whole health economy | • Outline Business Case being prepared for NHSE & Monitor – plan will comprise key outputs of “Better Care Together”  
• Outline strategic plan prepared for authorisation - plan will comprise key outputs of “Together for a healthier future” | • BCT Delivery Plan and vanguard Value Propositions produced  
• An Outline Business Case is currently being prepared, supported by Deloittes  
• Development of PCBC being supported by the Success Regime |
<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Existing Controls</th>
<th>Further Actions to Mitigate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity services cannot be provided in a way that is accessible, safe and</td>
<td>• On-going discussions with providers regarding mitigation of risks to existing</td>
<td>• Quality dashboard in place for both providers, service specification in place with both</td>
</tr>
<tr>
<td>sustainable for patients across Cumbria</td>
<td>service model</td>
<td>providers</td>
</tr>
<tr>
<td></td>
<td>• On-going discussions with providers regarding mitigation of risks to existing</td>
<td>• Morecambe Bay action plan in place and being implemented</td>
</tr>
<tr>
<td></td>
<td>service model</td>
<td>• Royal College of Gynaecology (RCOG) independent review commissioned, report upon and actioned</td>
</tr>
<tr>
<td></td>
<td>• Development of a whole system approach to reduce demand on Tier 3 services</td>
<td>• Comprehensive public engagement has taken place – Service sustainability issues i.e.</td>
</tr>
<tr>
<td></td>
<td>• Ongoing and regular monitoring of Tier 3 CAMHS services</td>
<td>recruitment escalated to NHSE</td>
</tr>
<tr>
<td>Cumbria Partnership Foundation Trust (CPFT) are not able to provide Child &amp;</td>
<td>• Ongoing discussions with providers regarding mitigation of risks to existing</td>
<td>• Formal action plan agreed with CPFT to improve services, including investment</td>
</tr>
<tr>
<td>Adolescent Mental Health Services (CAMHS) of an appropriate quality</td>
<td>service model</td>
<td>• Review of the original action plan following the initial review</td>
</tr>
<tr>
<td></td>
<td>• Development of a whole system approach to reduce demand on Tier 3 services</td>
<td>• Continued leadership input to the development of a whole system approach</td>
</tr>
<tr>
<td>Services provided by nursing homes do not meet the needs of patients</td>
<td>• Adult Safeguarding Board established with joint policies &amp; procedures</td>
<td>• Continued support to the development and implementation of Headstart in Cumbria</td>
</tr>
<tr>
<td></td>
<td>established with Cumbria County Council (CCC) and providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Review groups formed in each locality using soft intelligence on nursing home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>sector, GP Adult Safeguarding leads in each locality, comprehensive safeguarding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>programme (see childrens above) established</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Intelligence used to work with providers to prevent escalation of problems where possible</td>
<td></td>
</tr>
<tr>
<td>Services for adults with mental health problems do not adequately meet the</td>
<td>• On-going contract and quality review processs</td>
<td>• Risk summit held &amp; specific external review of services undertaken</td>
</tr>
<tr>
<td>needs of patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a risk that the cost of services commissioned exceed the budgeted level</td>
<td>• On-going system of budgetary control</td>
<td>• Risk assessed plan for 2015/16 approved by Governing Body based upon a QIPP plan agreed</td>
</tr>
<tr>
<td>of resources: this has been increased in 2015/16 by the Local Price Modification</td>
<td></td>
<td>by Clinical Leads Group</td>
</tr>
<tr>
<td>issue at UHMB</td>
<td></td>
<td>• Revised financial recovery plan being developed for 2016/17 &amp; CCG is in wave 1 for NHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Right care”</td>
</tr>
</tbody>
</table>
Internal controls are outlined in the Risk Management Framework section of this statement and are confirmed to be operating through routine management reporting and through the work of Internal Audit. Risks are identified from various sources and are reflected in the risk register which is reviewed by the Director Group, Finance & Performance Committee and reported to the Governing Body to ensure that risks are understood and managed by the Governing Body.

During 2015/16 the CCG has actively been engaging with NHSE on performance and financial issues. As detailed in the framework above the risk that the cost of services commissioned would exceed the budgeted level of resources has been increased in 2015/16 by the Local Price Modification at UHMB. With the support of NHSE actions were taken to mitigate this risk for 2015/16. However there is still a significant risk for 2016/17.

Throughout 2016/17 work will continue in line with the CCG’s internal reporting processes and it will continue to provide quarterly update reports to NHSE in order to offer assurance on all aspects of the CCG’s performance, including supplying details of actions being taken to mitigate any identified risks. Other workstreams with NHSE will also be undertaken to mitigate the significant financial risk across the Cumbria Health Economy.

The Clinical Commissioning Group Internal Control Framework

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

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

Through its committees, the Governing Body receives its assurance on the following control mechanisms:

- Constitution
- Risk assessments and risk management
- Counter Fraud annual plan
- Internal Audit annual plan
- External Audit annual plan
- Performance, quality and contract monitoring of CCG providers
- Review of the CCG’s performance
- IG toolkit submissions
- Incident and serious incident reporting
- Financial reporting
- Policies and procedures
- Safeguarding (Adults & Childrens) Annual Reports
- Governance reporting between the Governing Body and its committees/sub committees
All Constitutional changes are prepared by the Governing Body for approval at the Full Council of Members. The Constitution is regularly reviewed to ensure it remains in alignment with changes in legislation and to meet the emerging objectives and programmes of the CCG.

There is a clear reporting process detailed in the CCG’s Risk Management Framework section which lists the processes of control mechanisms which provides assurance to the Governing Body on Risk Management. This includes how the CCG has embedded risk assessments into the commissioning of services in all areas of the CCG.

The Audit Committee monitors the Counter Fraud, Internal Audit and External Audit annual audit plans and provides assurance to the Governing Body on the progress of these plans through the minutes of the committee.

Performance, Quality and Contract monitoring of CCG providers is covered in the Performance and Quality section of the Annual report. There are various performance, quality and contracting meetings and reporting mechanisms with providers, which feeds into the Outcomes & Quality Assurance and the Finance & Performance Committees. Both committees receive performance and quality reports, which are rigorously scrutinised before being presented to the Governing Body.

The CCG reviews its performance in a number of ways, these included:

- Appraisals
- Review of performance of each of its committees against their terms of reference
- Collation of data such as the results to the annual 360 degree stakeholder survey and staff survey
- External reviews, which are commissioned as and when appropriate

The Director Group utilise the findings to evaluate the CCG’s performance. These are then fed through the committees and are presented to the Governing Body.

The Finance & Performance Committee monitor all IG toolkit submissions and receives the IG Annual Report. Any breaches in IG would also be reported to the committee although, to date, the CCG has not had any. Assurance is given to the Governing Body through the receipt of the minutes of this committee. It is also worth noting that the non-executive members of the Governing Body all sit on this committee.

Incident and serious incident reporting also form part of the Quality Section of the Annual Report. Again this is fed into the Quality & Assurance Committee then on to the Governing Body.

The Finance & Performance Committee receives monthly finance reports which are considered in detail before onward submission to the Governing Body. In addition financial updates are provided to Director Group, Clinical Leads Group and the Full Council of Members.

Policies and procedures are regularly reviewed. Under the scheme of reservation and delegation of powers, the Governing Body has delegated the approval of policies to the following:

- Finance & Performance Committee – All operational policies (including Human Resources, Health & Safety, Code of Conduct etc.)
- Outcomes & Quality Assurance Committee – all Clinical Policies (including Safeguarding policies, Independent Funding Request policies, Continuing Health Care policies etc.)

Safeguarding (Adults and Childrens) Annual Reports are scrutinised in detail at the Outcomes & Quality Assurance Committee before they are presented to the Governing Body. In addition to these, the committee and the Governing Body receive an update report on progress against any work plans every six months.

Governance reporting between the Governing Body and its committees is by receipt of minutes. The Governing Body will be reviewing its reporting mechanisms from its committees during the course of 2016/17.
Information Governance

The NHS Information Governance Framework sets out 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.

The CCG takes the Information Governance (IG) agenda seriously including its compliance with the Data Protection Act 1998 and other legal frameworks upon which IG is based. NHS Cumbria CCG contracts it Information Governance services from Cumbria Partnership NHS Foundation Trust (CPFT).

Some of the key achievements this financial year include:

Strategic Aspects

Digital Roadmaps, Success Regime and Vanguard - The Head of Information Governance has developed an IG framework in preparation for the Digital roadmaps, Success Regime and Vanguard initiatives. This has been ratified via all organisations in Lancashire and Cumbria and has been shared with the North East as a model of good practice. The Head of Information Governance provides regular contact with the CCG CCIO on various initiatives linked to these projects and following an independent review undertaken by Janet King the CPFT IG department was quoted as “providing an excellent information governance service”.

Information Sharing Gateway – The Information Sharing Gateway (ISG) has been developed by a sub-group of organisations in the Lancashire and Cumbria IG Group in order to improve and modernise the administration and risk assessment of information sharing in the public sector. It has been designed by IG specialists, for IG specialists, to support their IG reporting on data flows and information sharing (principally to IG Toolkit). The development was funded by the LPRES programme in Lancashire, to support the use of the LPRES healthcare information exchange platform. It is a generic tool and is not ‘tied’ to use with LPRES, although it is developed with the needs of sharing via interoperable systems in mind.

It is a 'next generation' Sharing Framework that will adequately support electronic information sharing across care boundaries in a way that current, paper-based systems cannot.

The purpose of this system is to provide assurance that the information being shared, managed and processed will be done so in such a way that is Data Protection Act compliant. It centralises and shares key resources in a way that is accessible and transparent. This has been presented at William’s CCIO Conference in March 2016 as well as nationally (i.e. HSCIC) with the CCG being a key partner acknowledged through for its contribution through the attendance by the Head of IG for CPFT. The Information Sharing Gateway won the INetwork award for innovation.

IG Toolkit – Continue to supply successful IG services for the CCG with an end of year score of 90%. compared to 86% in 2014-15 although we did not meet the target of 93% a 4% year on year improvement has been achieved.

Information Governance Toolkit Workbook (version 13) – Clinical Commissioning Groups Attainment Levels for All Initiatives
Summary of the 2015-16 end of year position is as follows:

2015 –16 IG Concluding Report Progress Monitoring Completion Trajectory

Four requirements could not be signed off as level 3 as originally targeted, however, two requirements have been signed off at level 3 that were originally targeted to achieve level 2. This means that we did not meet the target of 80% (20) achieving level 3 with an actual achievement of 72% (18) although this still equates to a 20% improvement on the previous year.
Accountability Report - Part 2

In addition to monitoring progress against our trajectory we are also monitoring progress in terms of Caldicott 2 compliance. The end of year situation is as follows:

### 2015 – 16 IG Chaldicot 2 Report Compliance Monitoring – CCG

#### Recommendation 1

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<th>Actual</th>
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<td>250</td>
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**Projected Outcome:** Fully implemented  
**Actual:** Working towards

#### Recommendation 2

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**Projected Outcome:** Fully implemented  
**Actual:** Fully implemented

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**Projected Outcome:** Fully implemented  
**Actual:** Fully implemented

#### Recommendation 6

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**Projected Outcome:** Fully implemented  
**Actual:** Fully implemented

#### Recommendation 7

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**Projected Outcome:** Fully implemented  
**Actual:** Working towards

#### Recommendation 12

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<td>420</td>
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</table>

**Projected Outcome:** Fully implemented  
**Actual:** Working towards

#### Recommendation 15

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<thead>
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<tbody>
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</table>

**Projected Outcome:** Fully implemented  
**Actual:** Working towards

#### Recommendation 19

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<thead>
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<tbody>
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<td>250</td>
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<td>Level 2</td>
</tr>
</tbody>
</table>

**Projected Outcome:** Fully implemented  
**Actual:** Working towards

### Caldicott2 Recommendations – CCG Compliance

- **Not started:** 0  
- **Working towards:** 0  
- **Fully implemented:** 8  

- **Actual:** 0  
- **Actual:** 5  
- **Actual:** 3
Operational IG Issues

Data Mapping – 2015-16 saw the launch of a new workshop based Data Mapping process, the CCG were consulted and a workshop has been held with those who have engaged. It was encouraging to find that processes and policies put in place by CPFT are being followed and staff members are trying to mitigate risk within this area.

A full review will be carried out in 2016 – 17 and CPFT would look to ensure all recommendations provided have been implemented. The CCG currently have 229 data flows of which 28% are High Risk, 66% are Medium Risk and 8% are Low risk.

Asset Management – Information Asset Owner validation exercise has been undertaken in the CCG with increased compliance from 11% to 79% in year. The critical information asset list for both CCG and CPFT Have been agreed and out of those assets owned by CCG 66% have been accredited to the required level in the financial year.

In line with the success regime and other projects that have been undertaken by the CCG the IG Team have provided IG assessments and, where appropriate System Level Security Policies to ensure that all information risk has been considered and adequate mitigation put in place to minimise risk.

Mandatory IG Training – With support from the CCG’s Organisational Development & Business Programme Support Manager, the CCG achieved above 95% compliance in ensuring that all staff were up to date with their mandatory training.

Contractor – This project has three streams one is in relation to the contracts that are commissioned by the CCG and two; are those contractors (suppliers) who provide a service and/or system etc. following a procurement process and finally three; those contractors who come into the CCG to provide support and/or consultancy services.

The IG Performance team have been working with the Contracts department and now have processes in place to check IG compliance levels and share information about those providers who are not meeting the standard. Reports are provided quarterly and compliance levels are monitored by CPFT and CCG Contracts Team.

The suppliers picked up as part of a procurement process or review or an existing service/system are thoroughly checked via the IG Assessments that are completed and risks are reported to the CCG’s SIRO (Senior Information Risk Owner). Any third party contractor who has legitimate access to the CCG’s information for any reason is checked and honorary contracts are drafted and provided in line with the specific service need.

Risks are monitored and those picked up due to assets are held on a risk register and again provided in a report for the CCG’s SIRO. In 2016 – 17 CPFT aim to increase awareness of risk reporting and ensure that all information risks are notified to IG and these can be monitored effectively with risk mitigation plans developed to manage risks effectively.

Incidents - Incident reporting through 2015 – 16 has been low, this may be accurate with just over one hundred staff members, hundreds of IG incidents are not expected but an increased vigilance for IG incidents and reporting these directly to CPFT’s IG department is important. The quarterly report on incident reporting will continue. All reported incidents are coded in line with the national guidance provided by HSCIC (Health and Social Care Information Centre); if an incident reaches Level 2 this will be reported to the ICO for investigation as a data loss and/or breach – no incidents reached Level 2 for Cumbria CCG in 2015 – 16.

Registration Authority Services – CPFT RA Service was awarded the contract for RA Services for CCG and primary care in 2015 – 2016. There are 3184 current active users in primary care with 5075 completed requests since the service was transferred to CPFT. A set of KPIs are in operation with new cards and changes to access actioned in line with stipulated timescales. 52% of GPs and Pharmacists have been visited over the last 12 months to carry out a detailed audit which covers Smartcard security, training and a review of all staff. This is proving beneficial to all parties, to address any access issues, ensuring tighter controls, plus familiarisation of the new Card Identity Service etc.

The CCG will continue to work with CPFT to achieve Level 3 in 2016/17.
Review of Economy, Efficiency & Effectiveness of the Use of Resources

The risk to maintaining adequate and effective financial control and ensuring strong financial management, as well as achieving financial targets, has increased throughout 2015/16. This is due in part to the Local Price Modification issues at UHMB and has been further impacted by the continued significant financial pressures in all three of the Cumbria Trusts.

Throughout 2015/16 the CCG has continued to develop its Cost Improvement Plan and has identified further ways of achieving saving which are in the process of being implemented. In addition the CCG has established a “Financial Recovery Group” which includes the Director Group and senior managers from across all areas of the CCG. This Group meets weekly to manage and monitor the cost improvement programme. Every aspect of the services commissioned by the CCG has been considered (e.g. evaluating variations across practices in areas such as prescribing, pathology and referrals) and, where possible, measures have been put in place to effect savings.

The CCG has also established a vacancy panel during 2015/16 in order to consider whether or not to replace posts when people have left the organisation. A strict set of criteria has been established and a business case must be made by the line manager if they wish to advertise a post. The CCG will continue to review its resources throughout 2016/17 to ensure that they support the Success Regime and Better Care Together programmes.

As previously stated regular meetings with NHSE have taken place and a vigorous review of the CCG’s finances has been undertaken. Detailed financial update reports have been consistently presented at Director Group, Clinical Leads Group, Finance & Performance Committee, the Governing Body and the Full Council of Members.

An internal audit work plan was agreed by the Audit Committee at its meeting on the 21 May 2015 and Audit North has been systematically undertaking the reviews planned for 2015/16. Reviews undertaken include:

- Financial Management & Performance
- Governance and Risk Management Systems
- Serious Untoward Incidents
- Partnership Arrangements (Health & Wellbeing Board)
- Patient & Public Involvement
- Openness and Honesty
- Quality Improvement
- Data Quality
- Direct Payments Personal Health
- Monitoring Performance against Contracts

The Audit Committee is made aware of any findings of each review and proposed actions made by management to address any areas of concerns raised.

In addition to all of the above the Finance & Performance Committee gives detailed consideration to the CCG’s financial and performance issues to provide the Governing Body with assurance that all issues are being appropriately managed and escalated where necessary. This includes the determination of key financial assumptions to underpin the CCG’s medium term financial strategy and scrutiny of monthly financial reporting.

The Governing Body also receives a quality, performance and finance report at each meeting.
Feedback from delegation chains regarding business, use of resources and response to risk

The section above details how senior managers from across the organisation have been heavily involved in reviewing the use of CCG resources as part of the cost improvement programme and these have been reported through the mechanisms specified.

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

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the CCG. The CCG has continued to ensure that at all levels of management resources are aligned and focused to deliver the CCG’s strategic objectives, manage the associated risks and support the emerging programmes both north and south of the County. During 2015/16 work has been undertaken to further develop the organisations development programme in conjunction with Cumbria Learning Improvement Collaborative (CLIC) (further details of work undertaken by CLIC can be found in the annual report). Staff have continued to evaluate and review their objectives through the personal appraisals systems. Alongside of this they have been updating their personal development plans to support the delivery of those objectives. Relevant training on key operational risk related issues including risk management, information governance, safeguarding, standards of business conduct (e.g. bribery & fraud) and health & safety is provide at regular intervals to ensure staff are aware of what is required of them.

Capacity to Handle Risk

As Accountable Officer I work closely with the Chief Finance Officer who is the Senior Information Risk Owner (SIRO) and leads on the CCG Assurance Framework. This framework details the principal risks to the CCG achieving its objectives. As documented in the Risk Management Framework the CCG has ensured that there is ownership of the risk register at all levels including the Locality Executives, all of which will inform the corporate risk register. The CCG’s General Manager and NECS supports the risk management framework to ensure that staff receive advice and training on risk management. Throughout 2015/16 the CCG has actively continued to embed the risk management framework into the day to day running of the CCG. This has been supported through sessions on risk management being undertaken at staff events.

Review of Effectiveness

The CCG’s Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles and objectives have been reviewed. This has been particularly so during 2015/16 with the continued challenges facing the provision of health care services in Cumbria and the emerging programmes in the north and the south of the County.

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of control. My review is informed by the work of the Internal Auditor, Directors 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 which have been provided throughout 2015/16. I have been advised on the implications of the results of my review by the Governing Body, the Audit Committee, the Finance & Performance Committee and the Outcomes & Quality Assurance Committee, and I plan to address any weaknesses and ensure continuous improvement of systems are in place.
Managers within the organisation who have responsibility for the development and maintenance of the system of internal control continue to provide me with assurance. The Assurance Framework itself provides me with the evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by audit reports received by the Audit Committee from the CCG’s internal audit throughout the year. Other sources of evidence included:

- External Audit via their Annual Audit Letter which provides a high level summary of audit work carried out
- Regular Director Group Meetings
- Reports to the Audit Committee by the Local Counter Fraud Specialist
- Information Governance Toolkit submission
- Review of the Assurance Framework by the various Director Group and CCG committees and the Governing Body (as detailed in the Risk Management Framework section of this report)
- Regular meetings with the NHSE Area Team (Quality Surveillance Groups/Quarterly checkpoints)
- Attendance at the main providers of acute, community and mental health services quality committees/meetings
- Continuing to liaise with NHSE to address the challenges facing Cumbria
- Work being undertaken across Cumbria to redesign services via the Success Regime and Better Care Together programmes

The Head of Internal Audit Opinion

The purpose of our annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Accountable Officer’s own assessment of the effectiveness of the organisation’s system of internal control. This opinion will, in turn, assist the Accountable Officer in the completion of the Annual Governance Statement.

Our opinion is set out as follows:

1. Overall opinion
2. Basis for the opinion
3. Commentary

Our overall opinion is that 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.

The basis for forming our opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
2. An assessment of the range of individual opinions arising from risk based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management’s progress in respect of addressing control weaknesses;
3. Any reliance that is being placed upon third party assurances.

The commentary below provides the context for our draft opinion and, together with the opinion, should be read in its entirety.
The design and operation of the Assurance Framework and associated processes

The CCG assurance framework was reviewed and updated during the year, and been presented and reviewed regularly at the Governing Body Meetings. The CCG took part in a wide scale benchmarking exercise during the year undertaken by ourselves and Mersey Internal Audit Agency, which indicated that it compared favourably with other CCG assurance frameworks in terms of content and risks. Our review of the CCGs governance and risk management arrangements identified no issues of concern and was assigned ‘significant assurance’. On this basis we are content that the Board Assurance Framework provides a reasonable basis to support the CCG’s Annual Governance Statement.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported during the year

During the year 2015/16 we have undertaken our work in accordance with the Internal Audit annual plan. We report our findings to the Chief Finance Officer and Chief Operating Officer (and other Executive colleagues where applicable). Our internal audit progress reports to the Audit Committee set out the areas covered by internal audit work during the year, our results and any matters arising.

This work would indicate that significant assurance opinions have, or will be assigned to the majority of the CCG’s systems and processes. The CCG should review our findings in order to satisfy itself that any significant control issues have been recognised and appropriately disclosed in its Governance Statement.

At the time of compiling this report a number of draft reports had been completed or issued to management, and are being progressed in accordance with the Internal Audit Protocol. These draft reports have been considered as part of this process. By way of commentary it should also be noted that there have been no ‘no assurance’ final reports issued for 2015/16.

Third party assurances

As a result of the support service arrangements provided by NECS under a signed service level agreement, the CCG will receive a number of assurance reports covering the 1 April 2015 to 31 March 2016.

- Two reports on Internal Controls Type II (Finance Controls) – for the periods April 2015 to September 2015 and October 2015 to February 2016.
- A bridging letter for Internal Controls Type II (Finance Controls) for March 2016.
- Report on Internal Controls Type II (Information Technology) – 1 October 2014 to 30 September 2015.

The outcomes of these reports are noted below:

Internal Controls Type II (Finance Controls) – for the periods 1 April 2015 to 30 September 2015 and 1 October 2015 to 29 February 2016

This report, by Deloitte, covered the financial controls relating to key control objectives in relation to those services provided to the CCG by NECS. The Deloitte audit opinion was a qualified one, however of the noted control weaknesses within the reports none were applicable to the service areas provided to the CCG.

Internal Controls Type II (Finance Controls) – period 1 March 2016 to 31 March 2016 – Bridging letter

This letter, provided by NECS, confirms that there have been no material changes in control environment and procedures operated by NECS during the period 1 March 2016 to 31 March 2016 that would adversely affect the recently issued Service Auditors Opinion, and they have indicated that it should be read in conjunction with the Deloitte report for the period 1 October 2015 to 29 February 2016.
Report on Internal Controls Type II (Information Technology) – period 1 October 2014 to 30 Sep 2015

In relation to those services provided to the CCG by NECS, this report by Deloitte covered the Information Technology systems relating to key control objectives in Business Information Quality only. The Deloitte audit opinion was a qualified one, however of the noted control weaknesses within the report none were applicable to the service area provided to the CCG.

An assurance letter was also received from Northumbria Healthcare NHS Foundation Trust on 3 May 2016 which provided significant assurance with no issues of note on the payroll processes that are undertaken on behalf of the CCG.

In forming our overall opinion we have only taken into account these outcomes, and where they specifically relate to the financial year 2015/16. We have therefore not taken into account any unpublished reports, or for systems provided by third parties where no assurance has been provided for the financial year. The CCG will need to consider the significance of the lack of assurance from its service provider in respect of these areas as part of its Annual Governance Statement.

The CCG has received a Service Auditor Report from NECS covering the period 1 April 2015 to 30 September 2015.

The report covers control objectives in relation to those services provided to the CCG

- Accounts Payable
- Accounts Receivable
- Treasury and Cash Management
- Financial Ledger
- Financial Reporting
- Payroll

The Deloitte audit opinion was a qualified one, on account of five exceptions noted in the control environment. Of these exceptions only one was applicable to the CCG, this related to training for finance staff. The report provides reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the year. This report was issued to all CCGs that purchase support services from NECS, therefore this is not a report tailored to Cumbria CCG’s own arrangements with NECS.

Work is currently ongoing to produce the second report covering the second half of the year, and at the time of producing this report, it had not been issued. In addition, Service Auditor Reports are currently awaited for business continuity and contract management. A separate report has been produced in the year covering Continuing Health Care processes.

The CCG will also have access to a service auditor report from Shared Business Services for finance and accounting and procurement controls; and a separate service auditor report for payroll. However, at the time of producing this report, the remaining assurances are not available to us and as such have not been considered as part of our draft opinion.

Managing Director
Audit North

May 2016
Data Quality

The Governing Body relies on the data quality elements in its contracts with providers. This includes both the requirement that providers quality assure their data prior to submission, and the active monitoring and management of the data quality improvement plans included within the contracts. In addition, the CCG commissions the NECS services to manage all local and national information flows on behalf of the CCG, including quality assurance, analysis and reporting. Therefore the CCG’s contract with the CSU outlines our expectations with respect to data quality and reporting.

Business Critical Models

As part of the on-going accreditation of the CCG to become an accredited safe haven and to meet Level 3 of the Information Governance toolkit in line with HSCIC recommendations, all of the CCGs business-critical models have been identified and noted on the CCG Information Asset Register. An audit of our IG Toolkit was performed by Audit North who have provided significant assurance over our progress and submission.

Data Security

The CCG recognises the importance of appropriately managing information and keeping it secure. It has made significant improvement in the level of compliance with the Information toolkit as detailed in the IG section of this statement.

The CCG’s Chief Finance Officer has executive responsibility for IG and as the SIRO is required to ensure that information risk is assessed and managed within the organisation. Support is provided in attaining this by the CCG’s General Manager.

The CCG’s Medical Director is the Caldicott Guardian. The Caldicott Guardian acts as the ‘information conscience’ for the organisation and is responsible for protecting the confidentiality of patient/service-user information and enabling appropriate information sharing.

All GP practices and community pharmacies within the CCG are individually responsible for making their own IG submission. This is monitored by the Information Governance Department.

As demonstrated by the improvement in the CCG level of compliance with the Information toolkit, the CCG is committed to improving staff awareness of the importance of reporting all information security incidents. Whilst significant improvements have been made the CCG will continue to develop a robust reporting system to further enhance the CCG improved performance in this area.

Discharge of Statutory Functions

Throughout 2015/16 the CCG has continued to review and ensure that the arrangements put in place by the CCG and, explained within the Corporate Governance Framework, were developed with extensive, expert, external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decisions and the scheme of delegation.

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

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG’s statutory duties. This will continue to be reviewed and revised as necessary throughout 2016/17.
Conclusion

A system of internal control has been maintained up to 31 March 2016, and up to the date of approval of the annual report and accounts. Based on the work undertaken in 2015/15, significant assurance has been given by the Head of Internal Audit (although draft at this stage) 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. No significant issues have been identified.

Hugh Reeve

Interim Chief Clinical Officer (Accountable Officer)

May 2016

2.20 Independent Auditor’s Report to the Members of the Governing Body of NHS Cumbria Clinical Commissioning Group

We have audited the financial statements of NHS Cumbria Clinical Commissioning Group for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the “Act”). 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. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MfA) and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

This report is made solely to the members of the Governing Body of NHS Cumbria Clinical Commissioning Group, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of 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 and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.
Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Act (the “Code of Audit Practice”).

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG’s resources. We are required under Section 21 (1)(c) of the Act to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act.

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

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition, we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.
Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016, and to report by exception where we are not satisfied.

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Cumbria Clinical Commissioning Group as at 31 March 2016 and of its expenditure and income for the year then ended; and

- have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction; and

- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.
Matters on which we are required to report by exception

We are required to report to you if:

• in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or

• we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

• we issue a report in the public interest under section 24 of the Act; or

• we make a written recommendation to the CCG under section 24 of the Act; or

• we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of its resources for the year ended 31 March 2016.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of NHS Cumbria Clinical Commissioning Group in accordance with the requirements of the Act and the Code of Audit Practice.

Joanne Brown
for and on behalf of Grant Thornton UK LLP,
Appointed Auditor

Grant Thornton UK LLP
110 Queen Street, Glasgow, Lanarkshire G1 3BX
26 May 2016
Remuneration and Staff Report

The Remuneration Committee is a non-executive committee of the Governing Body and was established in accordance with the CCG’s constitution.

The remit of the Committee is to consider and make recommendations to the Governing Body on the appropriate remuneration and terms of service for the Clinical Chair, Deputy Clinical Chair, Medical Director, GP’s with a CCG role, Chief Officer, Chief Finance Officer and other Very Senior Managers.

The Committee’s responsibilities include:

- All aspects of salary (including performance-related elements/bonuses)
- Provisions for other benefits i.e. car allowances
- Severance payments for those specified above taking into account any legal relevant national guidance as is appropriate and oversee appropriate contractual arrangements for said staff
- Disciplinary arrangements where the Chief Officer is an employee or member of another CCG.

The Membership consists of:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Scott (Chair)</td>
<td>Lay Member (Finance &amp; Governance)</td>
<td>From April 2013</td>
</tr>
<tr>
<td>Jon Rush</td>
<td>Lay Member (Patient Engagement)</td>
<td>From April 2013</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member (Health Improvement)</td>
<td>From April 2013</td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>Clinical Member (Registered Nurse)</td>
<td>From June 2014</td>
</tr>
<tr>
<td>Anthony Woodyer</td>
<td>Clinical Member (Secondary Care Specialist Doctor)</td>
<td>From June 2014</td>
</tr>
</tbody>
</table>

The Committee meeting dates during 2015/16:

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Members</th>
<th>Attendance</th>
<th>Nature of advice or services</th>
</tr>
</thead>
</table>
| 24 September 2015| Peter Scott  
Jon Rush  
Ruth Gildert  
Anthony Woodyer | Hugh Reeve  
Janine Lutz | Present agenda item  
HR advice & support |
| 1 February 2016   | Peter Scott  
Jon Rush  
Ruth Gildert  
Les Hanley        | David Rogers  
Janine Lutz    | Present agenda item  
HR advice & support |
Senior Managers
Performance Related Pay

The Remuneration Committee has not given consideration during 2015/16 to the payment of senior managers’ performance related pay.

Interim Management Arrangements

Due to the long term sickness absence of the Chief Officer (Accountable Officer) the CCG sought, and was granted, approval from National Health Service England (NHSE) for the following interim senior management arrangements:

- Interim Chief Clinical Officer (Accountable Officer)
- Interim Clinical Chair
- Interim Chief Operating Officer

In September 2015 the Chief Officer resigned and the CCG is in the process of advertising the post. In the meantime approval has been given by NHSE for the interim arrangements to be extended from 31 March 2016 until the new Chief Officer is in post.

Policy on Senior Managers Contracts

The CCG remains committed to the principles it adopted to ensure that the CCG is in a position to attract and retain high quality senior officers. This includes maintaining salaries at a competitive level, whilst taking into account the previous level of experience of post holders; application of appropriate promotional increases to new appointees and application of relevant percentage increases (as determined at national level), all whilst recognising the restraint on the public purse.

As part the steps the CCG takes to satisfy themselves that remuneration is reasonable, the Remuneration Committee also takes cognisance of the following reference documents:

- NHS Commissioning Board (NHSCB) Clinical Commissioning Groups: Remuneration Guidance for Chief Officers (where the senior manager also undertakes the Accountable Officer role) and Chief Finance Officer
- The Hay Group CCG Remuneration Guidance on GPs Remuneration in CCGs in North West England
- Tenon Technical Employment Status Guidance – tax, national insurance and superannuation implications for GPs involved in Clinical Commissioning Group roles

The CCG currently has 8 posts which receive a remuneration in excess of £142,500 pro rata per annum; all except one are part-time. The CCG is now required to seek the views of ministers via NHS England before making VSM appointments to salaries higher than the Prime Minister’s salary of £142,500 per annum.

Very Senior Manager (VSM) contracts of employment apply to the Chief Officer, Chief Finance Officer and the Interim Chief Operating Officer. All other Directors attract the National Agenda for Change terms and conditions of employment. The CCG has specific GP Contracts for service and employment. Details are given below the contractual summary of VSM and other senior manager contracts, notice periods and termination payments.
The CCG also has specific GP Contracts for service and employment and details are provided in the following table:

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of contract</th>
<th>Unexpired term or notice period</th>
<th>Other liability in event of termination</th>
<th>Compensation for early termination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Hugh Reeve</td>
<td>1 April 2013</td>
<td>6 months’ notice</td>
<td>Redundancy payment if applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>1 April 2013</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Anthony Woodyer</td>
<td>1 April 2013</td>
<td>31 March 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter Scott</td>
<td>1 April 2013</td>
<td>31 March 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Les Hanley</td>
<td>1 April 2013</td>
<td>31 March 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jon Rush</td>
<td>1 April 2013</td>
<td>31 March 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Geoff Jolliffe</td>
<td>1 April 2013</td>
<td>30 September 2016</td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Dr. David Rogers (Medical Director)</td>
<td>1 February 2014</td>
<td>6 months’ notice</td>
<td>Redundancy payment if applicable</td>
<td></td>
</tr>
<tr>
<td>Dr Niall McGreevy</td>
<td>1 October 2013</td>
<td>31 September 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Colin Patterson</td>
<td>1 April 2013</td>
<td>31 December 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Rachel Preston</td>
<td>1 April 2013</td>
<td>31 May 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Alistair Mackenzie</td>
<td>1 April 2013</td>
<td>31 July 2016</td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Juliet Rhodes (left role 31 August 2015)</td>
<td>1 October 2014</td>
<td>31 September 2017</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helen Horton</td>
<td>1 September 2015</td>
<td>31 August 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jim Hacking</td>
<td>1 April 2015</td>
<td>31 March 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigel Maguire</td>
<td>1 April 2013</td>
<td>6 months’ notice</td>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>1 April 2013</td>
<td>6 months’ notice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>1 April 2013</td>
<td>3 months’ notice</td>
<td>Redundancy payment if applicable as per Agenda for Change</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Anthony Gardner</td>
<td>1 April 2013</td>
<td>3 months’ notice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter Rooney</td>
<td>1 April 2013</td>
<td>3 months’ notice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laura Carr</td>
<td>1 April 2013</td>
<td>3 months’ notice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eleanor Hodgson</td>
<td>1 April 2014</td>
<td>3 months’ notice</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Payments to past Senior Managers

No payments have been made to past senior managers in 2015/16.
The salaries and allowances of CCG senior managers and office holders during the reporting year are given below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary (bands of £5,000)</td>
<td>Expenses payments (taxable) (Note 6)</td>
<td>All pension-related benefits (Note 7B)</td>
</tr>
<tr>
<td></td>
<td>(£000)</td>
<td>(£000)</td>
<td>(£000)</td>
</tr>
<tr>
<td>Nigel Maguire</td>
<td>Chief Officer</td>
<td>130-135</td>
<td>33</td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td>110-115</td>
<td>69</td>
</tr>
<tr>
<td>David Rogers</td>
<td>Medical Director</td>
<td>170-175</td>
<td>22</td>
</tr>
<tr>
<td>Hugh Reeve</td>
<td>Interim Chief Clinical Officer</td>
<td>115-120</td>
<td>-</td>
</tr>
<tr>
<td>Dr Anthony Woodyer</td>
<td>Clinical Member: Secondary Care Clinician</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>Peter Scott</td>
<td>Lay Member: Finance &amp; Governance</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>Geoff Jolliffe</td>
<td>Interim Clinical Chair (Lead GP)</td>
<td>105-110</td>
<td>-</td>
</tr>
<tr>
<td>Rachel Preston</td>
<td>Lead GP (North)/GP Lead: Eden</td>
<td>2-75-80</td>
<td>-</td>
</tr>
</tbody>
</table>

Other Senior Managers

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary (bands of £5,000)</td>
<td>Expenses payments (taxable) (Note 6)</td>
<td>All pension-related benefits (Note 7B)</td>
</tr>
<tr>
<td></td>
<td>(£000)</td>
<td>(£000)</td>
<td>(£000)</td>
</tr>
<tr>
<td>Peter Rooney</td>
<td>Interim Chief Operating Officer</td>
<td>105-110</td>
<td>56</td>
</tr>
<tr>
<td>Anthony Gardner</td>
<td>Network Director</td>
<td>100-105</td>
<td>91</td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>Network Director</td>
<td>100-105</td>
<td>47</td>
</tr>
<tr>
<td>Laura Carr</td>
<td>Lead Nurse (Quality &amp; Safety)/Clinical Director for Mental Health</td>
<td>90-95</td>
<td>50</td>
</tr>
<tr>
<td>Eleanor Hodgson</td>
<td>Director for Children and Families</td>
<td>95-100</td>
<td>-</td>
</tr>
<tr>
<td>Helen Horton</td>
<td>GP Lead: Copeland</td>
<td>25-30</td>
<td>-</td>
</tr>
<tr>
<td>Juliet Rhodes</td>
<td>GP Lead: Copeland</td>
<td>10-15</td>
<td>-</td>
</tr>
<tr>
<td>Tom Ickes</td>
<td>GP Lead: Copeland</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Niall McGreedy</td>
<td>GP Lead: Allendale</td>
<td>60-65</td>
<td>-</td>
</tr>
<tr>
<td>Colin Patterson</td>
<td>GP Lead: Carlisle</td>
<td>65-70</td>
<td>-</td>
</tr>
<tr>
<td>Jim Hacking</td>
<td>GP Lead: South Lakes</td>
<td>60-65</td>
<td>-</td>
</tr>
<tr>
<td>Alistair MacKenzie</td>
<td>GP Lead: South Lakes</td>
<td>5</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes:
1. To cover the long-standing sickness absence of the Chief Officer, Hugh Reeve was appointed interim Accountable Office, acting as interim-Chief Clinical officer, as of 9 February 2015. and Geoff Jolliffe became interim Clinical Chair as of 23 February 2015 with Peter Rooney supporting both interim clinical roles as interim-Chief Operating Officer with effect 9 February 2015. Nigel Maguire left on 30 September 2015 and received a payment in lieu of notice.
2. Rachel Preston was appointed Lead GP (North) representative of the Governing Body wef 22 June 2014. David Rogers was Lead GP North representative of the Governing Body until he was appointed Medical Director wef 1 February 2015, the position of Medical Director achieved Governing Body status at the Full Council of Member’s meeting 19 June 2014 (the post is full-time and remuneration has remained the same year-on-year).
3. Lay members receive a flat daily rate and thus remuneration received reflects the number of days worked. Anthony Woodyer’s term of office ended 31 March 2016 and the other lay members had their tenure extended to 31 March 2017.
4. Helen Horton was appointed Lead GP for Copeland Locality as of 1 September 2015, taking over the role from Juliet Rhodes who had been post since October 2014. Tom Ickes had previously held the post from 1 February 2014 through to 31 July 2014.
5. Jim Hacking took over the GP Lead role for Copeland Locality wef 1 April 2015 from Alistair MacKenzie.
6. Taxable benefits of lease car.
7. The amount included here is the annual increase in pension entitlement and not actual remuneration received by individuals during the year. This is a notional figure (calculated by a formula directed by the Department of Health through to 31 July 2014).
8. Hugh Reeve and Alistair MacKenzie both opted out of the NHS Pensions scheme as of 1 April 2014.

No performance pay and bonuses were paid during the year ended 31 March 2016 (2014/15 £nil).
No long term performance pay and bonuses were paid during the year ended 31 March 2016 (2014/15 £nil).
As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions for Lay Members.

Payments for Loss of Office

No payments for loss of office have been made to a senior manager of the CCG in the current year.
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. CETVs are calculated in accordance with the Occupational Pension Schemes (transfer Values) Regulations 2008.

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SC APE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Real Increase in CETV

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

‘Fair Pay’ (Multiples) Disclosure (audited)

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

The banded remuneration of the highest paid member of the Governing Body in the clinical commissioning group in the financial year 2015-16 was £172.5k (2014-15, £142.5k) whereby the Medical Director post has been a Governing Body member for the full year 2015-16. This was 4.2 times (2014-15, 3.5 times) the median remuneration of the workforce, which was £42k (2014-15, £41k).

In 2015-16 no (2014-15, 2 employees) employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration packages ranged from £17k to £198k (2014-15, £16k to £198k).

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

Off Payroll Engagements

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number of existing arrangements as of 31 March 2016</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of which, the number that have existed:</td>
<td></td>
</tr>
<tr>
<td>for less than one year at the time of reporting</td>
<td>2</td>
</tr>
<tr>
<td>for between one and two years at the time of reporting</td>
<td>-</td>
</tr>
<tr>
<td>for between two and three years at the time of reporting</td>
<td>17</td>
</tr>
<tr>
<td>for between three and four years at the time of reporting</td>
<td>-</td>
</tr>
<tr>
<td>for four or more years at the time of reporting</td>
<td>-</td>
</tr>
</tbody>
</table>

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.
For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Number of existing arrangements as of 31 March 2015</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements which include contractual clauses giving NHS Cumbria CCG the right to request assurance in relation to income tax and National Insurance obligations, or those that reached six months in duration, between 1 April 2015 and 31 March 2016</td>
<td>-</td>
</tr>
<tr>
<td>Number for whom assurance has been requested</td>
<td>2</td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
</tr>
<tr>
<td>assurance has been received</td>
<td>2</td>
</tr>
<tr>
<td>assurance has not been received</td>
<td>-</td>
</tr>
<tr>
<td>engagements terminated as a result of assurance not being received</td>
<td>-</td>
</tr>
<tr>
<td>Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year</td>
<td>0</td>
</tr>
<tr>
<td>Number of individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements</td>
<td>21</td>
</tr>
</tbody>
</table>

**Exit Packages & Analysis of Staff Numbers**

Please refer to Part 3: Financial Statements, notes 4.4 and 4.1 for this information.

**Staff Numbers: Analysis of Average number of people employed.**

Please refer to Part 3: Financial Statements, notes 4.2 for this information.
Part 3

Financial Statements
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<tr>
<td>Statement of Financial Position as at 31 March 2016</td>
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<td>Statement of Changes in Taxpayers’ Equity for the year ended 31 March 2016</td>
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<td>Statement of Cash Flows for the year ended 31 March 2016</td>
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<td>Other operating revenue</td>
<td>3</td>
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<td>Employee benefits and staff numbers</td>
<td>4</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>5</td>
</tr>
<tr>
<td>Better payment practice code</td>
<td>6</td>
</tr>
<tr>
<td>Operating leases</td>
<td>7</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>8</td>
</tr>
<tr>
<td>Cash</td>
<td>9</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>10</td>
</tr>
<tr>
<td>Provisions</td>
<td>11</td>
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<td><strong>Other Notes:</strong></td>
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<tr>
<td>Contingencies</td>
<td>12</td>
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<td>Commitments</td>
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<td>Financial instruments</td>
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<td>Operating segments</td>
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<td>Pooled budgets</td>
<td>16</td>
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<td>Related party transactions</td>
<td>17</td>
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<tr>
<td>Events after the end of the reporting period</td>
<td>18</td>
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<td>Losses and special payments</td>
<td>19</td>
</tr>
<tr>
<td>Impact of IFRS</td>
<td>20</td>
</tr>
</tbody>
</table>
Statement of Comprehensive Net Expenditure for the year ended 31 March 2016

<table>
<thead>
<tr>
<th>Note</th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Total Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits 4.1</td>
<td>6,729</td>
<td>6,794</td>
</tr>
<tr>
<td>Operating Expenses 5</td>
<td>726,267</td>
<td>701,324</td>
</tr>
<tr>
<td>Other operating revenue 3</td>
<td>(4,103)</td>
<td>(1,746)</td>
</tr>
<tr>
<td><strong>Net operating expenditure for the financial year</strong></td>
<td>728,893</td>
<td>706,372</td>
</tr>
<tr>
<td>Of which:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Administration Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits 4.1</td>
<td>5,656</td>
<td>5,904</td>
</tr>
<tr>
<td>Operating Expenses 5</td>
<td>4,961</td>
<td>5,605</td>
</tr>
<tr>
<td>Other operating revenue 3</td>
<td>(172)</td>
<td>(242)</td>
</tr>
<tr>
<td><strong>Net administration expenditure</strong></td>
<td>10,445</td>
<td>11,267</td>
</tr>
<tr>
<td><strong>Programme Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits 4.1</td>
<td>1,073</td>
<td>890</td>
</tr>
<tr>
<td>Operating Expenses 5</td>
<td>721,306</td>
<td>695,719</td>
</tr>
<tr>
<td>Other operating revenue 3</td>
<td>(3,931)</td>
<td>(1,504)</td>
</tr>
<tr>
<td><strong>Net programme expenditure</strong></td>
<td>718,448</td>
<td>695,105</td>
</tr>
<tr>
<td><strong>Total comprehensive net expenditure for the financial year</strong></td>
<td>728,893</td>
<td>706,372</td>
</tr>
</tbody>
</table>

The notes 2-7 on pages 105 - 112 form part of this statement.
### Statement of Financial Position as at 31 March 2016

<table>
<thead>
<tr>
<th></th>
<th>31 March 2016</th>
<th>31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>7,814</td>
<td>3,829</td>
</tr>
<tr>
<td>Cash</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>7,816</td>
<td>3,836</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>7,816</td>
<td>3,836</td>
</tr>
</tbody>
</table>

| **Current liabilities**  |               |               |
| Trade and other payables | (29,743)      | (30,404)      |
| **Total current liabilities** | (29,743)  | (30,404)      |

| **Assets less Liabilities** |               |               |
| (21,927)                   | (26,568)      |

**Financed by Taxpayers’ Equity**

| General fund               | (21,927)      | (26,568)      |
| **Total taxpayers’ equity** | (21,927)      | (26,568)      |

The notes 8 – 20 on pages 113 - 119 form part of this statement.

The financial statements on pages 97 – 99 were approved by the Governing Body on 26 May 2016 and signed on its behalf by:

Dr Hugh Reeve
Interim Chief Clinical Officer (Accountable Officer)
Statement of Changes In Taxpayers Equity
for the year ended 31 March 2016

<table>
<thead>
<tr>
<th>Note</th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April</td>
<td>(26,568)</td>
<td>(29,945)</td>
</tr>
<tr>
<td>Changes in Clinical Commissioning Group taxpayers’ equity for 2015-16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(728,893)</td>
<td>(706,372)</td>
</tr>
<tr>
<td>Net Recognised Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(755,461)</td>
<td>(736,317)</td>
</tr>
<tr>
<td>Net funding</td>
<td>733,534</td>
<td>709,749</td>
</tr>
<tr>
<td>Balance at 31 March</td>
<td>(21,927)</td>
<td>(26,568)</td>
</tr>
</tbody>
</table>

Statement of Cash Flows for the year ended 31 March 2016

<table>
<thead>
<tr>
<th>Note</th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash Flows from Operating Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(728,893)</td>
<td>(706,372)</td>
</tr>
<tr>
<td>Increase in trade &amp; other receivables</td>
<td>8</td>
<td>(3,985)</td>
</tr>
<tr>
<td>Decrease in trade &amp; other payables</td>
<td>10</td>
<td>(661)</td>
</tr>
<tr>
<td>Net Cash Outflow from Operating Activities</td>
<td>(733,539)</td>
<td>(709,749)</td>
</tr>
<tr>
<td>Net Cash Outflow before Financing</td>
<td>(733,539)</td>
<td>(709,749)</td>
</tr>
<tr>
<td>Cash Flows from Financing Activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Funding Received</td>
<td>733,534</td>
<td>709,749</td>
</tr>
<tr>
<td>Net Cash Inflow from Financing Activities</td>
<td>733,534</td>
<td>709,749</td>
</tr>
<tr>
<td>Net Decrease in Cash</td>
<td>9</td>
<td>(5)</td>
</tr>
<tr>
<td>Cash at the Beginning of the Financial Year</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Cash at the End of the Financial Year</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>
NOTES TO THE ACCOUNTS

1. Accounting policies

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Pooled Budgets

Where the Clinical Commissioning Group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 (as amended) the Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the Clinical Commissioning Group is in a “jointly controlled operation”, the Clinical Commissioning Group recognises:

- The assets the Clinical Commissioning Group controls;
- The liabilities the Clinical Commissioning Group incurs;
- The expenses the Clinical Commissioning Group incurs; and,
- The Clinical Commissioning Group’s share of the income from the pooled budget activities.

If the Clinical Commissioning Group is involved in a “jointly controlled assets” arrangement, in addition to the above, the Clinical Commissioning Group recognises:

- The Clinical Commissioning Group’s share of the jointly controlled assets (classified according to the nature of the assets);
- The Clinical Commissioning Group’s share of any liabilities incurred jointly; and,
- The Clinical Commissioning Group’s share of the expenses jointly incurred.
1.4 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

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

1.4.1 Critical Judgements in Applying Accounting Policies

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

- Determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets.
- Determining the nature and accounting treatment of the pooled budget arrangement of the Better Care Fund which is a joint initiative between the NHS and Local Government to develop an integrated approach between health and social care.

1.4.2 Key Sources of Estimation Uncertainty

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

- IAS 36 Impairments: management makes judgement on whether there are any indications of impairments to the carrying amounts of the Clinical Commissioning Group’s assets;
- Significant estimates are inherent in a number of operational areas including accruals for prescribing costs, and expenditure dependent on secondary, tertiary and independent sector activity information. This is because the outturn information is not available at the time of preparation of the financial statements. Such estimates are informed by underlying data and trends and therefore are not expected to be significantly mis-stated; and,
- Maternity Pathways: expenditure relating to all antenatal maternity care is made at the start of a pathway. As a result at the year-end part completed pathways are treated as a prepayment. The Clinical Commissioning Group agrees to use the figures calculated by the local providers.

1.5 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. The Clinical Commissioning Group’s principle funding source is cash drawings from NHS England linked to its main revenue allocation.

Where revenue is received for a specific activity that is to be delivered in the following financial year, that income is deferred.
1.6 Employee Benefits

1.6.1 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.

1.6.2 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 NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Clinical Commissioning Group commits itself to the retirement, regardless of the method of payment.

1.7 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.

1.8 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.

1.8.1 The Clinical Commissioning Group 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.

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

1.9 Cash

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

In the Statement of Cash Flows, cash is shown net of bank overdrafts that are repayable on demand and that form an integral part of the Clinical Commissioning Group’s cash management.

1.10 Provisions

Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation.

The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury’s discount rates.

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

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

1.13 Continuing Healthcare Risk Pooling
In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme Clinical Commissioning Group contribute annually to a pooled fund, which is used to settle the claims.

1.14 Contingencies
A contingent liability is:
• a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group; or,
• a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

1.15 Financial Assets
Financial assets are recognised on the Statement of Financial Position when the Clinical Commissioning Group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise in accordance with generally accepted pricing models based on discounted cash flow analysis.

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.

This 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 Statement of Financial Position date, the Clinical Commissioning Group assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

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

1.16 Financial Liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Clinical Commissioning Group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.17 Value Added Tax

Most of the activities of the Clinical Commissioning Group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Losses and 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 each individual case is handled.

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

1.19 Accounting Standards that have been issued but have not yet been adopted

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

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

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

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

The Clinical Commissioning Group’s performance against those duties was as follows:

<table>
<thead>
<tr>
<th>NHS Act</th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maximum</td>
<td>Performance</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>223H (1) Expenditure not to exceed income</td>
<td>733,049</td>
<td>732,996</td>
</tr>
<tr>
<td>223I (2) Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>223I (3) Revenue resource use does not exceed the amount specified in Directions</td>
<td>728,946</td>
<td>728,893</td>
</tr>
<tr>
<td>223J (1) Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>223J (2) Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>223J (3) Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>11,373</td>
<td>10,445</td>
</tr>
</tbody>
</table>

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

The Clinical Commissioning Group received no capital resource during 2015-16 nor 2014-15 and incurred no capital expenditure in either year.
3. Other operating revenue

<table>
<thead>
<tr>
<th></th>
<th>2015/16 Total £000</th>
<th>2015/16 Admin £000</th>
<th>2015/16 Programme £000</th>
<th>2014/15 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education, training and research</td>
<td>360</td>
<td>35</td>
<td>325</td>
<td>657</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>47</td>
<td>47</td>
<td>-</td>
<td>54</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>3,215</td>
<td>-</td>
<td>3,215</td>
<td>625</td>
</tr>
<tr>
<td>Other revenue</td>
<td>481</td>
<td>90</td>
<td>391</td>
<td>410</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>4,103</strong></td>
<td><strong>172</strong></td>
<td><strong>3,931</strong></td>
<td><strong>1,746</strong></td>
</tr>
</tbody>
</table>

Note: ¹The Clinical Commissioning Group received £2.9m funding from Cumbria County Council as per a s256 agreement relating to the cost of additional non-elective hospital activity.

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 Clinical Commissioning Group and credited to the General Fund.

Revenue is totally from the supply of services. The Clinical Commissioning Group has received no revenue from the sale of goods in 2015-16 nor 2014-15.
### 4. Employee benefits and staff numbers

#### 4.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>Admin</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
<td>Permanent</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>5,567</td>
<td>5,100</td>
<td>467</td>
</tr>
<tr>
<td>Social security costs</td>
<td>520</td>
<td>503</td>
<td>17</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>629</td>
<td>604</td>
<td>25</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>13</td>
<td>13</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net employee benefits</strong></td>
<td><strong>6,729</strong></td>
<td><strong>6,220</strong></td>
<td><strong>509</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>5,607</td>
<td>5,309</td>
</tr>
<tr>
<td>Social security costs</td>
<td>527</td>
<td>513</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>660</td>
<td>643</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td><strong>6,794</strong></td>
<td><strong>6,465</strong></td>
</tr>
</tbody>
</table>

#### 4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Number</td>
<td>Permanent Employees Number</td>
</tr>
<tr>
<td>Medical and dental</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>92</td>
<td>85</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>103</strong></td>
<td><strong>93</strong></td>
</tr>
</tbody>
</table>
4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2015 Number</th>
<th>2014 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>748</td>
<td>794</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>100</td>
<td>109</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>7.45</td>
<td>7.28</td>
</tr>
</tbody>
</table>

No people retired on ill-health grounds nor took early retirement during 2015-16 or 2014-15. The data provided is for the full calendar year, January to December, of both years.

4.4 Exit packages agreed in the financial year

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2015/16</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Compulsory redundancies</td>
<td>Other agreed departures</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>Number</td>
<td>£</td>
<td>Number</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>1</td>
<td>3,171</td>
<td>1</td>
</tr>
<tr>
<td>Net employee benefits</td>
<td>1</td>
<td>3,171</td>
<td>1</td>
</tr>
</tbody>
</table>

Analysis of Other Agreed Departures:

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Other agreed departures</td>
</tr>
<tr>
<td>Voluntary redundancies</td>
<td>1</td>
</tr>
<tr>
<td>Contractual payments in lieu of notice</td>
<td>1</td>
</tr>
<tr>
<td>Total*</td>
<td>2</td>
</tr>
</tbody>
</table>

* As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change.

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

No exit payments were agreed with any individuals named in the remuneration report.

There were no departures where special payments have been made.

4.5 Pension costs

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

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

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

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

4.5.1 Full actuarial (funding) valuation

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

For 2015-16, employers’ contributions of £630,525 were payable to the NHS Pensions Scheme (2014-15: £656,182) at the rate of 14.3% of pensionable pay. The scheme’s actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.
## 5. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2015/16 Total £000</th>
<th>2015/16 Admin £000</th>
<th>2015/16 Programme £000</th>
<th>2014/15 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>5,995</td>
<td>4,922</td>
<td>1,073</td>
<td>6,126</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>734</td>
<td>734</td>
<td>-</td>
<td>668</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>6,729</td>
<td>5,656</td>
<td>1,073</td>
<td>6,794</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCG’s and NHS England</td>
<td>5,307</td>
<td>2,394</td>
<td>2,913</td>
<td>6,053</td>
</tr>
<tr>
<td>Services from NHS foundation trusts</td>
<td>321,317</td>
<td>375</td>
<td>320,942</td>
<td>315,005</td>
</tr>
<tr>
<td>Services from other NHS trusts(^1)</td>
<td>202,074</td>
<td>-</td>
<td>202,074</td>
<td>213,421</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies(^2)</td>
<td>83,084</td>
<td>-</td>
<td>83,084</td>
<td>58,774</td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>222</td>
<td>222</td>
<td>-</td>
<td>218</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>332</td>
<td>-</td>
<td>332</td>
<td>384</td>
</tr>
<tr>
<td>Supplies and services – general(^3)</td>
<td>1,458</td>
<td>27</td>
<td>1,431</td>
<td>327</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>815</td>
<td>219</td>
<td>596</td>
<td>721</td>
</tr>
<tr>
<td>Establishment</td>
<td>3,118</td>
<td>548</td>
<td>2,570</td>
<td>3,244</td>
</tr>
<tr>
<td>Transport</td>
<td>15</td>
<td>10</td>
<td>5</td>
<td>16</td>
</tr>
<tr>
<td>Premises</td>
<td>487</td>
<td>468</td>
<td>19</td>
<td>319</td>
</tr>
<tr>
<td>Audit fees</td>
<td>86</td>
<td>86</td>
<td>-</td>
<td>114</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>91,274</td>
<td>-</td>
<td>91,274</td>
<td>88,499</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>12,479</td>
<td>-</td>
<td>12,479</td>
<td>12,120</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>611</td>
<td>503</td>
<td>108</td>
<td>681</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Education and training</td>
<td>386</td>
<td>108</td>
<td>278</td>
<td>348</td>
</tr>
<tr>
<td>CHC Risk Pool contributions(^4)</td>
<td>3,194</td>
<td>-</td>
<td>3,194</td>
<td>994</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>7</td>
<td>-</td>
<td>7</td>
<td>85</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>726,267</td>
<td>4,961</td>
<td>721,306</td>
<td>701,324</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>732,996</td>
<td>10,617</td>
<td>722,379</td>
<td>708,118</td>
</tr>
</tbody>
</table>

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

Notes:

\(^1\)In 2014-15 the Clinical Commissioning Group received £12m non-recurrent funding to support specific policy initiatives such as waiting list backlog and provide additional system resilience over the winter period.

\(^2\)New investment in year to Better Care Fund £18m (see note16 Pooled Budgets); activity growth in Continuing Healthcare costs £2m and Independent Sector costs £2.5m.

\(^3\)£1m non-recurrent funding for Success Regime programme costs.

\(^4\)Contributions determined by NHS England; in 2014-15 £1.6m rebate was returned to the Clinical Commissioning Group.
## 6. Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2015/16</th>
<th>2015/16</th>
<th>2014/15</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£000</td>
<td>Number</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>35,287</td>
<td>118,882</td>
<td>31,296</td>
<td>95,995</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>35,139</td>
<td>118,545</td>
<td>31,150</td>
<td>95,718</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>99.58%</td>
<td>99.72%</td>
<td>99.53%</td>
<td>99.71%</td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>3,487</td>
<td>534,015</td>
<td>3,463</td>
<td>538,257</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>3,450</td>
<td>532,675</td>
<td>3,444</td>
<td>538,035</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>98.94%</td>
<td>99.75%</td>
<td>99.45%</td>
<td>99.96%</td>
</tr>
</tbody>
</table>

The Better Payment Practice Code requires the Clinical Commissioning Group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The Clinical Commissioning Group has achieved the set target to pay 95% of invoices within this requirement.
7. Operating leases

The Clinical Commissioning Group has entered into a small number of formal operating lease arrangements, relating to leased cars, 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 Clinical Commissioning Group also has arrangements in place with NHS Property Services Ltd and Community Health Partnerships Ltd in respect of the utilisation of various clinical and non-clinical properties. These largely relate to payments made in respect of void space in clinical properties, as well as for the Clinical Commissioning Group’s accommodation costs. Although formal signed contracts are not in place for these properties, the transactions involved do convey the right to use property assets.

The Clinical Commissioning Group has considered the substance of both arrangements under IFRIC 4 ‘Determining whether an arrangement contains a lease’ and determined that the arrangements are (or contain) leases. Accordingly the payments made in 2015-16 are disclosed as minimum lease payments in note 7.1.

While our arrangements with NHS Property Services Ltd and Community Health Partnerships Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed and consequently no disclosure of future minimum lease payments for these arrangements is made for buildings in note 7.2.

The Clinical Commissioning Group does not act as lessor.

7.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>Buildings £000</th>
<th>Other £000</th>
<th>2015/16 Total £000</th>
<th>2014/15 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>614</td>
<td>108</td>
<td>722</td>
<td>816</td>
</tr>
<tr>
<td>Total</td>
<td>614</td>
<td>108</td>
<td>722</td>
<td>816</td>
</tr>
</tbody>
</table>

7.2 Future minimum lease payments

<table>
<thead>
<tr>
<th>Payable:</th>
<th>Buildings £000</th>
<th>Other £000</th>
<th>2015/16 Total £000</th>
<th>2014/15 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>82</td>
<td>82</td>
<td>101</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>-</td>
<td>45</td>
<td>45</td>
<td>66</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>127</td>
<td>127</td>
<td>167</td>
</tr>
</tbody>
</table>
8. Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 31 March 2016</th>
<th>Current 31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>1,692</td>
<td>1,032</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>1,452</td>
<td>1,452</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>174</td>
<td>41</td>
</tr>
<tr>
<td>Non-NHS receivables: Revenue</td>
<td>3,472</td>
<td>568</td>
</tr>
<tr>
<td>Non-NHS prepayments</td>
<td>939</td>
<td>691</td>
</tr>
<tr>
<td>VAT</td>
<td>83</td>
<td>45</td>
</tr>
<tr>
<td>Other receivables</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Trade &amp; other receivables</strong></td>
<td><strong>7,814</strong></td>
<td><strong>3,829</strong></td>
</tr>
</tbody>
</table>

The great majority of trade is with NHS England and other NHS bodies. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considered necessary.

8.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2015-16 £000</th>
<th>31 March 2015 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>5,082</td>
<td>1,526</td>
</tr>
<tr>
<td>By three to six months</td>
<td>197</td>
<td>54</td>
</tr>
<tr>
<td>By more than six months</td>
<td>57</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,336</strong></td>
<td><strong>1,585</strong></td>
</tr>
</tbody>
</table>

£3,885,003.07 of the amount above has subsequently been recovered post the statement of financial position date, up to the date of signing the accounts.

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2016 nor 31 March 2015.

8.2 Provision for impairment of receivables

No provision for impairment of receivables was made at 31 March 2016 (31 March 2015: nil) as all receivables were deemed recoverable.

The Clinical Commissioning Group evaluates its receivables age analysis on a regular basis for potential irrecoverable debt. The Clinical Commissioning Group assesses receivables for recoverability on an individual basis and to make provision where it is considered necessary. In assessing recoverability the Clinical Commissioning Group takes into account any indicators of impairment up until 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 and other central and local government bodies.
9. Cash

<table>
<thead>
<tr>
<th></th>
<th>2015/16 £000</th>
<th>2014/15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Net change in year</td>
<td>(5)</td>
<td>7</td>
</tr>
<tr>
<td>Balance at 31 March</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

Made up of:

- Cash with the Government Banking Service: 2 7
- Cash as in statement of financial position: 2 7

10. Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 31 March 2016 £000</th>
<th>Current 31 March 2015 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>5,534</td>
<td>5,621</td>
</tr>
<tr>
<td>NHS accrued and deferred income</td>
<td>5,391</td>
<td>5,746</td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td>1,162</td>
<td>1,228</td>
</tr>
<tr>
<td>Non-NHS accrued and deferred income</td>
<td>17,243</td>
<td>17,491</td>
</tr>
<tr>
<td>Social security costs</td>
<td>67</td>
<td>72</td>
</tr>
<tr>
<td>Tax</td>
<td>89</td>
<td>88</td>
</tr>
<tr>
<td>Other payables</td>
<td>257</td>
<td>158</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td><strong>29,743</strong></td>
<td><strong>30,404</strong></td>
</tr>
</tbody>
</table>

Other payables include £99,958 outstanding pension contributions at 31 March 2016 (£100,806 at 31 March 2015).


The Clinical Commissioning Group had no provisions as at 31 March 2016 nor at 31 March 2015.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before the establishment of the Clinical Commissioning Group. However, the legal liability remains with the Clinical Commissioning Group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this Clinical Commissioning Group at 31 March 2016 is £2.065million (£4.575million at 31 March 2015).
OTHER NOTES

12. Contingencies

The Clinical Commissioning Group had no contingencies as at 31 March 2016 nor at 31 March 2015 which could be quantified.

The following information is supplied relating to areas where it is not possible to give a reliable cost:

Unreported incidents

In common with many other healthcare providers, it is possible that claims and litigation could arise in the future due to incidents that have already occurred. The future expenditure which may arise from such incidents cannot be determined until such time as claims are made.

13. Commitments

The Clinical Commissioning Group had no contracted capital commitments nor non-cancellable contracts (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2016 nor at 31 March 2015.

14. Financial instruments

14.1 Financial risk management

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

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

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

14.1.1 Currency risk

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

14.1.2 Interest rate risk

The Clinical Commissioning Group has no borrowings and therefore has low exposure to interest rate fluctuations.

14.1.3 Credit risk

Because the majority of its revenue comes from parliamentary funding, the Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note 8.

14.1.4 Liquidity risk

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

<table>
<thead>
<tr>
<th>Note</th>
<th>Loans and Receivables 31 March 2016 £000</th>
<th>Loans and Receivables 31 March 2015 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS</td>
<td>8</td>
<td>1,866</td>
</tr>
<tr>
<td>• Non-NHS</td>
<td>8</td>
<td>3,472</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Total at 31 March</td>
<td></td>
<td>5,342</td>
</tr>
</tbody>
</table>

14.3 Financial liabilities

<table>
<thead>
<tr>
<th>Note</th>
<th>Other 31 March 2016 £000</th>
<th>Other 31 March 2015 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS</td>
<td>10</td>
<td>10,925</td>
</tr>
<tr>
<td>• Non-NHS</td>
<td>10</td>
<td>18,662</td>
</tr>
<tr>
<td>Total at 31 March</td>
<td></td>
<td>29,587</td>
</tr>
</tbody>
</table>

15. Operating segments

The Clinical Commissioning Group considers it has only one segment: commissioning of healthcare services.
16. Pooled budgets

The Clinical Commissioning Group operates two pooled funds in partnership with Cumbria County Council under section 75 of the Health Act 2006 (as amended). Both funds are hosted by Cumbria County Council.

The Better Care Fund (BCF) is a joint initiative between the NHS and Local Government to develop an integrated approach between health and social care. It is a single pooled budget to support health and social care services to deliver integrated services, based on plans developed and agreed between Cumbria County Council and the Clinical Commissioning Group.

Both the Integrated Community Equipment Service (ICES), which provides a stock management and delivery service for occupational therapy equipment used in the community across health and social care, and the Locality pooled fund, which develops local services to maintain the independence of (predominantly) older people by helping them to stay at home for longer, preventing admission to hospital and assisting discharge from hospital, have been integrated into the Better Care Fund (BCF).

The Learning Disability Specialised Commissioning Pooled Fund jointly commissions services to improve the general well-being and life chances of people of all ages with a learning disability.

The Clinical Commissioning Group’s shares of the income and expenditure handled by the pooled budgets in the year to 31 March 2016 were:

<table>
<thead>
<tr>
<th></th>
<th>BCF £000</th>
<th>Learning Disability £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(36,013)</td>
<td>(7,659)</td>
<td>(43,672)</td>
</tr>
</tbody>
</table>

The Clinical Commissioning Group’s shares of the income and expenditure handled by the pooled budgets in the year to 31 March 2015 were:

<table>
<thead>
<tr>
<th></th>
<th>Locality £000</th>
<th>ICES £000</th>
<th>Learning Disability £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(3,511)</td>
<td>(384)</td>
<td>(7,891)</td>
<td>(11,786)</td>
</tr>
</tbody>
</table>
17. Related party transactions

Details of related party transactions with individuals are as follows:

During the year none of the Department of Health Ministers, Clinical Commissioning Group Governing Body members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Clinical Commissioning Group, other than the members set out below.

<table>
<thead>
<tr>
<th>2015 – 16</th>
<th>Payment to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workington Health Ltd (Dr N. McGreevy)</td>
<td>1,161</td>
<td>46</td>
<td>-</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2014 – 15</th>
<th>Payment to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workington Health Ltd (Dr N. McGreevy)</td>
<td>53</td>
<td>55</td>
<td>64</td>
<td>212</td>
</tr>
</tbody>
</table>

Transactions are between the Clinical Commissioning Group and the declared organisation, not the individual, and form part of the Clinical Commissioning Group’s normal activities. Workington Health Ltd, a consortium of GPs from five GP practices in Workington, runs Workington Primary Care Centre (WPCC). WPCC, launched in October 2014, provides same day urgent appointments for patients of those practices and also provides a walk-in minor injuries services for patients from those practices and elsewhere alongside other services including an electrocardiogram & wound clinic and a frail elderly assessment team.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities are:

- NHS England (including North of England Commissioning Support Unit)
- Blackpool Teaching Hospitals NHS Foundation Trust
- Central Manchester University Hospitals NHS Foundation Trust
- Cumbria Partnership NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Northumbria Healthcare NHS Foundation Trust
- The Newcastle Upon Tyne Hospitals NHS Foundation Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust
- Wrightington, Wigan & Leigh NHS Foundation Trust
- North Cumbria University Hospitals NHS Trust
- Northumberland, Tyne & Wear NHS Foundation Trust
- North West Ambulance Service NHS Trust

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Cumbria County Council.
18. Events after the end of the reporting period

There are no events after the reporting period which will have a material effect on the financial statements of the Clinical Commissioning Group.

19. Losses and special payments

19.1 Losses

The Clinical Commissioning Group had no losses cases during 2015-16 nor 2014-15.

19.2 Special payments

<table>
<thead>
<tr>
<th></th>
<th>Total Number of Cases 2015-16</th>
<th>Total Value of Cases 2015-16 £000</th>
<th>Total Number of Cases 2014-15</th>
<th>Total Value of Cases 2014-15 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ex gratia payments</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

20. Impact of IFRS

Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during 2015-16 nor 2014-15.