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

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

Building partnerships has been 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.

Maternity services are under real scrutiny across Cumbria. The Kirkup Inquiry laid bare the inadequacies of maternity care at Furness General Hospital during the past decade, but also acknowledged the improvements that are already taking place, along with the commitment and dedication of many professionals working in local hospitals. Close on the heels of the Kirkup report came a review of the future of maternity services across the county, carried out for ourselves and NHS Lancashire North CCG by the Royal College of Obstetricians and Gynaecologists. This has provided a clear roadmap to follow but does not pretend that the goal of high quality maternity services that are easily accessible for all will be easy to achieve. With our partners we have started the journey.

Recruitment of high quality health and care professionals is a challenge for our hospitals, the local authority, community services and general practices. This is possibly the biggest risk we face, and although it is a national problem it is more acute in Cumbria than virtually anywhere else. We need innovative services to attract the best to join us and perhaps the community of Millom is showing the way forward. A year ago the town’s GP practice and community hospital were in crisis due to an inability to recruit GPs to the town. The community took up the challenge, supported by local politicians and health and care partners. A recruitment video produced by local school children with local GPs and the community trust has led to three new GPs being appointed, and has attracted national attention.

Better Care Together – the programme of work in place to introduce new models of health and social care for the people of south Cumbria and north Lancashire - has been recognised nationally as being at the forefront of innovation. It has been awarded Vanguard status by the NHS nationally, which will bring with it extra resources and our CCG has taken a leading role in this. Through this programme we have the opportunity to build a system of health and social care that is both affordable and delivers quality that is amongst the best nationally. The journey will be challenging, with some difficult decisions to be made, but it is one we are committed to - in partnership with local communities.

In the north of the county a similar programme of work has commenced – Together for a Healthier Future – and again we will work with local people and health and care professionals to build a health service that not only meets the needs of those it serves but over time will become an example for others to follow.

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. These are our unsung heroes and we want to take this opportunity to express our thanks and to give them the recognition they deserve. 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
1.1 Introduction

This Strategic report complies with Chapter 4A of the Companies Act (2006). It provides an overview of the CCG’s activity over the past year and offers a forward view into 2015/16. 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

1.2. NHS Cumbria Clinical Commissioning Group (CCG)

NHS Cumbria CCG became a statutory organisation on 1 April 2013, following the passing of the Health and Social Care Act 2012. The CCG is a membership organisation; consisting of 82 GP practices, 81 in Cumbria and one in North Yorkshire, and is responsible for planning and commissioning approximately 80 per cent of the financial value of NHS services in Cumbria. This includes the majority of hospital and community health services. Primary care services, including GPs, dentists, opticians and pharmacies are commissioned by NHS England, as are a defined set of specialist services.

The CCG operates across six localities (Allerdale, Carlisle, Copeland, Eden, Furness and South Lakes). Each locality has a lead GP and a locality executive, a structure which ensures the needs of the population are met both locally and county-wide.

Full details of the CCG’s Governing Body, Directors and Senior Management can be found in the CCG’s Member’s Report – Part 2 of the Cumbria Annual Report and Accounts 2014/15.

1.3 Our Vision and Objectives

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 vison 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, where necessary changing, which organisation delivers services, where it is delivered and how it is paid for
• Putting patients and health ahead of organisational and professional interests.

Our strategic objectives are:
• Radically increase the scale and integration of out of hospital services based around Primary Care Communities.
• Deliver modern integrated services, ensuring an optimal use of resources for patient pathways across community and hospital services.
• Achieve sustainable, high-quality service provision through delivery of a programme of hospital services and, where necessary, a consolidation of hospital services.
• Working with partners to improve the population’s health outcomes.
NHS North of England Commissioning Support (NECS)

To support the CCG in meeting our objectives we commission a range of commissioning support functions from NHS North of England Commissioning Support (NECS), including service planning and reform, clinical quality, financial support and medicine optimisation. NECS has been named as one of seven successful Commissioning Support Units to join NHS England’s procurement framework.

1.4 Our Strategic Plan

In June 2014 all CCGs were required to produce an overarching strategic plan to set the direction for the next five years. The CCG worked jointly with our partner organisations to produce the plan.

In the short term the plan commits to stabilise services and get them back on track in order to achieve:

- A reduction in harm caused to people
- Momentum through credible steps towards financial balance
- An open narrative for the public which reduces anxiety instils confidence and encourages participation.

In the medium term the plan outlines the commitment to transform the local health and care system, based around the CCG strategic objectives.

1.3 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.

During 2014/15 the Cumbria Health and Wellbeing Board, supported by the Local Government Association to review its governance arrangements. Following the review, the Board is now chaired by the Leader of the Cumbria County Council, and the Clinical Chair of the Clinical Commissioning Group is the Vice Chair. The membership is comprised of senior leaders, including Cabinet Members, from Cumbria County Council, representatives from NHS Cumbria CCG, and a representative from NHS England, Cumbria Healthwatch.

The Health and Wellbeing Board is now designed to provide a structure for the strategic local planning and accountability of health and wellbeing related services across a range of sectors and providers. Some of its key functions are:

- To assess the needs of the local population and lead the statutory enhanced Joint Strategic Needs Assessment (JSNA)
- To formulate and ensure the delivery of a Joint Health and Wellbeing Strategy, and to promote integration and partnership working across the NHS, social care and Public Health
- To support and encourage strong partnership working between local organisations in the six localities Cumbria
- To improve the transparency and accountability of services.

The Health and Wellbeing Board will be supported by the new Public Health Alliance, which will focus on population health, including primary prevention and addressing the social determinants of health.

1.3.1 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 for Cumbria is currently being updated. It will identify the current and future health-care and wellbeing needs of the people of Cumbria to support the development of the County’s JHWS. 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.

www.cumbriaobservatory.org.uk
The Cumbria Joint Strategic Needs Assessment (JSNA) identifies four key challenges in relation to the health and well-being of Cumbria’s population:

- Responding to the challenge of improving care for an ageing population
- Improving the health of children and young people and the quality of and integration of care services
- Reducing alcohol misuse and improving mental wellbeing
- Removing health inequalities and premature mortality from cancer and cardiovascular disease.

Cumbria’s overall performance, in a range of health and wellbeing indicators, disguises significant inequalities in health outcomes. There is a 19.5 year gap between the wards with the highest and lowest life expectancies in the county, with life expectancy in some areas 8.4 years below the national average. Deprivation is particularly severe in the urban areas of Barrow and West Cumbria. 15.4% of children in the county live in poverty which is below the national average of 21.3%. However in one ward in Copeland the percentage of children living in poverty rises to 49.2%. Although deprivation is most prevalent in our urban areas there are also hidden pockets of deprivation in some of the county’s most rural communities.

Reducing health inequalities is embedded in our strategic vision and is fundamental to all our clinical strategies. The Health and Social Wellbeing system is the emerging model of health prevention/early intervention work in Cumbria. Outcome measures will be defined in line with this model of care during 2015/16. Implementation of the five most cost-effective high impact interventions, recommended by the National Audit Office (NAO) report on health inequalities, is underway. This is being implemented through improving the uptake of Health Checks in Cumbria and increasing the prescribing of drugs to control blood pressure and reduce cholesterol.

One further feature of the JSNA is the recognition of our unique geography. Cumbria is England’s second largest county, covering over 2,600 square miles. With a population of only half a million people, Cumbria is also England’s second least densely populated county. The challenge of providing quality health services to isolated clusters of population is unique in the north of England.

1.4 Better Care Fund

The local drive to achieve integration of health and care services has been supported, at a national level, through the introduction of the Better Care Fund. This is a joint initiative between the NHS and Local Government to develop approaches to joint working across health and social care. It is a single pooled budget to support health and social care services to work more closely together, based on plans developed and agreed between Local Authorities and Clinical Commissioning Groups.

The Cumbria Health and Wellbeing Board was required to submit a plan in September 2014 to NHS England for how the Better Care Fund would be used within the county to support strategic objectives. This involved close working by colleagues across the health and care economy.

The Cumbria Better Care Fund Plan was approved in January 2015, and addresses a series of national requirements which include better data-sharing between organisations, seven day working to support health and social care patients and joint approaches to assessments and care planning. It also details local initiatives that will support the aim of providing people with the right care, in the right place, at the right time, including a significant expansion of care in community settings.

The Cumbria Better Care Fund plan sets out how the fund will be used to help deliver the objectives identified in the Cumbria Local Health Economy Strategic Plan 2014/2019 and the Cumbria County Council Plan. The key initiatives in the plan are built up from the existing Better Care Together, Together for a Healthier Future and Better Mental Health for All strategies described in section 1.5.
To support the achievement of the system-wide objectives the plan identifies six strategic and delivery programmes for 2015/16. These are:

- **Prevention**: To assist people in maintaining their independence, and to prevent, reduce or delay the need for more intensive services and support in the future. This includes support for carers and access to equipment.

- **Rapid response, re-ablement and clinical coordination**: To provide a single pathway into co-ordinated re-ablement/rehabilitation services that promote independence, safety and well-being.

- **A common platform - clinical informatics**: To ensure consistent approaches to the development of infrastructure across health and social care organisations, that will improve the safety and quality of care provided to patients; improve the timeliness of care, and be more effective and efficient.

- **Psychiatric liaison**: To improve both the experience and outcomes for people who are managing physical and mental health problems at the same time.

- **Sustaining adult social care**: To ensure that the increasing social care needs of the population can be met.

- **Primary care communities and specialists in the community**: To enable care to be delivered as close to home as possible, based around natural populations.

### 1.5 Our Strategic Programmes

During 2014/15, and continuing into 2015/16, the CCG is focussed on four key programmes. The first two are focussed on physical health in geographical areas:

- Better Care Together, working jointly with partners in north Lancashire and South Cumbria, established 2013
- Together for a Healthier Future, covering the North Cumbria area, established 2014.

In some respects Cumbria works as two distinct health economies: North Cumbria based on the population footprint served by North Cumbria University Hospitals NHS Trust and the flow of patients to centres in the North East; and South Cumbria and Lancashire North, based on the population served by University Hospitals of Morecambe Bay NHS Foundation Trust and the flow of patients to centres in Lancashire and Greater Manchester. Recognising these two footprints, health and care leaders are working to develop Better Care Together and Together for a Healthier Future programmes.

Both programmes are focussed on working with patients, the public, staff and a wide range of partner organisations to co-design a blueprint for a completely different way of working in primary, community, social and hospital care. Overall the models developed in terms of the basic functions and the outcomes delivered will be consistent across Cumbria.

The further two programmes cover the whole of Cumbria and have clear connections and interdependencies with our geographically based strategies. These are:

- Better Mental Health For All
- Children and Families.
1.5.1 Better Care Together

The Better Care Together programme is the review of health and care services across Morecambe Bay. All the health and social care organisations that deliver services across Morecambe Bay have united under the banner of “Better Care Together” (BCT) to co-design high quality adult, children’s, and social care services that will be safe, affordable and fit for the future.

In 2015, the BCT partner organisations published the Better Care Together Strategy. The Strategy is a five year vision of services shaped around the unique geography and demographics of Morecambe Bay. It is based on sound clinical evidence, national and international best practice and detailed analysis by independent third parties. The work has been led by hospital doctors, GPs, nurses and social care colleagues who have been committed to find out what local people and partners think of their health and care services and their aspirations for the future. The findings of this extensive engagement have influenced the proposals of the Strategy.

Our plans focus on improving the integration of services across the Morecambe Bay area e.g. improving how health services work with social care services, strengthening the links between primary care and secondary care. We have started to develop locality-based teams in North Lancashire and in South Cumbria which will see care tailored around the patient to encompass a greater range of their needs. There will be smaller, more productive hospital services working hand-in-hand with integrated out of hospital services: our hospitals remain vital and will focus on the services only they can deliver. An increased use of Information Management & Technology, community specialists, care co-ordination and the further development of rapid response teams will also help improve this joined up working.

Responsibility for health and social care will become a true partnership between the people needing to access services and those who provide them. People will be supported to make lifestyle choices that will keep them healthy for longer and to take control and manage their long term conditions with local clinical teams linking together the support and technology they will need.

GPs will work closely with a wide range of other health and social care colleagues to ensure people’s needs are met. Hospital specialists will work increasingly with these new teams in the community to share their expertise, so that more staff are able to help patients cope with the long term conditions that so many of us will encounter in our later years.

Over the next two years our focus will be on developing out-of-hospital services, as more progress will need to be made before any significant changes could be made to hospitals.

The Better Care Together Strategy was shared soon after the publication of the NHS Five Year Forward View, which offered a national perspective on how the NHS should respond to many of the challenges it is facing.

Our local proposals are supported by the news that in March 2015, NHS England confirmed that Better Care Together was chosen, as one of only 29 local health economies, to take a national lead on transforming care for patients as part of the NHS Five Year Forward View Vanguard programme. We are confident this will help us to implement many of the key proposals we set out in Better Care Together.
1.5.2 Together for a Healthier Future

The ‘Together for a Healthier Future’ programme board has been meeting since February 2014 to drive forward the improvements needed in health and care services across North Cumbria. It is led by NHS Cumbria CCG and comprises of senior representatives from local NHS organisations, NHS England, Cumbria County Council and Healthwatch. For the first few months of the year their focus was on the development of a five year plan for health and care services which the CCG was required to submit to NHS England by the end of June 2014.

To inform the plan there was an extensive programme of public engagement including 13 roadshows in towns and villages across Allerdale, Copeland, Carlisle and Eden facilitated by Healthwatch, two large events for the community and voluntary sector organised by Cumbria Voluntary Service, 20 focus groups run by an independent research company and meetings with parish, district and county councillors.

The plan focuses on the development of more services in people’s own homes and in communities, more joined up working across health and care organisations, including the community and voluntary sector and the consolidation of a small number of hospital services where there is evidence to show that patients would have a better outcome.

In describing the development of more local services the plan included the concept of ‘primary care communities’. This means health and care organisations in natural communities coming together to provide wraparound services for patients, particularly older and more vulnerable people, including those living with long term conditions. The aim would be to provide more support to help people to stay well and independent and reduce avoidable hospital admissions. In doing so this would reduce travelling and achieve greater integration across services which were two of the key issues that emerged during the public and stakeholder engagement.

The plan stated that the board was committed to ensuring positive futures for both Cumberland Infirmary and West Cumberland Hospital and would continue to look at different possibilities across a scale of change. In particular it looked at medical admissions including some pathways for very sick patients to consider whether there would be clinical benefits by centralising their care on one site.

In terms of planned care there was reference to the opportunities that existed with the redeveloped West Cumberland Hospital to develop an elective centre of excellence for low risk, high volume procedures. This would reduce the risk of routine operations being cancelled because an emergency took priority which was a theme that emerged during the public and stakeholder engagement.

For unplanned care that would usually come through A&E departments, the report said that high quality care needed to be provided seven days a week with the right skills and expertise. Therefore there may need to be some consolidation of the higher risk and more complex care. However, it stressed that there would still be A&E services at West Cumberland Hospital.
1.5.3 Children’s Services

Children and Family services are an integral part of both the Better Care Together and Together for a Healthier Future strategic 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, and
- improving care for children and young people at risk of being admitted to hospital in need of a psychosocial assessment.

Following major investment in 2013/14 the continued development of the Children Adolescent Mental Health Services 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 and because of the high level of turnover in staffing, particularly in South Cumbria. Plans are in place not only to secure the existing service but also to continue its development.

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.

1.5.4 Maternity Services

2014/15 was a very important year in relation to maternity services, with the publication of both the Morecambe Bay Investigation report, which focussed retrospectively on the serious failures of clinical care at Furness General Hospital, and the Independent Review of Maternity Services which focussed on the future options for high quality maternity care across Cumbria and North Lancashire.

The two reports are summarised, and will provide the basis for how NHS Cumbria CCG takes forward maternity services, with our partners and the local communities, through 2015/16 and into the future.

The Morecambe Bay Investigation

The Morecambe Bay Investigation, led by Dr. Bill Kirkup CBE, was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report, published in March 2015, makes 44 recommendations for the trust and the wider NHS.

Covering the period from January 2004 to June 2013, the report found that the maternity unit at FGH was ‘dysfunctional’ and that ‘serious failures of clinical care led to the unnecessary deaths of mothers and babies.’ The Investigation Panel also reviewed pregnancies at other maternity units run by the Trust and found serious concerns over clinical practice were confined to FGH. Importantly for patients, the local community, staff and the Trust itself, the report concludes that significant progress is being made at Morecambe Bay and states that these recommendations are aimed to support further improvement.

A preliminary action plan to address the report’s recommendations has been produced with University Hospitals of Morecambe Bay NHS Foundation Trust electing to set up an additional sub-committee of its board to oversee the development and delivery of the action plan. In the light of these recommendations, both Cumbria and Lancashire North CCGs have agreed to respond together as part of a Bay-wide approach. This is consistent with the Better Care Together approach.

A copy of the full report can be accessed at:
Maternity Services: Independent Review

Cumbria CCG and NHS Lancashire North Clinical Commissioning Group commissioned a review from the Royal College of Obstetricians and Gynaecologists (RCOG) during autumn 2014 to provide expert and independent clinical advice that would help inform future commissioning arrangements.

This was led by Dr Anthony Falconer, former president of the RCOG, who, before he retired, was a consultant obstetrician at Plymouth Hospitals NHS Trust.

The report following the review, also published in March 2015, included six options, three of which were not recommended by the review team. The team’s preferred option (Option 1) was four consultant-led maternity units at Carlisle, Whitehaven, Barrow and Lancaster with the immediate development of ‘alongside’ (on the same site or next to) midwifery-led units at Carlisle and Lancaster and in the longer term to evaluate the development of the same at Barrow and Whitehaven.

However, the team said that this can only be supported on ‘safety and sustainability grounds’ if steps are taken to reform the approach to staffing, improve antenatal, labour and delivery and postnatal care, address anaesthetic issues and agree sufficient paediatric cover for a special care neonatal unit.

It recommended that a project team should now be established, including an external senior manager, external obstetrician, local head of midwifery and patient representatives. This would be accountable to the lead clinical commissioning group and would develop a detailed feasibility report on the cost, viability and risks of proceeding with this option. Local views and social deprivation would be important considerations.

These deliberations should take place within a year and if they showed that Option 1 was not possible then Option 2 should be considered, as follows:

Option 2a – Two consultant-led units at Carlisle and Lancaster and developing two on the same site or next to midwifery-led units at Carlisle and Lancaster. This was the team’s second favoured option should it not be possible to achieve Option 1. It would mean the closure of consultant-led units at Whitehaven and Barrow.

Option 2b – Two consultant-led units at Carlisle and Lancaster, developing two on the same site or next to midwifery-led units at Carlisle and Lancaster and converting the consultant-led units at Whitehaven and Barrow to become ‘free-standing’ midwifery-led units, which means they have no consultant obstetric services on site.

The full maternity review report can be accessed at: www.cumbriaccg.nhs.uk

1.5.5 Better Mental Health For All

Feedback from users of mental health services, their carer’s and staff working within services throughout 2014/2015 has reinforced that Cumbria is facing major challenges in how people are supported in achieving good mental health and wellbeing.

NHS Cumbria CCG is clear that Cumbria needs to find new and different ways to build mental resilience in local villages and towns, giving people the tools, skills and information they need to help themselves and to help each other. The CCG is also clear that where people do need to access treatment and support from specialist clinical services, these services will be accessible, joined up, effective, high quality and are responsive to the needs of the population.

As a result in 2014, NHS Cumbria CCG and Cumbria County Council (CCC) undertook the development of a joint mental health commissioning strategy for adults in Cumbria for the five year period 2015/2020.

The joint commissioning strategy titled ‘Better Mental Health for All’ has been informed by significant stakeholder involvement from users of mental health services, their carer’s, the public and the whole health and social care system across Cumbria.

This high level strategy is in the final stages of development, and seeks to draw together the commissioning priorities and approach for NHS Cumbria CCG and CCC and aims to be clear about the priorities for the whole mental health system over the next five years.
A number of key priority areas have been identified within the strategy and four mandated work streams have been agreed on to progress improvement, redesign and development in these key areas:

- Primary care and community services,
- Urgent care systems,
- Care for people with specialist needs and
- Third sector transformation.

A number of significant pieces of service review, redesign and development projects are already underway within the governance of the mandated work streams including:

- Services for people with personality disorder
- Services for people in crisis (National Mental Health Crisis Concordat)
- Services for people who come into contact with the criminal justice system (National Liaison and Diversion).

The work and outputs from all of the above projects are being monitored by the Cumbria Mental Health Partnership Group (CMHPG), which was established in November 2014 to oversee the implementation of the Mental Health Strategy. The Cumbria mental health service user and carer forum are key members of CMHPG and provide assurance that any service redesign opportunities will make real changes and improvements to the mental health and wellbeing of all people in Cumbria.

1.5.6 Learning Disabilities

There is a planned, coordinated and integrated approach to continue to improve the system of care for people with learning disabilities. The commissioning of mainstream learning disability services is via a section 75 agreement within the terms of the NHS Act 2007. A joint commissioning group with representatives from the CCG and the Local Authority oversee governance arrangements for the section 75 agreement and service developments for people with a learning disability.

There are developments in primary and secondary care, continuing to improve the system of care, for people who have a learning disability. This includes the recruitment of learning disability liaison nurses, whose responsibility will span across all departments, to ensure that patients who have a learning disability are supported and that staff have a thorough understanding of the patients they are caring for. A dashboard is in use throughout primary care for GP’s to share and develop best practice and to improve overall patient care. Enhanced reviews are in use throughout Cumbria. A thorough process is in place to ensure that people who may be at risk of admission to inpatient care are identified and effective planning is in place to provide support where possible in the community.

With our partner organisations the CCG continues to ensure that people receive appropriate care in the right environment, including enabling service users with complex needs to return to Cumbria where appropriate. The CCG has developed a framework which comprises of seven providers who can develop services within the county for people with complex needs. This framework ensures that there is flexibility and capacity to support advanced planning and increase the availability of specialist provision in the community. During 2014/15 patients continued to be discharged from out of county inpatient care back into Cumbria into services within the community, which will continue in 2015/16.

Planned legislative changes are having a major impact on joint working around children. This process has begun in Cumbria with the development and planning of training around Continuing Care, the re-development of a Complex Needs panel and the transfer to Education Health and Care Plans.
1.6 Locality Focus

Recognising the variation in need, and the natural communities that exist across Cumbria, commissioning and implementation of many community health care initiatives is managed by the six localities in Cumbria.

These localities form the main mechanism for the CCG to engage with its member GP practices but are also a key building block to enable locally responsive services. This year, to further enhance the link with the public, each locality has recruited lay representatives to their locality executive board.

A countywide recruitment exercise was held which resulted in nine representatives being recruited. Three localities chose two representatives and the other three, one.

**Allerdale:**

Susan Gallagher – Retired primary school teacher, Sue is passionate about ‘joined-up’ services and engaging with young people about health issues. Previous experience includes working with dementia as a carer and with the Kings Fund project, ‘Enhancing the Healing Environment’. Sue is also part of the Dementia Strategy team for Cumbria, a member of her local GP patient group and a trustee for Age UK.

**Carlisle:**

Jane Anderson – Retired restauranteur and hotelier, plus many years’ experience in the voluntary sector. A keen fundraiser and Chairperson for MacMillan Cancer Relief for ten years she has been involved with the Croftlands Trust since 2001. Jane is keen to ensure communities have a voice in the provision of care needed in their community.

Olwyn Luckley – Retired Carlisle City Councillor and previously the portfolio holder for health and housing with an interest in health inequalities. Olwyn is also involved in the Carlisle Healthy City project and a board member of Cumbria Gateway, a social enterprise assisting recovering addicts through peer mentoring, housing education and employment. Olwyn wants to support and encourage partnership working with organisations working to eliminate health inequalities.
Copeland:

Bernard Courtney – Retired from Head of Environment for Sellafield sites and became involved in a number of voluntary roles, many of them concerned with local health issues. Bernard wants to use his local knowledge, expertise and experience, gained over many years in industry, to support the improvement of health care for local people.

Chris Wood: Retired Electrical Project Engineer and Chair of Cumbria Cancer Patient and Carers Advisory Panel after being diagnosed with chronic myeloid leukaemia. Chris is keen to ensure health professionals consider the patient perspective and value the importance of the patients’ voice when developing health services.

Eden

Neil Hughes – An Eden District Councillor, with years of experience in patient and public involvement. Neil wants to ensure that people in Eden continue to receive a good service from their local health providers. Neil wants to help keep local people informed and involved in any changes and discussions regarding the future of NHS provision.

Furness

Kath Simm – Worked in the NHS for 20 years in various departments including Health Education, Public Health, Commissioning and a Health Education Library. She was also a Volunteer Gateway Advisor for the Citizen Advice Bureau and Chair of the Towns Women’s Guild. Kath is keen to support people to remain at the heart of health and social care by participating fully in the development and decision making processes.

Ian Reed – Worked for the Pharmaceuticals Industry with GlaxoSmithKline whose mission statement is ‘to enable people to do more, feel better and live longer’. This is a sentiment to which Ian is fully committed and would like to extend this ethos to the provision and improvement of healthcare in the local community. Ian is also involved in the Millom Health Action Group.

South Lakes

Jim Lawson – Following a career in the justice system Jim is a passionate believer in the NHS and keen to promote the best quality health care for people living in South Lakes and Cumbria. Jim brings a user voice, free of vested interests, aimed at ensuring that the needs of patients are at the forefront of its decision-making. Jim is an active member of a number of local groups.
Below is a summary of some of the work each of the localities led during 2014/15.

1.6.1 Allerdale

Five primary care communities in Workington, Maryport, Solway, Keswick and Cockermouth are being established. District nurse, rehabilitation and social work teams are aligned around these communities and Allerdale’s five community hospitals.

A key project launched in October 2014 has established the Workington Primary Care Centre, following a successful bid to the Prime Minister’s Challenge Fund for £500k to provide same day urgent appointments for patients with one of the practices involved in this project. It also provides walk-in minor injuries services for patients from those practices and elsewhere. Since December the centre has been open 8am to 8pm seven days a week and by the end of January 2015 was seeing 1,000 patients a week. A patient survey shows high satisfaction rates and sharing the provision of same-day care allows GPs more time supporting those with complex needs and long term conditions.

Specialist nurses are supporting vulnerable older people in their own homes and residents in care homes across Workington, as well as managing access to ‘interim beds’ in care homes to avoid hospital admissions. Specialist nurse practitioners are working with people with diabetes, who need to take insulin to manage their conditions, and people with respiratory conditions.

In Solway specialist nurses are providing case management and care planning support for frail older people and the rehabilitation team has been extended to provide additional physiotherapy and home care practitioner cover over longer hours.

A new falls prevention service and frail elderly assessment team is providing improved support, in Maryport, including weekly, multi-disciplinary assessment clinics and outreach services including work in care homes.

In Keswick an enhanced falls service has started and a nurse is being recruited to work with frail older people targeting care home residents. In Cockermouth a nurse is being recruited to identify and provide more support for frail elderly patients with complex needs to reduce the risk of their health deteriorating.

Across the locality GPs are developing their skills in the management of older peoples’ health needs by undertaking training to obtain a specialist diploma in geriatric medicine.

1.6.2 Carlisle

Carlisle Locality continues to build on the ongoing ‘Mrs Carlisle’ programme delivering of ‘out of hospital care’ services. This includes developing and implementing projects as key building blocks towards achieving increased integration as defined for Primary Care Communities (PCC).

A successful pilot of a Hospital at Home service led to the decision to create the service on a permanent basis, extending its scope and capacity. The staffing and investment in the service was part of a planned programme to transfer care from a ward based service (Reiver House) to a community service.

The Mrs Carlisle “Patient Stories” have helped tell the story of the patient’s journey, with reported improved quality of care and patient experience. Feedback from patients stories related to the schemes suggest that people feel more in control of their care and report reduced social isolation with prevention of unnecessary hospital admissions.

The Locality has had a number of events in 2014 working closely with GP member practices, partners and stakeholders in the development of PCC.
has seen the launch of the Carlisle Care Home Team which is an integrated clinical team that focuses on optimising care co-ordination for people living in care homes.

1.6.3 Copeland

Discussions have focused on the establishment of one Primary Care Community (PCC) covering the whole locality.

Plans are in place to develop a single point for GPs to access a range of enhanced community services including a rapid response team, working 8am to 8pm, with an out of hours service available overnight and at weekends. The team will link into all existing providers and resources to optimise services for older and more vulnerable patients.

There will be a named district nurse and social worker/social care worker for each GP practice to ensure continuity of care for patients. All of this will be managed by an integrated team working across organisations.

Another scheme involves care coordinators who have been working in GP practices since April 2014. Evaluation has shown positive results, with support provided for more than 700 people over the age of 75. The locality is hoping to extend the scheme to include people aged over 65. The care coordinators can organise various types of support ranging from garden tidying, district nurse visits to benefits advice helping older people to stay well and independent. Copeland has successfully evaluated the scheme and will be embedding the role as part of the Primary Care Community team.

New roles in the community team include Advance Practitioners, Home Care Practitioners and a Tissue Viability Nurse. Working closely with the voluntary sector, Local Area Coordinators and the PCC team will have access to four step up/step down beds at Pow Beck residential home avoiding unnecessary hospital admissions and aiming to get people out of hospital and back home quicker.

In January 2015 a minor ailments scheme was launched in pharmacies across Copeland providing quick access to basic medicines without a GP appointment for patients eligible for free prescriptions.

1.6.4 Eden

In 2014/15 Eden Locality has worked closely with its member practices to promote and embed a culture of continuous improvement and ensure sustainability. This approach has helped practices to focus on systems and processes to improve patient care. GP access is key to delivery and is therefore a high priority. Processes and improvement tools, developed by Cumbria Learning and Improvement Collaborative (CLIC), have supported this process.

The Locality is developing Primary Care Communities in Penrith, Upper Eden and Alston. The aim is to create systematic care to anticipate, rather than just respond to, patient needs enabling better planning of resources to meet demands and improve capacity. The locality has invested in social prescribing, Eden Health & Wellbeing Hub and community volunteers. Service developments include: Mindfulness and Pulmonary Rehabilitation and a falls prevention service is currently being developed.
1.6.5 Furness

Over the past 12 months Furness locality has been developing a new way of working in communities; this supports our overarching strategy of Better Care Together and we are beginning to see the start of new service models across the health and social care system. Primary Care Communities (PCC) have begun to implement key pilot roles to work across groups of practices in each PCC and test the Better Care Together out of hospital model. Specific elements in the first pilot phase are the care navigator function and case management.

Induction is underway and by the 1 May 2015 the pilots will be active in all the PCC. Other projects across the PCC include the development of an integrated new building, with a focus on same day urgent care, the development of self-management and, for all PCC, an enabling patient and stakeholder engagement plan. Outcomes for each PCC include improving health and well-being, improving access to care and supporting people to live well and to manage living with long term or debilitating conditions.
Public engagement continues to grow with The Furness Listening Event and Maternity Matters in Furness becoming an established part of the event calendar. Furness has embarked on a new project spreading across South Cumbria in relation to recruitment and collaboration across health and industry. ‘Choose South Cumbria’ is a new integrated website for sharing recruitment opportunities and making connections for potential employees into the economy and communities.

Progress on the Alfred Barrow Medical Centre is continuing and development of new ways of working and opportunities for greater cross-organisational working is evolving through the process of designing a shared building.

The improvement of health services in Millom has seen the locality working jointly with Waterloo House Surgery, the local community and Cumbria Partnership NHS Foundation Trust to test new ways of working to ensure health services remain high quality and are sustainable. Local school children in Millom produced a YouTube video calling for a new GP, saying the shortage of doctors was having a negative impact on local health services. The film received over 5,000 views and resulted in three new GPs joining the practice. A strong Millom Alliance is seeking ways to improve care and they were successful in a recent capital bid for over £900,000 for building work to improve and dramatically change the hospital site. The Alliance of health services has also secured a new North West Ambulance Service Advanced Community Paramedic, the first of its kind in the North West. The success of Millom and its evolution to include Kirkby-in-Furness in its PCC provides a real example of the art of the possible across Furness and lessons are being shared in our system.

The locality has continued to work on improving services for the frail and elderly and the successful Kendal Care Home Pilot has shown positive outcomes with emergency admissions to hospital decreasing. Staff have also worked more closely with residents and their families and used existing resources to expand patient pathways. The locality is extending this pilot to enable shared learning across the PCC and to inform opportunities within our Out of Hospital model of care.

1.6.6 South Lakes

From 1 April 2015 Dr Jim Hacking was welcomed as the new GP lead and Chair of South Lakes Locality. Dr Alistair MacKenzie steered the ship successfully through NHS restructure and internal transition to the CCG and thanked Alistair for commitment, energy and challenge.

South Lakes has been delivering the ‘Better Care Together’ strategy across its evolving Primary Care Communities (PCC), and with Furness locality, has developed a range of projects, pilots and new models to deliver change across our system. The PCC in South Lakes are beginning to implement key pilot roles and test functions with a wide range of partners across the third sector, community services and Primary Care. South Lakes PCC are exploring the opportunity to create social and community assets to drive change and share best practice, learn from early pilots and share expertise across different groups of patients and two communities.
A new Advice and Guidance (A&G) tool has been launched to all GP Practices in South Lakes and Furness allowing GPs to request advice from secondary care specialists at University Hospitals of Morecambe Bay NHS Trust (UHMBT) in a two-way secure electronic conversation. A&G covers ten specialities at Furness General Hospital and Royal Lancaster Infirmary. This has resulted in improved clinical dialogue and avoided outpatient referrals saving patients unnecessary journeys to hospital.

The locality has established a maternity users group with a view to developing a Maternity Services Liaison Committee and ensuring a South Lakes perspective is represented in the strategy design for maternity services going forward. It is important to the locality and CCG that both south based maternity liaison and maternity groups help get the user voice into health planning and together find solutions to the recent national reviews. South Lakes maternity group held their first event in April 2015 where the ambition was explained to local parents and healthcare professionals.

1.7 Quality

The CCG 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), National Reporting and Learning System (NRLS), NHS England (NHSE), Healthwatch, the Strategic Executive Information Systems (STEIS) and from feedback the CCG receives from patient experience data including ‘I Want Great Care’, General Practice and CCG localities. Individual and collective aspects are addressed directly with the providers by the CCG’s Quality Team.

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 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.

1.7.1 Patient Experience

The CCG has prioritised the gathering of real time patient experience through ‘I Want Great Care’. This is the UK’s first patient experience system capable of receiving feedback from any aspect of care across the whole health economy. Launched in September 2014, the system will ensure the local population can provide and access user feedback on clinical services across acute hospitals, community mental health and primary care in Cumbria.

The system is now fully operational and covers the entire Cumbrian population. It is beginning to provide important information, which the CCG is able to use to improve the patient experience either directly with the providers or through the commissioning and contracting processes.

So far the system has yielded over 60,000 reviews with all providers supplying key data to the system. A pilot for children’s services, funded by NHS England last year, allows young people to register their feedback on wireless tablet devices. This has yielded over 15,000 reviews in all healthcare settings.

The system is currently being piloted for out of hours GP services and other providers in the county. Furthermore, a pilot for British Sign Language users will be rolled out in the next few months. The system
is available in ‘easy read’ formats and the major foreign languages in Cumbria.

The system is monitored by the CCG and providers who have agreed a ‘You said, we did’ feedback loop to ensure patients can see the results of their reviews and comments. The CCG is developing its own data dashboard which will provide management information for monitoring and commissioning purposes. This will provide real time alerts where services are given three stars or below ratings. Providers are expected to take action on poor reviews and respond to patient feedback whether they have their own patient experience system or are using the iWantGreatCare platform.

1.7.2 Safeguarding

The CCG has met all its statutory requirements in respect of children and adult safeguarding as described in the NHS England Safeguarding Assurance Framework (2013). This has included establishing clear accountabilities and safeguarding leadership roles.

The CCG’s safeguarding leads are actively engaged on the respective multi-agency Safeguarding Children’s and Adult Boards and subgroups. The leads are also active members of the provider Trusts’ safeguarding committees for assurance and oversight of the health safeguarding system.

A range of contractual and quality mechanisms are in place for the CCG, as a commissioner, to assure itself of the safety and effectiveness of the service it has commissioned.

1.7.3 Regulatory Intervention

North Cumbria University Hospitals NHS Trust was included in the Mortality Review led by Sir Bruce Keogh, NHS England Medical Director, in 2013. The review identified a significant number of impediments to the delivery of quality services. The review led to the Trust being placed in special measures. In the period following the review the Trust has taken forward many improvements and is now within the expected range for Hospital Related Mortality. A further review undertaken by the Care Quality Commission in May 2014 confirmed the overall CQC (CQC) rating as ‘Requires Improvement’.
University Hospitals of Morecambe Bay NHS Foundation Trust was included in the wave one of the new Chief Inspector of Hospitals reviews. Following the review, published in June 2014, and the subsequent risk summit, the Trust placed in special measures, with an overall rating of Inadequate. A summary of the CQC ratings for both Trusts is shown below.

This means that at the time of writing, both the major Acute Trusts serving Cumbria are in special measures, the highest level of escalation in the NHS. The CQC undertook a planned re-inspection of North Cumbria University Hospitals beginning on 30 March 2015, and also plan to undertake a re-inspection of University Hospitals of Morecambe Bay NHS FT in 2015/16.

Additionally there has been significant regulatory intervention in relation to Residential and Nursing Homes in 2014/15. The CCG will continue to work with the Local Authority and the CQC to address those challenges in 2015/16.

### 1.8 Continuous Service Improvement: Cumbria Learning and Improvement Collaborative (CLIC)

Over the last year, CLIC has had contact with over 2,000 individuals, consisting of both health and care staff and the people who use health services. The reception received by the team has been fantastic with many staff, volunteers, patients and service users eager to work differently and more collaboratively, in order to transform and improve services across Cumbria.

CLIC have three key strategies and work programmes in support of the changes needed to how we work jointly in Cumbria across health and care to approach education and learning, leadership and continuous improvement. In the last year CLIC has delivered a number of workshops and supported many events and initiatives in support of the four key priorities identified in the five year plan.

In October 2014, CLIC held its first patient engagement event with 135 health and social care professionals, service users and local sixth form students attending over two days. The ‘People in Control’ conference was a huge success, allowing both service users and providers to contribute to discussion at workshops and virtually through live streaming and Twitter. CLIC aim to make patient engagement events a regular occurrence and are planning a ‘Young People in Control’ conference later this year.
1.9 Performance Against Key Indicators

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.

At the end of March 2015 the CCG had achieved the targets in only five of the 24 Expected Rights and Pledges. Detailed reviews have been carried out and action plans are being implemented with local providers to improve standards in the underachieving or failing standards of the rights and pledges across Cumbria.

Diagrams 1 and 2, below, indicate how well the CCG is achieving the standards set out in the NHS Constitution Rights and Pledges for 2014/15.

Area for improvement and what the CCG is doing about them:

**NHS Constitution Rights and Pledges 2014/15**

CCG Aggregate Performance

Referral to Treatment Times (Mar 2015) & Cancer Waiting Times (Quarter 4 2014/15)

Diagram 1. Covers Referral to Treatment Time (RTT) standards for elective care and cancer waiting times

*Acronyms: 2WW – two week wait, Radiother. – radiotherapy, RTT – Referral to Treatment*
Diagram 2. Covers: cancelled operations, mixed sex accommodation breaches, ambulance standards and accident and emergency standards.

**Acronym:** CPA – Care Programme Approach, EMSA – Eliminating Mixed Sex Accommodation, A&E – Accident and Emergency

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 a 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 and NHS England North East as well as the providers of the services.
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) have not achieved some of the cancer standards consistently over the year and have implemented actions plans which have resulted in their performance improving significantly. The CCG continues to work with North Cumbria University Hospitals NHS Trust (NCUHT) to implement a Recovery Plan that will ensure that these standards can be consistently met in the future. The main contributing factor to failure of some of the standards is a lack of appropriate staff as Cumbria has difficulty recruiting highly qualified and skilled staff to the area, particularly at a time when there is a national shortage of highly skilled and qualified clinical staff. Currently cancer services are supported by trusts from the North East such as the Newcastle-upon-Tyne Hospitals NHS Foundation Trust. The Recovery plan is however enabling improvements in the appointment system and in the process for tracking patients through their cancer pathway to ensure that it is highlighted if there are delays in their pathway. Each specialty is being assessed to identify what the issues are that are preventing achievement of the standards and solutions are being identified.

Nationally there has been a lot of media coverage about urgent and emergency care pressures and the experience locally in Cumbria reflects the national picture of increased pressure due to higher numbers of patients being admitted who are extremely unwell with multiple conditions to be managed. Urgent Care Working Groups or System Resilience Groups have been established in North and South Cumbria, chaired by the CCG but with multi-agency support. Nationally additional funding was allocated this winter to support urgent and emergency services. These groups developed plans to utilise the funding to ensure that the right services are in place both in the acute hospital and in the community to treat urgent care needs in the appropriate place, reducing the need for people to be admitted to hospital. Many of these plans have been effective such as Pathfinder, an initiative to enable ambulance paramedics to use alternative services for patients not requiring admission to hospital, but again, limits on the ability to recruit suitable staff, has limited the potential to implement all the schemes originally planned. The increase in very frail patients requires more beds and care packages in the community for patients to receive the level of support they need following discharge. Work is taking place with Social Care to increase the capacity of nursing home beds, home care packages and particularly care homes able to take patients with severe dementia. However, developing and procuring these services takes time to achieve.

A higher proportion than is acceptable of elective care pathways have not been completed within the 18 week timeframe at both the main acute trusts serving Cumbria (NCUHT and UHMBT). Again, nationally additional funding has been allocated to Trusts to enable them to treat patients that have been waiting for more than 18 weeks. Both Trusts have been able to treat many of those patients waiting more than 18 weeks, either through additional operating sessions at the Trust or by purchasing extra sessions at alternative providers, where the patient is willing to travel. Unfortunately NCUHT has been less successful in reducing waiting lists for surgery in the latter part of 2014/15 due to a prolonged outbreak of norovirus that led to many surgical operations having to be cancelled. In the longer term the CCG and both Trusts are exploring the use of independent sector capacity to support specialties which have particular challenges in providing sufficient capacity to meet the demand. UHMBT expect to achieve the elective care pathway standards from May 2015 onwards and NCUHT expect to achieve the standards from October onwards, as they have a larger number of patients who have been waiting for longer than the standard 18 week timeframe.
1.10 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, Northumberland, Tyne and Wear (CNTW) Area Team and 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 senior 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.

1.11 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 2014/15 Financial Plan recognised the financial pressures it faced and targeted the delivery of a £5 million surplus. Despite a number of significant financial challenges in the year we have managed to finish the year with an operational surplus of £5 million as planned. The Accounts have been prepared under a direction from NHS England, under the NHS Act 2006 (as amended).

The chart shows how the CCG’s revenue resources of just over £700 million were spent in 2014/15. This expenditure reflects that during 2014/15, in addition to the CCG’s on-going funding allocation, the CCG received around £15 million in additional central funding. These resources were allocated to health providers to improve system resilience for emergency care (e.g. winter pressures) and improve patient waiting times for planned care.

![Chart showing expenditure categories]

A full breakdown of our annual accounts is included as Part 7.
In 2015/16 the CCG will continue to work closely together with fellow stakeholder organisation as part of the “Better Care Together” (South Cumbria) and “Together for a Healthier Future” (North Cumbria) strategic programmes with the objective of establishing clinically and financially sustainable health services for the future across Cumbria. Complementary to this approach is the introduction of the Better Care Fund for 2015/16 where the CCG is working very closely with Cumbria County Council to implement plans to transform and integrate services in the community (for both health and social care) to reduce the reliance on the acute hospital sector in future.

1.12 Sustainability and the Environment

The CCG continues to promote environmental sustainability. The biggest impact the CCG has is on carbon emissions. With a county of 2,613 square miles and office’s in six locations, the CCG is mindful to minimise journeys and to use alternative technical solutions for meetings (i.e. video conferencing, teleconferencing, and webinars) wherever possible in order to reduce the carbon footprint.

Buildings occupied, in the main, are owned by NHS Property Services and Cumbria Partnership NHS Foundation Trust. The CCG continues to work with these two bodies to ensure plans to reduce the carbon footprint are in line with the recommendations of the Sustainability Development Unit of NHS England.
Part 2

Members’ Report
2.1 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 81 GP practices in Cumbria and one 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 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:

www.cumbriaccg.nhs.uk

A full copy of NHS Cumbria CCG Annual Governance Statement containing: committee structures, roles and responsibilities, membership attendance record. An overview of the year’s work coverage can be found in the Annual Accounts.
Membership of the Governing Body is set out below:

**Governing Body Members**

**Dr Hugh Reeve – Clinical Chair**
Dr Reeve is Clinical Chair of NHS Cumbria CCG and a GP in Grange-over-Sands. Previously he was Medical Director and Chair of the Professional Executive Committee at Morecambe Bay Primary Care Trust. He is also Chair of the Governing Body, Clinical Leads Group and Finance & Performance Committee.

*Dr Reeve is currently Interim Chief Clinical Officer.*

**Les Hanley – Lay Member Health Improvement**
Les is a Director at Age UK, West Cumbria. He chairs the Outcomes and Quality Assurance Committee, is a member of the Remuneration Committee, Audit Committee and Finance and Performance Committee at 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 was born and educated in Carlisle and retired in 2010 after over 30 years in the NHS. As a Director of Finance he has held posts at a national, regional and local level. He chairs the Remuneration Committee, Audit Committee and is a member of the Finance and Performance Committee.

**Ruth Gildert – Nurse Member**
Ruth was born in Carlisle and returned to Cumbria after over 40 years of nursing and senior management posts in both community and hospital settings. Having recently retired from her role as Divisional General manager (Family Care) for East Lancashire Hospitals NHS Trust. Ruth has extensive experience of commissioning new hospitals, service redesign and workforce development. She is a member of the Remuneration Committee, Outcomes and Quality Assurance Committee and the Finance and Performance Committee.

**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.
Members’ Report - Part 2

Dr Geoff Jolliffe – GP Member
Dr Jolliffe is part of Risedale Surgery in Barrow and has special interests in respiratory disease and palliative care. He is the Lead GP for Furness and chairs the Furness Locality Executive. He is currently Vice Chair of Cumbria CCG, leading on Health and Wellbeing, End of Life Commissioning and Carers.

Dr Jolliffe is currently Interim Clinical Chair.

Dr Rachel Preston – GP Member
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 David Rogers – Medical Director
Dr Rogers is the Medical Director for NHS Cumbria CCG and the Clinical Lead for Serious Untoward Incidents (SUIs). He Chairs the CCG SUI panel which has the responsibility of ensuring all serious incidents are fully investigated. He is a member of the Clinical Leads Group, Outcomes and Quality Assurance Committee and Chairs the IFR panel. Prior to that he was the Lead GP for Copeland and a GP at Fellview Healthcare.

Nigel Maguire – Chief Officer
Nigel has worked in the NHS in a range of nursing and managerial positions for over 30 years. Nigel was most recently the Chief Operating Officer/Nurse Executive for NHS Cumbria prior to taking up his current position. Nigel is a member of the Governing Body, Clinical Leads Group and Finance & Performance Committee.

Nigel is currently on long term sick leave.

Charles Welbourn – Chief Finance Officer
Charles was formerly the Director of Finance for NHS Cumbria Primary Care Trust before taking up his current position in April 2013. Charles is a member of the Clinical Leads Group and Finance & Performance Committee.
Locality Lead GPs

Dr Geoff Jolliffe
Dr Jolliffe is the Lead GP for Furness and chair of the Furness Locality Executive. Dr Jolliffe is part of Risedale Surgery in Barrow and has special interests in respiratory disease and palliative care.

Dr Alistair MacKenzie
Dr MacKenzie is the Lead GP for South Lakes and chairs the South Lakes Locality Executive. Dr MacKenzie is part of Kendal’s James Cochrane Practice.

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 and chair of the Eden Locality Executive. Dr Preston is a GP at the Lakes Medical Practice in Penrith.

Dr Juliet Rhodes
Dr Rhodes became the Lead GP for Copeland in August 2014, taking over from Dr Tom Ickes. She was previously a member of Copeland Locality Executive. Dr Rhodes is a GP at Fellview Healthcare Ltd, which has surgeries at Whitehaven, Cleator Moor, Egremont and Frizington. Dr Rhodes is chair of the Copeland Locality Executive.
Members’ Report - Part 2

Clinical Leads

Dr Amanda Boardman
Dr Boardman is the Clinical GP Lead (Children and Safeguarding) and her role is to support GPs to be effective in safeguarding vulnerable children. She provides GP clinical leadership in developing high quality children’s services.

Dr Jim Hacking
Dr Hacking is the Clinical Mental Health GP Lead. He is the CCG’s lead on shaping clinical pathways across primary, secondary and specialist care through the commissioning process.

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. Her role is to bring her paediatric and safeguarding expertise to Cumbria’s children’s strategy through commissioning arrangements by working closely with clinicians and multi-agency partnership to improve outcomes for children and young people.

Senior Management Team

Laura Carr
Laura is NHS Cumbria CCGs’ Lead Nurse for Quality and Safety and is the Clinical Director for Mental Health and Learning Disabilities. Laura is a member of the Clinical Leads Group and Outcomes and Quality Assurance Committee.

Anthony Gardner
Anthony is the lead director for Furness and South Lakes localities and the commissioning and performance lead for the CCGs activities with University Hospitals of Morecambe Bay NHS Foundation Trust. Anthony is a member of the Clinical Leads Group and the Furness and South Lakes Locality Executives.

Eleanor Hodgson
Eleanor worked for the North of England Commissioning Support Unit during 2013/14, before transferring to the CCG on April 1 2014 as the Director for Children and Families. Eleanor is a member of the Clinical Leads Group.

Caroline Rea
Caroline is the lead director for Allerdale, Carlisle, Copeland and Eden localities and Director of Primary Care for the CCG. Caroline is a member of the Clinical Leads Group, Outcomes and Quality Assurance Committee and the Allerdale, Carlisle, Copeland, and Eden Locality Executives.
Peter Rooney
Peter is the lead Director for the CCG’s strategic planning and performance management. Peter is a member of the Clinical Leads Group and the Finance and Performance Committee and attends the Governing Body.

Peter is currently Interim Chief Operating Officer.

The CCG’s staffing structure as of 31 March 2015 is available at:
www.cumbriaccg.nhs.uk/about-us/who-we-are/ccg-structure.aspx

2.3 Employee Consultation
The CCG is committed to regular communication with its staff to ensure that their views are heard and they are fully aware of the direction of travel of the CCG and the day to day challenges.

Staff development days take place on a quarterly basis to provide opportunities to update staff on key developments and share views.

The production of a regular e bulletin – The Wave, provides ongoing updates of plans and developments.

2.4 Employees with disabilities
The CCG has policies in place to ensure all employees and CCG applicants for employment are treated fairly and equally. As part of the NHS Jobs application process any applicants with disabilities are identified and given automatic consideration.

All members of staff undertake annual mandatory training, which includes awareness raising of legislation relating to equality and diversity.

2.5 Equality and Diversity
The CCG is committed to delivering equality of opportunity for all staff and the 528,000 registered patients and visitors across Cumbria.

The Equality Act 2012 came into force on 1 October 2010, replacing existing anti-discrimination laws with a single act. It aims to help public authorities avoid discriminatory practices and integrate equality into their core business by:

- eliminating discrimination, harassment and victimisation;
- advancing equality of opportunity between people who share a protected characteristic and those who do not; and to
- foster good relations between people who share a relevant protected characteristic and those who do not.

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 wellbeing of the local community
- Deliver services that improve patient experience.

The Equality Report for 2015 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.

The CCG is committed to making sure that equality and diversity is a priority when planning and commissioning local health care. Across Cumbria there are two major programmes, Better Care Together in the South and Together for a Healthier Future in the North, which are driving the implementation of The Five Year Plan to improve services for local people.
2.6 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 cannot 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.

2.7 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 (NECS), who the CCG commissions the HR service from. Where appropriate advice is sought from appropriate medical professionals through the Occupation Health service. All new starters are made aware of the relevant policies and procedures during their induction.

NHS Cumbria CCG’s full Absence Management Policy is available at www.cumbriaccg.nhs.uk

The annual absence rate as at 31 March 2015 for the CCG is 2.93% and the cost of sickness absence during the year amounts to £152,402. Further sickness data can be found in section 5.3 of the Annual Accounts.

2.8 Pension liabilities

Details of how the CCG manages pension liabilities can be found in note 5.6 of the Annual Accounts.

2.9 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 learnt to help avoid a similar incident occurring again.

Complaints are an essential source of information about the services commissioned and the CCG believe that all complaints provide us with 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:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement.

All healthcare providers must provide a complaint service within the requirements of the Complaint Regulations 2009 and any complaint made about NHS services is to be acknowledged within three working days and properly investigated.
Number of Complaints and Enquiries received by NHS Cumbria CCG
April 2014 to March 2015

Two of the twenty formal complaints were Joint Protocol Complaints. These are complaints that involve more than one NHS Organisation or an NHS Organisation and a Local Authority. One of these Joint Protocol Complaints related to ‘Continuing Health Care’ (CHC) and the other ‘Diagnosis Problems’.

Number of Formal Complaints received by NHS Cumbria CCG from April 2014 to March 2015 by Category
2.10 Freedom of Information

NHS Cumbria CCG takes it requirements under the Freedom of Information Act 2000 seriously as it endeavours to be an open and transparent organisation. It follows the Act’s guidelines and has a policy in place which aims to answer all requests within the legally binding 20 day period.

The number of Freedom of Information requests received from 1 April 2014 to 31 March 2015 was 244.

Full details are available at: www.cumbriaccg.nhs.uk/about-us/foi/index.aspx

2.11 Disclosure of Serious Untoward Incidents

The CCG commissions Serious Untoward Incidents (SUIs) and Strategic Executive Information Systems (StEIS) management processes from North of England Commissioning Support (NECS). These are operated from within the Quality & Safety Team and all processes are carried out in line with the latest NHS England Framework. There is an escalation process in place for more serious SUIs, for example, when there are immediate patient safety concerns.

Ongoing SUI cases and trends are monitored and reported through the Quality & Safety Team, Outcomes & Quality Assurance Committee, and Quality Surveillance/Review groups with the Area Team. Assurance is given to the Governing Body through the Outcomes & Quality Assurance Committee and the Quality & Safety report. In addition all completed SUI reports are reviewed by Cumbria Executive (Clinical Leads Group) and reports are presented to a Clinically Led panel who determines closure of the cases on the StEIS system. The outcomes from the panel are:

- Issues for service contracts
- Implications for future CQUIN (commissioning for quality and innovation) programme
- Issues to be considered in the hospital audit visiting programme
- Issues which need a further ’line of enquiry’
- Gathering intelligence on trends.

2.12 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 Cumbria CCG therefore NECS are responsible for Health and Safety/Fire and Security and the CCG as an employer are accountable.

The CCG has a Health and Safety Strategy in place which sets the vision for how the CCG will discharge its duties around Health and Safety and includes the approach and arrangements for the management of Health and Safety.

Health and Safety audits have been carried out in all the CCG office bases. The audit comprised of 149 questions split up into 25 sections covering a range of Health and Safety regulations.

The CCG is developing their incident reporting system via Safeguarding Incident Reporting Management System (SIRMS). This is an electronic system designed to capture all incidents across CCG directorates/estates. Robust governance arrangements are in development to ensure that incidents are reported correctly and in a timely manner.

There were no reported incidents for 2014/15 around Health and Safety/Fire and Security.
2.13 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.

2.14 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.

2.15 Audit Services

The external auditor appointed by the CCG is:

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
MANCHESTER
M3 3EB

Services commissioned for 2014/15 were: External audit services at a cost of £114,000.

2.16 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 Statement of Accountable Officer’s Responsibilities in Part 4.

2.17 Disclosure to Auditors

At the time this Members’ Report was approved each Director/Member confirmed the following:

So far as the Director/Member is aware, there is no relevant audit information of which the CCG’s external auditor is unaware; and,

The Director/Member has taken all the steps that they ought to have taken as a Director/Member in order to make themselves aware of any relevant audit information and to establish that the CCG’s auditor is aware of that information.
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, GPs 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 Terms of Reference of this Committee were reviewed in 2014/15 and the Membership increased to include the Lay Clinical Members of the Governing Body. 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 2014/15:

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Members</th>
<th>Attendance</th>
<th>Nature of advice or services</th>
</tr>
</thead>
</table>
| 24 June 2014       | Peter Scott  
                   Jon Rush  
                   Ruth Gildert  
                   Anthony Woodyer | Hugh Reeve        | Present agenda item         |
| 18 July 2014       | Peter Scott  
                   Jon Rush  
                   Ruth Gildert  
                   Anthony Woodyer | Janine Lutz       | HR advice & support         |
| 25 February 2015   | Peter Scott  
                   Jon Rush  
                   Ruth Gildert  
                   Anthony Woodyer | Hugh Reeve  
                                               Janine Lutz & Jenna McGuinness (via telephone) | Present agenda item  
                                                                               HR advice & support |
3.1 Policy on Remuneration of Senior Managers

During 2014/15 the Remuneration Committee have reviewed the process that they undertook and remain committed when making recommendations on remuneration that any decisions need to be fair, justifiable, based on evidence and recognising the size and complexity of the CCG.

It also remains committed to the principles it adopted to ensure that the CCG was 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 Nation Level), all whilst recognising the restraint on the public purse.

The Committee has taken 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

Senior Managers Performance Related Pay

The Remuneration Committee has not given consideration during 2014/15 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, in conjunction with NHS England, sought, and was granted, approval for the following interim senior management arrangements until May 2015 (at which time it will be reviewed):

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

Working within the principles specified above the remuneration for these interim arrangements were considered by the Remuneration Committee in February 2015 and interim salaries set based on the specific interim arrangements (i.e. without setting a precedent for any future structure which may be determined).

Policy on Senior Managers Contracts

Very Senior Manager (VSM) contracts of employment apply to the Chief Officer, Chief Finance Officer and the Interim Chief Operating Offer (from 9 February 2015 to 31 May 2015). 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 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></td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>1 April 2013</td>
<td>31 March 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Anthony Woodyer</td>
<td>1 April 2013</td>
<td>31 March 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peter Scott</td>
<td>1 April 2013</td>
<td>31 March 2016</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Les Hanley</td>
<td>1 April 2013</td>
<td>31 March 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jon Rush</td>
<td>1 April 2013</td>
<td>31 March 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Geoff Jolliffe</td>
<td>1 April 2013</td>
<td>30 September 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. David Rogers</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 2017</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>Not applicable</td>
</tr>
<tr>
<td>Dr Rachel Preston</td>
<td>1 April 2013</td>
<td>31 May 2016</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>Dr Alistair Mackenzie</td>
<td>1 April 2013</td>
<td>31 July 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Tom Ickes (Interim) (left GP Lead role 31 July 14)</td>
<td>1 February 2014</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juliet Rhodes</td>
<td>1 October 2014</td>
<td>31 September 2018</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigel Maguire</td>
<td>1 April 2013</td>
<td>6 months’ notice</td>
<td>Redundancy payment if applicable</td>
<td></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></td>
<td></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 2013</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 2014/15.
Salaries and Allowances

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>Note</th>
<th>Governing Body Members</th>
<th>Other Senior Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigel Maguire</td>
<td>Chief Officer</td>
<td></td>
<td>135-140</td>
<td>80-85</td>
</tr>
<tr>
<td>Charles Weibourn</td>
<td>Chief Finance Officer</td>
<td>110-115</td>
<td>79</td>
<td>17.5-20</td>
</tr>
<tr>
<td>Dr David Rogers</td>
<td>Medical Director</td>
<td>2</td>
<td>170-175</td>
<td>15</td>
</tr>
<tr>
<td>Dr Hugh Reeve</td>
<td>Chair</td>
<td>1</td>
<td>115-120</td>
<td>-</td>
</tr>
<tr>
<td>Ruth Gilert</td>
<td>Clinical Member: Nurse</td>
<td>10</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>Dr Anthony Woodyer</td>
<td>Clinical Member: Secondary Care Clinician</td>
<td>10</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member: Health Improvement</td>
<td>10</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>Peter Scott</td>
<td>Lay Member: Finance &amp; Governance</td>
<td>10</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>Dr Geoff Jolliffe</td>
<td>Lead GP (South) / GP Lead: Furness</td>
<td>1</td>
<td>75-80</td>
<td>7.5-10</td>
</tr>
<tr>
<td>Rachel Preston</td>
<td>Lead GP (North) / GP Lead: Eden</td>
<td>2</td>
<td>70-75</td>
<td>12.5-15</td>
</tr>
</tbody>
</table>

### Governing Body Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Note</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigel Maguire</td>
<td>Chief Officer</td>
<td></td>
<td>Salary</td>
<td>Expense payments (taxable) (Note 7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(£000)</td>
<td>(£000)</td>
</tr>
<tr>
<td>Charles Weibourn</td>
<td>Chief Finance Officer</td>
<td></td>
<td>135-140</td>
<td>160-165</td>
</tr>
<tr>
<td>Dr David Rogers</td>
<td>Medical Director</td>
<td></td>
<td>110-115</td>
<td>125-130</td>
</tr>
<tr>
<td>Dr Hugh Reeve</td>
<td>Chair</td>
<td></td>
<td>115-120</td>
<td>115-120</td>
</tr>
<tr>
<td>Ruth Gilert</td>
<td>Clinical Member: Nurse</td>
<td></td>
<td>15-20</td>
<td>15-20</td>
</tr>
<tr>
<td>Dr Anthony Woodyer</td>
<td>Clinical Member: Secondary Care Clinician</td>
<td></td>
<td>15-20</td>
<td>15-20</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member: Health Improvement</td>
<td></td>
<td>15-20</td>
<td>15-20</td>
</tr>
<tr>
<td>Peter Scott</td>
<td>Lay Member: Finance &amp; Governance</td>
<td></td>
<td>15-20</td>
<td>15-20</td>
</tr>
<tr>
<td>Dr Geoff Jolliffe</td>
<td>Lead GP (South) / GP Lead: Furness</td>
<td></td>
<td>75-80</td>
<td>85-90</td>
</tr>
<tr>
<td>Rachel Preston</td>
<td>Lead GP (North) / GP Lead: Eden</td>
<td></td>
<td>70-75</td>
<td>85-90</td>
</tr>
</tbody>
</table>

### Other Senior Managers

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Note</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peter Rooney</td>
<td>Director of Strategic Planning &amp; Performance</td>
<td></td>
<td>80-85</td>
<td>105-110</td>
</tr>
<tr>
<td>Anthony Gardner</td>
<td>Network Director</td>
<td>100-105</td>
<td>17.5-20</td>
<td>125-130</td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>Network Director</td>
<td>100-105</td>
<td>10-12.5</td>
<td>115-120</td>
</tr>
<tr>
<td>Laura Carr</td>
<td>Lead Nurse (Quality &amp; Safety) / Clinical Director for Mental Health</td>
<td>80-85</td>
<td>220-222.5</td>
<td>305-310</td>
</tr>
<tr>
<td>Diane Eden</td>
<td>Programme Director: Long Term Conditions &amp; Primary Care</td>
<td>4</td>
<td>-</td>
<td>35-40</td>
</tr>
<tr>
<td>Eleanor Hodgson</td>
<td>Director for Children and Families</td>
<td>95-100</td>
<td>67.5-70</td>
<td>165-170</td>
</tr>
<tr>
<td>Juliet Rhodes</td>
<td>GP Lead: Copeland</td>
<td>15-20</td>
<td>67.5-70</td>
<td>80-85</td>
</tr>
<tr>
<td>Dr Tom Ikes</td>
<td>GP Lead: Copeland</td>
<td>15-20</td>
<td>15-20</td>
<td>5-10</td>
</tr>
<tr>
<td>Dr Niall McGreave</td>
<td>GP Lead: Allerdale</td>
<td>75-80</td>
<td>42.5-45</td>
<td>115-120</td>
</tr>
<tr>
<td>Fayzaaz Chaudhri</td>
<td>GP Lead: Allerdale</td>
<td>6</td>
<td>-</td>
<td>30-35</td>
</tr>
<tr>
<td>Dr Colin Patterson</td>
<td>GP Lead: Carlisle</td>
<td>60-65</td>
<td>0</td>
<td>60-65</td>
</tr>
<tr>
<td>Dr Alastair Mackenzie</td>
<td>GP Lead: South Lakes</td>
<td>45-50</td>
<td>45-50</td>
<td>190-192.5</td>
</tr>
</tbody>
</table>

### Note:

1. To cover the long-term sickness absence of Nigel Maguire, Hugh Reeve was appointed interim Accountable Officer, acting as interim Chief Clinical Officer, as of 9th February 2015 and Geoff Jolliffe became interim Clinical Chair as of 23rd February 2015 with Peter Rooney supporting both interim clinical roles as interim Chief Operating Officer with effect 9th February 2015.
2. Juliet Rhodes was appointed Lead GP (North) representative of the Governing Body wef 1st February 2014. David Rogers was Lead GP North representative of the Governing Body until he was appointed Medical Director wef 1st February 2014; the position of Medical Director achieved Governing Body status at the Full Council of Members meeting 19th June 2014.
3. Tom Ikes took over the GP-Lead role for Copeland Locality wef 1st February 2014 through to 31 July 2014. Juliet Rhodes was appointed as of 1st October 2014.
4. Diane Eden left 28th September 2013 and following a managerial review the post was removed from the management structure.
5. Eleanor Hodgson transferred from the North of England Commissioning Support Unit on 1st April 2014.
6. Fayzaaz Chaudhri stepped down wef 30th September 2013 and Niall McGreave took over as acting GP-Lead for Allerdale Locality with his role being made permanent 1st October 2013. Service Level Agreement payments 15-20 (£’000) were made to Maryport Group Practice for Fayzaaz for April to June 2014 and then he was paid via payroll. Niall McGreave was paid via payroll from 1st April 2014; Service Level Agreement payments (15-20 £’000) were made to a senior manager of the CCG in the current year.

The content of this Table will be audited by our external auditor.

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.
## Pension Benefits

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Note</th>
<th>Real increase in pension at age 60</th>
<th>Real increase/ (decrease) in pension lump sum at age 60</th>
<th>Total accrued pension at age 60 at 31 March 2015</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2015</th>
<th>Cash Equivalent Transfer Value at 1 April 2014</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
<th>Cash Equivalent Transfer Value at 31 March 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laura Carr</td>
<td>Lead Nurse/Clinical Director for Mental Health</td>
<td>1</td>
<td>7.5-10</td>
<td>27.5-30</td>
<td>35-40</td>
<td>115-120</td>
<td>559</td>
<td>198</td>
<td>773</td>
</tr>
<tr>
<td>Anthony Gardner</td>
<td>Network Director: Furness &amp; South Lakes</td>
<td>0-2.5</td>
<td>-</td>
<td>-</td>
<td>10-15</td>
<td>-</td>
<td>117</td>
<td>19</td>
<td>139</td>
</tr>
<tr>
<td>Eleanor Hodgson</td>
<td>Director for Children and Families</td>
<td>2.5-5</td>
<td>7.5-10</td>
<td>35-40</td>
<td>110-115</td>
<td>708</td>
<td>75</td>
<td>803</td>
<td></td>
</tr>
<tr>
<td>Tom Ickes</td>
<td>GP Lead: Copeland</td>
<td>0</td>
<td>0</td>
<td>0-5</td>
<td>10-15</td>
<td>56</td>
<td>0</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Geoff Jolliffe</td>
<td>GP Lead (South)/ GP Lead Furness</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>25-30</td>
<td>75-80</td>
<td>525</td>
<td>22</td>
<td>561</td>
<td></td>
</tr>
<tr>
<td>Niall McGreevey</td>
<td>GP Lead: Allerdale</td>
<td>0-2.5</td>
<td>5-7.5</td>
<td>5-10</td>
<td>20-25</td>
<td>103</td>
<td>47</td>
<td>153</td>
<td></td>
</tr>
<tr>
<td>Nigel Maguire</td>
<td>Chief Officer</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>55-60</td>
<td>175-180</td>
<td>1027</td>
<td>32</td>
<td>1,087</td>
<td></td>
</tr>
<tr>
<td>Colin Patterson</td>
<td>GP Lead: Carlisle</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>5-10</td>
<td>25-30</td>
<td>147</td>
<td>9</td>
<td>160</td>
<td></td>
</tr>
<tr>
<td>Rachel Preston</td>
<td>Lead GP (North) / GP Lead: Eden</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>10-15</td>
<td>35-40</td>
<td>173</td>
<td>89</td>
<td>267</td>
<td></td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>Network Director: Allerdale &amp; Copeland</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>35-40</td>
<td>115-120</td>
<td>744</td>
<td>22</td>
<td>786</td>
<td></td>
</tr>
<tr>
<td>Juliet Rhodes</td>
<td>GP Lead: Copeland</td>
<td>10-12.5</td>
<td>7.5-10</td>
<td>10-15</td>
<td>40-45</td>
<td>0</td>
<td>28</td>
<td>240</td>
<td></td>
</tr>
<tr>
<td>David Rogers</td>
<td>Medical Director</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>20-25</td>
<td>65-70</td>
<td>404</td>
<td>23</td>
<td>437</td>
<td></td>
</tr>
<tr>
<td>Peter Rooney</td>
<td>Director of Strategic Planning &amp; Performance</td>
<td>0-2.5</td>
<td>2.5-5</td>
<td>10-15</td>
<td>40-45</td>
<td>172</td>
<td>17</td>
<td>194</td>
<td></td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>30-35</td>
<td>90-95</td>
<td>513</td>
<td>20</td>
<td>547</td>
<td></td>
</tr>
</tbody>
</table>

Note: 1. Anthony Gardner is a member of the NHS 2008 scheme, which carries no automatic right to a pension lump sum. Pension information provided excludes general practitioner pension contributions.

The content of this Table will be audited by our external auditor.

As Lay Members do not receive pensionable remuneration, there will be no entries in respect of pensions for Lay Members.

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

Pay Multiples Disclosure
The CCG is required to disclose the relationship between the remuneration of the highest paid director within the organisation and the median remuneration of the CCGs workforce.

The banded remuneration of the highest paid member of the Governing Body in the CCG in the financial year 2014/15 was £142.5k (2013/14, £142.5k). This was 3.5 times (2013/14, 3.5 times) the median remuneration of the workforce, which was £41k (2013/14, £41k).

In 2014/15 two (2013/14, one employee) employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration packages ranged from £16k to £198k (2013/14, £16k to £180k).

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 2015, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of existing arrangements as of 31 March 2015</td>
<td>23</td>
</tr>
<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>21</td>
</tr>
<tr>
<td>for between two and three years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>for between three and four years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>for four or more years at the time of reporting</td>
<td>0</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 2014 and 31 March 2015, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of existing arrangements as of 31 March 2015</td>
<td>2</td>
</tr>
<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 2014 and 31 March 2015</td>
<td>0</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>0</td>
</tr>
<tr>
<td>engagements terminated as a result of assurance not being received</td>
<td>0</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>

### 3.2 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.

Part 4
Statement of Accountable Officer’s Responsibilities
4 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.

Dr Hugh Reeve
Interim Accountable Officer

21 May 2015
Annual Governance Statement by the Accountable Officer
**Introduction & Context**

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 2014, 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 NHS Cumbria 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 is 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 2014/15, especially in relation to the Lay/Clinical Members who constructively challenge and help develop proposals on strategies, ensuring conflicts of interests are managed along with the everyday working practices of the CCG.

**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 2014/15 development sessions for the Governing Body have been maintained to ensure that there is sufficient knowledge within the decision making body to enable them to discharge their responsibilities effectively. However, the CCG acknowledges that during 2015/16 there will be a requirement to develop a formal, rigorous and transparent procedure for the appointment of the Lay/Clinical Members due to be undertaken in March 2016.

**Accountability** - The Governing Body receives regular updates to enable them to have an understandable assessment of the CCG’s position and prospects. In addition the CCG’s risk assurance framework has continued to be developed 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 Managers (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** - The CCG works closely with its stakeholders to ensure that they have a mutual understanding of its objectives. This is key to improving the Cumbrian Health economy whilst working within the current financial constraints across the system.

**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 2014/15 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 the 2013/14 Annual Governance Statement the CCG stated that it had reviewed its Governance arrangements and was in the process of amending its Constitution, Standing Orders, Reservation and Delegation of Powers and Prime Financial Regulations to reflect those changes. These were approved by the Full Council of Members on 19 June 2014 and ratified by NHS England in March 2015.

The CCG remains accountable to its 82 Member Practices who 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. 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.

The Full Council of Members

The Full Council of Members has specific responsibilities for:

- Approving the CCG’s Constitution
- The arrangements for members joining and leaving the CCG
- The arrangements for the appointment of the Clinical Chair and Chief Officer
- Ensuring publication of the Annual Report and Statement of Accounts by the Governing Body

The membership comprises of a representative from each of the 82 GP practices which cover the whole of Cumbria together with Bentham in North Yorkshire. Each practice has close working links with one of the six Localities and a representative from each practice attends the Locality Executive meetings.

During 2014/15 the Full Council of Members met to approve the changes to the CCG’s governance arrangements prior to submission to NHS England (for approval) in January 2015. It also considered proposals by NHS England for the joint commissioning of GP primary care services.

An additional meeting was called in December of 2014. However this meeting was not quorate and therefore was used as a discussion forum on how the CCG should develop a primary care strategy to enable it to consider whether, during the course of 2015/16, the CCG should undertake the commissioning of GP primary care from NHS England.

<table>
<thead>
<tr>
<th>Attendance at the Full Council of Members 2014/15:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Membership</strong></td>
</tr>
<tr>
<td>82</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 (both Adults & Children’s) 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 of employment for the Clinical Chair, Clinical Deputy Chair, GP’s with a CCG role, Chief Officer, Chief Finance Officer Medical Director and other VSM officer.

As part of the revision of the Constitution and other key governance documents in 2014 the Governing Body membership was reviewed and now consists of:

I. The Clinical Chair of the CCG (appointed through election by the elected GP’s)
II. Six non-officer members (appointed by the Chair of the CCG) including:
   - Four Lay Members (Finance & Governance Lead; Patient Engagement Lead; Health Improvement Lead and Third Sector Organisation Lead - yet to be appointed)
   - 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 (one to represent South Lakes and Furness [South of the County] one to represent Allerdale, Copeland, Carlisle and Eden [North of the County])
   - the Chief Finance Officer
   - the Medical Director.

Both the Local Medical Committee (LMC) and Healthwatch Cumbria have full observer status on the Governing Body.

2014/15 has 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. As appropriate this report also details progress on contract negotiations

• The joint development of a Mental Health Strategy with partner organisations

• 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

• Dr Bill Kirkup Report into the Morecambe Bay Investigation

• Royal College of Obstetricians & Gynaecologists Report Maternity Review November 2014 (jointly commissioned with NHS Lancashire North CCG)

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

• Together for a Healthier Future - developing facilities to improve access to services in the North of the County

• Procurement of the 111 service

• 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

• Vanguard applications.

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

• Out of Care Model and Primary Care Communities in Cumbria

• NHS England Five Year Forward View

• CCG Work programme & delivery of said programme

• Primary Care Commissioning

• Local Government Association report on the Health & Wellbeing Board.

<table>
<thead>
<tr>
<th>Attendance at the Governing Body 2014/15:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Membership</strong></td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>11</td>
</tr>
</tbody>
</table>
Committees of the Governing Body
Clinical Leads Group

Previously known as the NHS Cumbria Executive Committee, 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 re-design 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:

- Managing the continuing care budget and other County-wide risk budgets on behalf of the Localities
- Responding to decisions on Specialised Commissioning made by the 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 2014/15 include:

- Quality, Performance & Finance issues
- Learning Disabilities services
- Out of Hospital care initiatives/schemes to change patient flows
- Co-commissioning of Primary Care Services
- General Practice Development
- Care Quality Commission (CQC) Risk Summits regarding University Hospitals of Morecambe Bay Foundation Trust (UHMBT) & North Cumbria University Hospitals NHS Trust (NCUHT)
- Procurement of 111 services
- Mental Health Review
- Dr Bill Kirkup Report into the Morecambe Bay Investigation
- Royal College of Obstetricians & Gynaecologists Report Maternity Review November 2014 (jointly commissioned with NHS Lancashire North CCG).
Locality Executives

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.

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.

As part of the Governance review undertaken during 2013/14 the Localities reviewed their Terms of Reference and the membership of each Locality is now as follows:

### 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 Locality Executive Meetings 2014/15:

<table>
<thead>
<tr>
<th></th>
<th>Allerdale</th>
<th>Carlisle</th>
<th>Copeland</th>
<th>Eden</th>
<th>Furness</th>
<th>South Lakes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>9</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Total number of meetings held</td>
<td>11</td>
<td>11</td>
<td>12</td>
<td>11</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>% attendance</td>
<td>77</td>
<td>72</td>
<td>86</td>
<td>72</td>
<td>64</td>
<td>63</td>
</tr>
</tbody>
</table>

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.
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).

Items considered during 2014/15 include:

- Final accounts & Annual Report 2013/14
- Board Assurance Framework & Risk Register
- Internal & External Audit report
- Counter Fraud Issues
- Suspension of Standing Orders
- Losses & Special Payments
- Three Year Strategic Internal Audit Plans.

<table>
<thead>
<tr>
<th>Attendance at the Audit Committee 2014/15:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>
Remuneration Committee

The Remuneration Committee considers and makes recommendations to the Governing Body on the determination of salaries and conditions of service for the Clinical Chair, Deputy Clinical Chair, Medical Director, GP’s with a CCG role, Chief Officer and other Very Senior Managers. The Committee’s responsibilities include:

- 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 Terms of Reference of this Committee were reviewed and the Membership increased to include the new Lay Member for Third Sector Organisations and the Clinical Members of the Governing Body. The Membership now consists of:

- Lay Member for Finance & Governance (Chair)
- Lay Member for Public & Patient Engagement
- Lay Member for Health Improvement
- Lay Member for Third Sector Organisation (yet to be appointed)
- Registered Nurse
- Secondary Care Specialist 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 2014/15 has included the following: review of the complexity allowance for the Chief Officer and Chief Finance Officer’s remuneration for the Clinical Director for Cumbria Learning and Improvement Collaborative, Interim Clinical Chair and Interim Chief Operating Officer; and a general pay rise consideration for all VSM posts.

<table>
<thead>
<tr>
<th>Attendance at the Remuneration Committee:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Membership</strong></td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</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.

The Membership has been reviewed and now consists of:

- Lay Member for Health Improvement (Chair)
- Lay Member for Public & Patient Engagement
- Registered Nurse
- Secondary Care Specialist Doctor
- Medical Director
- Network Directors (North & South)
- Lead Nurse (Quality & Safety)
- Clinical Quality Safety Manager
- Primary Care Development Lead and Medicines Lead
- Head of Integrated Intelligence
- 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:

- Updates on Nursing Homes, Safeguarding (Adults & Children) and the Mental Health Strategy
- Approval of Clinical Policies.

Please note: Under the current Terms of Reference the Membership of this Committee includes Officers who need only attend when presenting reports - hence the percentage attendance appearing low. Terms of Reference are currently being reviewed.

### Attendance at the Outcomes & Quality Assurance Committee:

<table>
<thead>
<tr>
<th>Total Membership</th>
<th>Total of Number of Meetings Held</th>
<th>% Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>8</td>
<td>56</td>
</tr>
</tbody>
</table>
Finance & Performance Committee

During 2014/15 the CCG recognised the need to establish a Committee to provide leadership in:

- making recommendations to the Governing Body for the deployment of resources and budgets; and
- ensuring the CCG is fulfilling its responsibilities in improving the performance of the health care system against standards, and in managing its contract activity effectively.

During 2013/14 an Interim Finance Committee was created pending the review of the CCG governance arrangements and during 2014/15 the Finance & Performance Committee was created to undertake the following 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:
  I. Strategic and Annual Operating Plans in accordance with NHS England’s requirements
  II. Financial Plan (i.e. the Annual Budget, including cost improvement plans)
  III. 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.

The Membership consists of:
- Clinical Chair
- Chief Officer
- Chief Finance Officer
- Director of Planning and Performance
- Lay Member for Public & Patient Engagement
- Lay Member for Finance & Governance
- Lay Member for Health Improvement
- Lay Member for Third Sector Organisations (yet to be appointed)
- Registered Nurse
- Secondary Care Specialist Doctor.

Items considered during 2014/15:
- Approval of Corporate Strategies/Polices/Plans
- Finance Report
- Cost Improvement Plans
- Performance Report
- Performance Management Processes - Cancer
- Management Structures
- Better Care Fund
- Locality/Network Investments
- NHS 111 Procurement
- Patient Experience System - I Want Great Care
- North West Ambulance Service (NWAS) contracting Issues.

<table>
<thead>
<tr>
<th>Attendance at the Finance &amp; Performance Committee 2014/15:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
</tr>
<tr>
<td>9</td>
</tr>
</tbody>
</table>
Better Care Fund – Section 75 Agreement

Under Section 75 of the National Health Service Act 2006 and Part 1 of the Local Government Act 2000, organisations wanting to work in partnership to commission services with pooled funding arrangements, need to ensure that appropriate governance arrangements are in place. To achieve this aim the CCG and Cumbria County Council have established a partnership agreement relating to the commissioning of integrated Health and Social Care Services (Better Care Fund). This agreement reflects the overall nature of the partnership and details the responsibilities of each partner in terms of managing the fund and associated risks.

Interim 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

During this interim period the Interim Chief Clinical Officer will attend the required committees as the Accountable Officer.

The key relationships between the constitutional committees is 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. As appropriate the Constitution, Standing Orders, Scheme of Delegation and Prime Financial Regulations are updated in line with the requirements of NHS England. In March 2015 NHS England approved Version 7 of these documents which have now been published and are available on the CCG website via the following link:

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

At its development session on 6 May 2015 the Governing Body reviewed the work it had undertaken throughout 2014/15. Within this process Members also considered the assurance provided by:

- its Committees;
- work undertaken at its development sessions;
- and regular Internal Audit Reports

Overall Members felt that the Governing Body had been assured that the CCG had 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, the work undertaken to further strengthen and improve the governance arrangements was acknowledged, especially in relation to the Risk Assurance Framework and Information Governance (the developments/improvements made in these areas have been detailed in the next section of this statement).

However the Governing Body also recognised the need to ensure that within its work programme for 2015/16 mechanisms were developed to enable the Governing Body to monitor how effective the CCG has been at improving the services it commissions for people of Cumbria.

The Clinical Commissioning Group Risk Management 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. These include 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 2014/15 the CCG has reviewed and updated its Risk Management Framework to support the operations of the CCG (as approved by the Governing Body in December 2015). This has included providing CCG staff with training on the approach to risk management and the development of a CCG-wide risk register which is maintained electronically in the Safeguard Incident Risk Management System (SIRMS). All six Localities, along with the Children’s and Mental Health/Learning Disabilities team have established individual risk registers that have been consolidated on to the system.

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 have met and recognised that there are a number of risks that cut across more than one Locality (e.g. recruitment in primary care) and further work will be undertaken 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.
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.

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:
The Clinical Commissioning Group Internal Control Framework

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

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

The following control mechanisms are in place:
- Constitution
- Risk management
- Counter Fraud annual plan
- Internal Audit annual plan
- External Audit annual plan
- Performance monitoring of CCG providers
- Review of the CCG’s performance
- IG toolkit submissions
- Incident and serious incident reporting
- Quality and financial reporting
- Contract /quality performance monitoring arrangements with providers
- Policies and procedures
- Risk assessments
- Governance reporting between the Governing Body and its committees/sub committees
- Safeguarding (Adults & Children’s) annual reports.

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. Some of the key achievements this financial year include:

- Reviewed and approved the Information Governance Management Policy & Strategy (Finance & Performance Committee, February 2015)
- Awarded a contract for the provision of Information Governance Services to Cumbria partnership NHS Foundation Trust (CPFT)
- Increased the CCG’s IG Toolkit compliance from 69% (2013/14) to 86% based on version 12 of the toolkit
- Increased the overall assurance level on the CCG’s Information Governance processes to “Significant Assurance”. This was by Audit North, the CCG’s Internal Auditors
- Over 95% of its workforce was trained on the information governance requirements in 2014/15
- Information asset owners and administrators attended training presented by COFT, The National Archives Office and Ward Hadaway Solicitors in February 2015
- Implemented new Registration Authority Service within primary care (GPs, Pharmacists) – 98% satisfaction results and increased to level 3 compliance on IG Toolkit.

The Finance & Performance Committee will be responsible for reviewing every IG incident. Further work will be undertaken during 2015/16 to review the mechanism for IG incident reporting. However during 2014/15 there have been no incidents classified as Level 2 in the IG Incident reporting tool and hence the CCG has had a nil response.
The graph below denotes the achievements identified:

**Concluding Report Completion Status**

**Current Status of Concluding Reports**

By Domain

**Of those completed - performance against target**

**Behind Target (Achieved level 2):**

CCG 234, 235, 347, 349, 420

**Exceeding Target (Achieved level 3):**

CCG 182, 237

**Level 3 Achievement**

% Improvement from previous year

CCG 650%

**Completion Status**

CCG 100% Excluding not relevant & Exempt
Risk Assessment in Relation to Governance, Risk Management & Internal Control

Throughout 2014/15 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 valid today. These include:

- University Hospital of Morecambe Bay NHS Foundation Trust (UHMBT) 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 2014/15 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 out-of-hospital models through projects like ‘Better Care Together’ and ‘Together for a Healthier Future’.
A summary of the major risks identified, during 2014/15 in the CCG’s Assurance Framework are set out below:

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Existing Controls</th>
<th>Further Actions to Mitigate</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CCG is not delivering key NHS constitution targets</td>
<td>• Monthly review of all performance targets across providers</td>
<td>• Action plans agreed with all providers</td>
</tr>
<tr>
<td></td>
<td>• Providers monitored by regulators on achievements of targets</td>
<td>• On-going review of action plans with agreed compliance dates</td>
</tr>
<tr>
<td>Maternity services cannot be provided in a way that is accessible, safe and sustainable for patients across Cumbria</td>
<td>• On-going discussions with providers regarding mitigation of risks to existing service model</td>
<td>• The CCG has jointly commissioned (with NHS Lancashire North CCG) a Maternity Review by the Royal College of Obstetricians &amp; Gynaecologists to identify innovative models to sustain local services (report to Governing Body 1 April 2015)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• CCG’s are working with networks to engage clinical staff in solution focussed event</td>
</tr>
<tr>
<td>Cumbria Partnership Foundation Trust (CPFT) are not able to provide Child &amp; Adolescent Mental Health Services (CAMHS) of an appropriate quality</td>
<td>• The CCG commissioned an external review of CAHMS services</td>
<td>• Work with partners to develop &amp; implement a comprehensive framework for emotional health &amp; wellbeing in Cumbria</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Work with partners to reduce hospital admissions for deliberate self-harm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Continue transformation of Tier 3 CAMHS to improve quality of service &amp; improve access to Tier 4 CAMHS</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 established with Cumbria County Council (CCC) and providers</td>
<td>• Agree standardised structured approach with Adult Social Care to systematically and consistently review quality issues in the sector and provide formal reporting mechanisms</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 Finance & Performance Committee and reported to the Governing Body to ensure that risks are understood and managed by the Governing Body.

In addition to the above, Lay/Clinical Members of the Governing Body received a detailed briefing in March 2015 on the evolving processes for the production and monitoring of the CCG’s assurance framework.

The CCG reports monthly to NHSE on performance and finance issues which is completely aligned to, and consistent with, the CCG’s internal reporting processes. In addition, the CCG meets quarterly with NHSE to provide assurance on all aspects of the CCG’s performance, including providing details of actions being taken to mitigate any identified risks.

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Existing Controls</th>
<th>Further Actions to Mitigate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services for adults with mental health problems do not meet the needs of patients</td>
<td>• On-going contract and quality review process</td>
<td>• Mental Health strategy for Cumbria under production</td>
</tr>
<tr>
<td>The cost of services commissioned exceed the budgeted level of resources</td>
<td>• On-going system of budgetary control</td>
<td>• Cost improvement plan under development for 2015/16</td>
</tr>
<tr>
<td>CPFT is unable to continue to provide clinically and financially sustainable services that are accessible to the population of Cumbria</td>
<td>• CPFT is forecasting an operating deficit in 2015/16 but significantly less than NCUHT &amp; UHMBT</td>
<td>• Agreed specific service reviews in 2015/16 \  • CPFT included in system-wide case for change</td>
</tr>
<tr>
<td>The workforce arrangements in general practice may be destabilised owing to on-going recruitment issues and the age profile of the workforce. Although the CCG does not commission these services directly this issue clearly has an impact on the services that are commissioned by the CCG</td>
<td>• CCG team meets NHSE on a monthly basis to provide information on risks to general practice in Cumbria</td>
<td>• Primary Care Strategy under development in conjunction with the Full Council of Members</td>
</tr>
<tr>
<td>The sustainability of the local neurology service in the long-term with gaps identified in current service</td>
<td>• Contracting process with CPFT</td>
<td>• Stabilisation position agreed for 2015/16 contract with commitment of both CCG &amp; CPFT to review long-term service requirements</td>
</tr>
</tbody>
</table>
Review of Economy, Efficiency & Effectiveness of the Use of Resources

Maintaining adequate and effective financial control and ensuring strong financial management, as well as achieving financial targets, have continued to be high risk throughout 2014/15. This has been impacted by the continued financial pressures in all three of the Cumbria NHS Trusts. The CCG is continually monitoring its use of resources to ensure that it operates economically, efficiently and effectively. This has included reviewing the requirement for all posts as they become vacant and the development of a Cost Improvement Plan.

The Cost Improvement Plan has been developed to ensure that, where possible, effective savings are made whilst continuing to commission safe, effective services for the people of Cumbria. This plan has been considered in detail at all levels including the Director Group, Clinical Leads Group, Finance & Performance Committee and the Governing Body.

In 2014/15 the internal audit function transferred from the CPFT to Audit North and a review of the internal audit work plan was undertaken and agreed by the Audit Committee. Audit North has undertaken a number of reviews of internal functions, including a review of the CCG’s Assurance Framework. As part of the above plan, Audit North has carried out a piece of work which has included a review on the construction and use of the Risk Management Framework document. This was in order to assess the effectiveness of its use in helping to drive the Governing Body agenda in respect of identifying and managing risk.

These findings acknowledge that the Risk Management Framework is presented to the Governing Body. However Audit North has suggested that the CCG may wish to formally consider how it collectively views risk reporting.

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 including the delivery of Quality Innovation Productivity Prevention (QIPP) schemes.

The Governing Body also receives a finance report at each meeting.

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 and the associated risk. During 2014/15 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 and update their personal development plans to support the delivery of those objectives. Staff also continue to undertake relevant training on key operation risk related issues including risk management, information governance, safeguarding, standards of business conduct (e.g. bribery & fraud) and health & safety.

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 the North of England Commissioning Services (NECS) supports the risk management framework to ensure that staff receive advice and training on risk management. Throughout 2014/15 the CCG has actively continued to embed the risk management framework into the day to day running of the CCG by informing staff through staff events. In addition
training has been provided to Risk Managers, Risk Champions & Risk administrators on the use of the relevant systems and processes for identifying risk.

**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 2014/15 with the continued challenges facing the provision of health care services in Cumbria.

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 2014/15. 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:

- Review of the Assurance Framework by the various CCG committees and Governing Body (as detailed in the Risk Management Framework section of this statement)
- Regular meetings with the Area Team (Quality Surveillance Groups/Quarterly checkpoints)
- Attendance at the main providers of acute, community and mental health services quality committees/meetings
- Continuing to be licensed without conditions.

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

“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 opinion and, together with the opinion, should be read in its entirety.
The design and operation of the Assurance Framework and associated processes

During 2014/15 we have provided significant challenge and support to the CCG regarding the assurance framework in terms of the format and content, including discussions at Audit Committee meetings. We have also provided horizon scanning support and prompted the CCG to undertake assurance mapping to source providers to enable the CCG to effectively manage the process. The assurance framework has existed throughout the year and although it may require some development it is generally ‘fit for purpose’. Risk management processes have been in place throughout the year and detailed discussions have been held at Audit Committee meetings.

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

We were formally appointed as the CCG’s internal auditors from 1 August 2014, and prior to this date the internal audit service was provided by Cumbria Internal Audit Service. One of the first exercises we completed was a review of the CCG’s internal audit plan, and compared it to the assurance framework and risk register. We presented a revised internal audit plan that aligned to the CCG’s corporate documents and assurance needs which was approved by the Audit Committee in December 2014.

Following a request from the Chief Finance Officer in February 2015 to identify the audit work that would be completed by 30 April 2015, we revised the internal audit plan to reflect work that had already been completed prior to 1 August 2014 and work that we had already undertaken, and a revised plan was agreed to reflect audit work that would be completed in line with the CFO’s request.

We have undertaken our work in accordance with the Internal Audit annual plans as mentioned above. Throughout the year we have reported our findings to the Chief Finance Officer and Chief Officer (and other Executive colleagues where applicable). Our internal audit progress reports to the Audit Committee have set out the areas covered by internal audit work during the year, our results and matters arising.

The majority of this work would indicate that significant assurance opinions have, or will be assigned, to the majority of the CCG’s systems and processes. By way of commentary it should also be noted that there have been no ‘no assurance’ final reports issued for 2014/15, and at the time of writing this draft report, no ‘limited assurance’ opinions.

In undertaking our duties we have identified some weaknesses in the design or effectiveness of controls in certain systems. We have reported these issues during the year, and post the year end.

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 2014 to 31 March 2015, some of which post-date this draft opinion.

The CCG has received a Service Auditor Report from NECS covering the period 1 April 2014 to 30 September 2014. The report covers 123 controls relating to 39 control objectives in Payroll, Business Intelligence, Information Governance, Finance, IT and Quality in relation to those services provided to the CCG. The Deloitte audit opinion was a qualified one, on account of five exceptions noted in the control environment. These exceptions related to Payroll, Finance Training, Management Accounts, Finance and routine reports. 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.

At the time of writing this report, initial results of the SAR covering the period 1st October 2014 to 31st March 2015 had been issued. Across the 26 key control objectives tested, issues were identified in 5 areas and NECS had identified actions that would be implemented. Again, this report is not tailored to Cumbria CCG’s reduced arrangements with NECS, compared to other CCGs.
The CCG will also receive a Service Auditor Report on continuing healthcare controls operated by NECS on a specific date which has not yet been determined. We understand that the report will not be available until June 2015. In providing our overall assurance opinion, we can place our reliance on unseen Service Auditor Report(s).

However, following the issue of these reports, we would suggest that the CCG takes appropriate action with NECS, for the support services they procure, if there are any reported weaknesses in NECS operating controls.

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. An assurance letter was received from Northumbria Healthcare NHS Foundation Trust on 29th April 2015 which provided significant assurance with no issues of note on the payroll processes that are undertaken on behalf of the CCG. At the time of finalising this report, the remaining assurances are not available to us and as such have not been considered as part of our opinion.

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 North of England Commissioning Support (NECS) service 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 NECS 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.

Audit North

May 2015

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

During the year Internal Audit issued no audit reports with a conclusion of no assurance.
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 2014/15 the CCG has continued to review and ensure that the arrangements put in place by the CCG and as, explained within the Corporate Governance Framework, were developed with extensive, expert, external legal input, to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body 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 2015/16.

Conclusion

A system of internal control has been maintained up to 31 March 2015, and up to the date of approval of the annual report and accounts. Based on the work undertaken in 2014/15, significant assurance has been given by the Head of Internal Audit 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)

29 May 2015
Part 6

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

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

- the table of salaries and allowances of senior managers and related narrative notes on page 51
- the table of pension benefits of senior managers and related narrative notes on page 52
- the disclosure of pay multiples on page 53.

This report is made solely to the members of NHS Cumbria CCG in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Clinical Commissioning Group (CCG)’s members and the CCG as a body, for our audit work, for this report, or for the opinions we have formed.

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 which comprises the Strategic Report, Member’s Report and Annual Governance Statement to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.
Opinion on regularity
In our opinion, in all material respects the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on financial statements
In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Cumbria CCG as at 31 March 2015 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to the National Health Service in England.

Opinion on other matters
In our opinion:

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

Matters on which we report by exception
We report to you if:

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

We have nothing to report in these respects.

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

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

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

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

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

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

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

The Audit Commission has determined these two criteria as those 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 2015.

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

Conclusion

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

Certificate

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

Karen Murray
for and on behalf of Grant Thornton UK LLP,
Appointed Auditor

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

21 May 2015
Part 7

Annual Accounts 2014/15
# Statement of Comprehensive Net Expenditure
for the year ended 31 March 2015

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
<th>2014/15 £000</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2014/15</td>
<td>2013/14</td>
</tr>
<tr>
<td></td>
<td><strong>Total Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Employee benefits</strong></td>
<td>5.1</td>
<td>6,794</td>
</tr>
<tr>
<td></td>
<td><strong>Operating Expenses</strong></td>
<td>6</td>
<td>701,324</td>
</tr>
<tr>
<td></td>
<td><strong>Other operating revenue</strong></td>
<td>3</td>
<td>(1,746)</td>
</tr>
<tr>
<td></td>
<td><strong>Net operating expenditure for the financial year</strong></td>
<td></td>
<td>706,372</td>
</tr>
<tr>
<td></td>
<td><strong>Of which:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Administration Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Employee benefits</strong></td>
<td>5.1</td>
<td>5,904</td>
</tr>
<tr>
<td></td>
<td><strong>Operating Expenses</strong></td>
<td>6</td>
<td>5,605</td>
</tr>
<tr>
<td></td>
<td><strong>Other operating revenue</strong></td>
<td>3</td>
<td>(242)</td>
</tr>
<tr>
<td></td>
<td><strong>Net administration expenditure</strong></td>
<td></td>
<td>11,267</td>
</tr>
<tr>
<td></td>
<td><strong>Programme Income and Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Employee benefits</strong></td>
<td>5.1</td>
<td>890</td>
</tr>
<tr>
<td></td>
<td><strong>Operating Expenses</strong></td>
<td>6</td>
<td>695,719</td>
</tr>
<tr>
<td></td>
<td><strong>Other operating revenue</strong></td>
<td>3</td>
<td>(1,504)</td>
</tr>
<tr>
<td></td>
<td><strong>Net programme expenditure</strong></td>
<td></td>
<td>695,105</td>
</tr>
<tr>
<td></td>
<td><strong>Total comprehensive net expenditure for the financial year</strong></td>
<td></td>
<td>706,372</td>
</tr>
</tbody>
</table>

The notes 1-8 on pages 92-106 form part of this statement.
Statement of Financial Position as at 31 March 2015

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 2015</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td></td>
<td>31 March 2015</td>
<td>31 March 2014</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>9</td>
<td>3,829</td>
</tr>
<tr>
<td>Cash</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3,836</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3,836</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>11</td>
<td>(30,404)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(30,404)</td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(26,568)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers’ Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td>(26,568)</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(26,568)</td>
</tr>
</tbody>
</table>

The notes 9-22 on pages 107-115 form part of this statement.

The financial statements on pages 88-91 were approved by the Governing Body on 21 May 2015 and signed on its behalf by:

Dr Hugh Reeve
Interim Accountable Officer
### Statement of Changes In Taxpayers Equity
for the year ended 31 March 2015

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General fund £000</td>
<td>General fund £000</td>
</tr>
<tr>
<td>Balance at 1 April</td>
<td>(29,945)</td>
<td>-</td>
</tr>
<tr>
<td>Changes in Clinical Commissioning Group taxpayers’ equity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(706,372)</td>
<td>(675,272)</td>
</tr>
<tr>
<td>Net Recognised Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(736,317)</td>
<td>(675,272)</td>
</tr>
<tr>
<td>Net funding</td>
<td>709,749</td>
<td>645,327</td>
</tr>
<tr>
<td>Balance at 31 March</td>
<td>(26,568)</td>
<td>(29,945)</td>
</tr>
</tbody>
</table>
Statement of Cash Flows for the year ended 31 March 2015

<table>
<thead>
<tr>
<th>Note</th>
<th>2014/15 £000</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(706,372)</td>
<td>(675,272)</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>9 (190)</td>
<td>(3,639)</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>11 (3,187)</td>
<td>33,591</td>
</tr>
<tr>
<td><strong>Net Cash Outflow from Operating Activities</strong></td>
<td>(709,749)</td>
<td>(645,320)</td>
</tr>
<tr>
<td><strong>Net Cash Outflow before Financing</strong></td>
<td>(709,749)</td>
<td>(645,320)</td>
</tr>
<tr>
<td><strong>Cash Flows from Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Funding Received</td>
<td>709,749</td>
<td>645,327</td>
</tr>
<tr>
<td><strong>Net Cash Inflow from Financing Activities</strong></td>
<td>709,749</td>
<td>645,327</td>
</tr>
<tr>
<td><strong>Net Increase in Cash</strong></td>
<td>10 -</td>
<td>7</td>
</tr>
<tr>
<td>Cash at the Beginning of the Financial Year</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Cash at the End of the Financial Year</td>
<td>7</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 2014/15 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

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

1.3 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 asset.

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;
- IAS 37 Provisions: where the Clinical Commissioning Group can place a reasonable estimate on a potential future liability, and that liability is reasonably likely to materialise, the Clinical Commissioning Group makes provision in its accounts for that liability. Where one of these conditions is not met, the Clinical Commissioning Group discloses details under Contingencies;
- 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 has been received for a specific activity 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
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at the fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Clinical Commissioning Group’s net operating cost.

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

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

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 has been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme Clinical Commissioning Group contribute annually to a pooled fund, which is used to settle the claims.
1.14 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 or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 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 2014/15, all of which are subject to consultation:

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

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

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

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

<table>
<thead>
<tr>
<th>NHS Act</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maximum £000</td>
<td>Performance £000</td>
</tr>
<tr>
<td>223H (1) Expenditure not to exceed income</td>
<td>713,160</td>
<td>708,118</td>
</tr>
<tr>
<td>223I (2) Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>223I (3) Revenue resource use does not exceed the amount specified in Directions</td>
<td>711,414</td>
<td>706,372</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>13,445</td>
<td>11,267</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 2014/15 nor 2013/14 and incurred no capital expenditure in either year.
3. Other operating revenue

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2014/15</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>657</td>
<td>80</td>
<td>577</td>
<td>-</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>54</td>
<td>54</td>
<td>-</td>
<td>166</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>625</td>
<td>48</td>
<td>577</td>
<td>1,613</td>
</tr>
<tr>
<td>Other revenue</td>
<td>410</td>
<td>60</td>
<td>350</td>
<td>2</td>
</tr>
<tr>
<td>Total other operating revenue</td>
<td>1,746</td>
<td>242</td>
<td>1,504</td>
<td>1,781</td>
</tr>
</tbody>
</table>

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.

4. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.
## 5. Employee benefits and staff numbers

### 5.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>Admin</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Employees</td>
<td>Other</td>
<td>Total Employees</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>5,607</td>
<td>5,309</td>
<td>298</td>
</tr>
<tr>
<td>Social security costs</td>
<td>527</td>
<td>513</td>
<td>14</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>660</td>
<td>643</td>
<td>17</td>
</tr>
<tr>
<td>Net employee benefits</td>
<td>6,794</td>
<td>6,465</td>
<td>329</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
</tr>
<tr>
<td></td>
<td>Total Employees</td>
</tr>
<tr>
<td></td>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>4,963</td>
</tr>
<tr>
<td>Social security costs</td>
<td>462</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>604</td>
</tr>
<tr>
<td>Gross employee benefits expenditure</td>
<td>6,029</td>
</tr>
</tbody>
</table>
5.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2013/14</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>99</td>
<td>96</td>
</tr>
<tr>
<td>Nursing, midwifery and health visiting staff</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>109</td>
<td>105</td>
</tr>
</tbody>
</table>

The main increase in the average number of employees resulted from the transfer of the Children’s commissioning team (7 employees) from the North of England Commissioning Support Unit on 1st April 2014.

5.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2014/15 Number</th>
<th>2013/14 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>794</td>
<td>382</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>109</td>
<td>98</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>7.28</td>
<td>3.90</td>
</tr>
</tbody>
</table>

The data provided for 2014/15 is for the full calendar year 1 January to 31 December 2014; 2013/14 data is for the nine months to 31 December 2013 as this was the only data available.

No people retired on ill-health grounds nor took early retirement during 2014/15 or 2013/14.
5.4 Exit packages agreed in the financial year
The Clinical Commissioning Group did not agree any exit packages during 2014/15 nor 2013/14.

5.5 Severance payments
The Clinical Commissioning Group made no severance payments during 2014/15 nor 2013/14.

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

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

5.6.1 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.

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

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

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>2014/15 Admin £000</th>
<th>2014/15 Programme £000</th>
<th>2013/14 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>6,126</td>
<td>5,236</td>
<td>890</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>668</td>
<td>668</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>6,794</td>
<td>5,904</td>
<td>890</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCG’s and NHS England</td>
<td>6,053</td>
<td>2,928</td>
<td>3,125</td>
</tr>
<tr>
<td>Services from NHS foundation trusts</td>
<td>315,005</td>
<td>473</td>
<td>314,532</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>213,421</td>
<td>-</td>
<td>213,421</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>58,774</td>
<td>-</td>
<td>58,774</td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>218</td>
<td>218</td>
<td>-</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>384</td>
<td>-</td>
<td>384</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>327</td>
<td>147</td>
<td>180</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>721</td>
<td>171</td>
<td>550</td>
</tr>
<tr>
<td>Establishment</td>
<td>3,244</td>
<td>549</td>
<td>2,695</td>
</tr>
<tr>
<td>Transport</td>
<td>16</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Premises</td>
<td>319</td>
<td>292</td>
<td>27</td>
</tr>
<tr>
<td>Audit fees</td>
<td>114</td>
<td>114</td>
<td>-</td>
</tr>
<tr>
<td><strong>Other non statutory audit expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>88,499</td>
<td>-</td>
<td>88,499</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>12,120</td>
<td>-</td>
<td>12,120</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>681</td>
<td>574</td>
<td>107</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Education and training</td>
<td>348</td>
<td>125</td>
<td>223</td>
</tr>
<tr>
<td>CHC Risk Pool contributions</td>
<td>994</td>
<td>-</td>
<td>994</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>85</td>
<td>1</td>
<td>84</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>701,324</td>
<td>5,605</td>
<td>695,719</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>708,118</td>
<td>11,509</td>
<td>696,609</td>
</tr>
</tbody>
</table>

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.
## 7. Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2014/15</th>
<th>2014/15</th>
<th>2013/14</th>
<th>2013/14</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>31,296</td>
<td>95,995</td>
<td>15,595</td>
<td>79,014</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>31,150</td>
<td>95,718</td>
<td>15,496</td>
<td>78,828</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>99.53%</td>
<td>99.71%</td>
<td>99.37%</td>
<td>99.76%</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>3,463</td>
<td>538,257</td>
<td>2,710</td>
<td>505,088</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>3,444</td>
<td>538,035</td>
<td>2,703</td>
<td>505,014</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>99.45%</td>
<td>99.96%</td>
<td>99.74%</td>
<td>99.99%</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.

For both NHS and non-NHS payables, 2013/14 was first year of commissioning so there is a full year effect of paying invoices in 2014/15. With regard to the non-NHS payables, the method of paying GP practices for the locally enhanced services (LES) they provide changed, effective 1st April 2014, to pay for each service each month individually as opposed to one payment covering all LESs each month as paid in 2013/14. Also funded nursing care (FNC) payments changed, effective 1st July 2014, to pay direct to nursing homes for each FNC client individually every four weeks instead of paying Cumbria County Council every two weeks for all clients on one invoice.
8. Operating lease expenditure and commitments

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 2014/15 are disclosed as minimum lease payments in note 8.1.

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 8.2.

The Clinical Commissioning Group does not act as lessor.

8.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>Buildings £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>698</td>
<td>118</td>
<td>816</td>
<td></td>
<td>1,222</td>
</tr>
<tr>
<td>Total</td>
<td>698</td>
<td>118</td>
<td>816</td>
<td></td>
<td>1,222</td>
</tr>
</tbody>
</table>

8.2 Future minimum lease payments

<table>
<thead>
<tr>
<th>Payable:</th>
<th>Buildings £000</th>
<th>Other £000</th>
<th>Total £000</th>
<th>2014/15</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>101</td>
<td>101</td>
<td></td>
<td>114</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>-</td>
<td>66</td>
<td>66</td>
<td></td>
<td>92</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>167</td>
<td>167</td>
<td></td>
<td>206</td>
</tr>
</tbody>
</table>
9. Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 31 March 2015 £000</th>
<th>Current 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>1,032</td>
<td>1,296</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
<td>1,493</td>
<td>1,588</td>
</tr>
<tr>
<td>Non-NHS receivables: Revenue</td>
<td>568</td>
<td>477</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
<td>691</td>
<td>141</td>
</tr>
<tr>
<td>VAT</td>
<td>45</td>
<td>62</td>
</tr>
<tr>
<td>Operating lease receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other receivables</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total Trade &amp; other receivables</strong></td>
<td><strong>3,829</strong></td>
<td><strong>3,639</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.

9.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>31 March 2015 £000</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>1,526</td>
<td>1,773</td>
</tr>
<tr>
<td>By three to six months</td>
<td>54</td>
<td>-</td>
</tr>
<tr>
<td>By more than six months</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,585</strong></td>
<td><strong>1,773</strong></td>
</tr>
</tbody>
</table>

£698,162 of the amount above has subsequently been recovered post the statement of financial position date up to the date of signing the accounts (2013/14 £1,353,261).

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2015 nor 31 March 2014.

9.2 Provision for impairment of receivables

No provision for impairment of receivables was made at 31 March 2015 (31 March 2014 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.
10. Cash

<table>
<thead>
<tr>
<th></th>
<th>2014/15 £000</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2014</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Net change in year</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Balance at 31 March 2015</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Made up of:

Cash with the Government Banking Service

<table>
<thead>
<tr>
<th></th>
<th>2014/15 £000</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Cash as in statement of financial position

<table>
<thead>
<tr>
<th></th>
<th>2014/15 £000</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

11. Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 31 March 2015 £000</th>
<th>Current 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>5,621</td>
<td>7,780</td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td>5,746</td>
<td>4,032</td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td>1,228</td>
<td>3,105</td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td>17,491</td>
<td>18,204</td>
</tr>
<tr>
<td>Social security costs</td>
<td>72</td>
<td>67</td>
</tr>
<tr>
<td>Tax</td>
<td>88</td>
<td>88</td>
</tr>
<tr>
<td>Other payables</td>
<td>158</td>
<td>315</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td><strong>30,404</strong></td>
<td><strong>33,591</strong></td>
</tr>
</tbody>
</table>

Other payables include £100,806 outstanding pension contributions at 31 March 2015 (£97,898 at 31 March 2014).


The Clinical Commissioning Group had no provisions as at 31 March 2015 nor at 31 March 2014.

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 2015 is £4,574,765 (£8,675,421 at 31 March 2014).
OTHER NOTES

13. Contingencies
The Clinical Commissioning Group had no contingencies as at 31 March 2015 nor at 31 March 2014 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.

14. 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 2015 nor at 31 March 2014.
15. Financial instruments

15.1 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.

15.1.1 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.

15.1.2 Interest rate risk

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

15.1.3 Credit risk

Because the majority of the Clinical Commissioning Group’s 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 9.

15.1.4 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.
15.2 Financial assets

<table>
<thead>
<tr>
<th>Loans and Receivables</th>
<th>Note</th>
<th>31 March 2015 £000</th>
<th>Loans and Receivables</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiveables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS</td>
<td>9</td>
<td>1,032</td>
<td>1,296</td>
<td></td>
</tr>
<tr>
<td>• Non-NHS</td>
<td>9</td>
<td>568</td>
<td>477</td>
<td></td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>10</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Other financial assets</td>
<td>9</td>
<td>-</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total at 31 March</strong></td>
<td></td>
<td><strong>1,607</strong></td>
<td><strong>1,781</strong></td>
<td></td>
</tr>
</tbody>
</table>

15.3 Financial liabilities

<table>
<thead>
<tr>
<th>Other</th>
<th>Note</th>
<th>31 March 2015 £000</th>
<th>Other</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS</td>
<td>11</td>
<td>11,367</td>
<td>11,812</td>
<td></td>
</tr>
<tr>
<td>• Non-NHS</td>
<td>11</td>
<td>18,877</td>
<td>21,309</td>
<td></td>
</tr>
<tr>
<td><strong>Total at 31 March</strong></td>
<td></td>
<td><strong>30,244</strong></td>
<td><strong>33,121</strong></td>
<td></td>
</tr>
</tbody>
</table>

16. Operating segments

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

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

The Locality pooled fund consolidates the former Generic Care, Intermediate Care and Prevention pooled funds. Six District based Health and Social Care Joint Management teams use funds flexibly across these three services to develop local services which 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.

The Integrated Community Equipment Service (ICES) provides a stock management and delivery service for occupational therapy equipment used in the community across health and social care.

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.

**Financial performance in the year to 31 March 2015 was as follows:**

<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>Contributions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS Cumbria Clinical Commissioning Group</td>
<td>3,522</td>
<td>383</td>
<td>7,753</td>
<td>11,658</td>
</tr>
<tr>
<td>• Cumbria County Council</td>
<td>3,330</td>
<td>387</td>
<td>13,999</td>
<td>17,716</td>
</tr>
<tr>
<td>Total Contributions</td>
<td>6,852</td>
<td>770</td>
<td>21,752</td>
<td>29,374</td>
</tr>
<tr>
<td>Share of Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS Cumbria Clinical Commissioning Group</td>
<td>(3,511)</td>
<td>(384)</td>
<td>(7,891)</td>
<td>(11,786)</td>
</tr>
<tr>
<td>• Cumbria County Council</td>
<td>(3,323)</td>
<td>(388)</td>
<td>(14,248)</td>
<td>(17,959)</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>(6,834)</td>
<td>(772)</td>
<td>(22,139)</td>
<td>(29,745)</td>
</tr>
<tr>
<td>Under/(over) spend</td>
<td>18</td>
<td>(2)</td>
<td>(387)</td>
<td>(371)</td>
</tr>
<tr>
<td>Share of under/(over)spend</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS Cumbria Clinical Commissioning Group</td>
<td>11</td>
<td>(1)</td>
<td>(138)</td>
<td>(128)</td>
</tr>
<tr>
<td>• Cumbria County Council</td>
<td>7</td>
<td>(1)</td>
<td>(249)</td>
<td>(243)</td>
</tr>
</tbody>
</table>

**Financial performance in the year to 31 March 2014 was as follows:**

<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>Contributions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS Cumbria Clinical Commissioning Group</td>
<td>3,587</td>
<td>298</td>
<td>7,799</td>
<td>11,684</td>
</tr>
<tr>
<td>• Cumbria County Council</td>
<td>3,632</td>
<td>298</td>
<td>40,558</td>
<td>44,488</td>
</tr>
<tr>
<td>Total Contributions</td>
<td>7,219</td>
<td>596</td>
<td>48,357</td>
<td>56,172</td>
</tr>
<tr>
<td>Share of Expenditure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS Cumbria Clinical Commissioning Group</td>
<td>(3,785)</td>
<td>(307)</td>
<td>(7,926)</td>
<td>(12,018)</td>
</tr>
<tr>
<td>• Cumbria County Council</td>
<td>(3,870)</td>
<td>(307)</td>
<td>(41,220)</td>
<td>(45,397)</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>(7,655)</td>
<td>(614)</td>
<td>(49,146)</td>
<td>(57,415)</td>
</tr>
<tr>
<td>Overspend</td>
<td>(436)</td>
<td>(18)</td>
<td>(789)</td>
<td>(1,243)</td>
</tr>
<tr>
<td>Share of (over)spend</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS Cumbria Clinical Commissioning Group</td>
<td>(198)</td>
<td>(9)</td>
<td>(127)</td>
<td>(334)</td>
</tr>
<tr>
<td>• Cumbria County Council</td>
<td>(238)</td>
<td>(9)</td>
<td>(662)</td>
<td>(909)</td>
</tr>
</tbody>
</table>
## 18. Intra-government and other balances

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balances with NHS bodies:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS bodies outside the Departmental Group</td>
<td>199  6</td>
<td>1,265  230</td>
<td></td>
</tr>
<tr>
<td>• NHS Trusts and Foundation Trusts</td>
<td>2,325  11,361</td>
<td>1,619  11,582</td>
<td></td>
</tr>
<tr>
<td>Total of balances with NHS bodies:</td>
<td>2,524  11,367</td>
<td>2,884  11,812</td>
<td></td>
</tr>
<tr>
<td>Balances with:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Central Government bodies</td>
<td>55  376</td>
<td>62  260</td>
<td></td>
</tr>
<tr>
<td>• Local Authorities</td>
<td>289  776</td>
<td>388  2,466</td>
<td></td>
</tr>
<tr>
<td>• Bodies external to Government</td>
<td>961  17,885</td>
<td>305  19,053</td>
<td></td>
</tr>
<tr>
<td>Total balances at 31 March</td>
<td>3,829  30,404</td>
<td>3,639  33,591</td>
<td></td>
</tr>
</tbody>
</table>
19. Related party transactions

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>Payments 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>
</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.

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
- 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.
20. 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.

21. Losses and special payments
The total number of the Clinical Commissioning Group’s losses and special payments cases, and their total value, was as follows:

21.1 Losses
The Clinical Commissioning Group had no losses cases during 2014/15 nor 2013/14.

21.2 Special payments

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
<th>Total Value £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2013/14</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

22. Impact of IFRS
Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during 2014/15 nor 2013/14.