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

It has been a momentous year and we have faced a range of significant challenges, including some major concerns about quality of care which have been compounded by serious recruitment difficulties and ongoing financial problems. This has resulted in national focus on our organisations, culminating in Cumbria being included in a list of 11 distressed economies.

However, we have reached a turning point and are now building strong foundations for wide ranging improvements to ensure better and safer care for patients. A key development during the year has been the formation of the Cumbria Health and Care Alliance, comprising of NHS organisations, Cumbria County Council and Healthwatch Cumbria.

This is demonstrating a strong will to move forward as a single system to collectively address the difficulties we are facing. The building blocks are in place and we are already seeing tangible improvements.

We have substantial programmes of work in the north and the south of the county, branded together for a healthier future and better care together respectively which are driving forward the changes we need to make sure that Cumbria’s population receives the health and care services it deserves.

These programmes involve extensive engagement with our workforce, patients, the public and the CCG’s key partner organisations so it can build trust and confidence to achieve the changes that are needed.

We recognise the CCG’s staff are its greatest strength and to support them as they strive to provide the best and safest possible care for patients the Cumbria Learning and Improvement Collaborative (CLIC) has been established.
The CCG is pleased that the level of cooperation we are now seeing across all of the health and care organisations within Cumbria is palpably different. There is a strong recognition and determination that together we have got to find a solution and as we approached the year end we were working with some confidence on a five year plan for health and care services in Cumbria.

This will describe a direction of travel to make sure that going forward our patients receive safe and sustainable services that are affordable and provided as close to home as possible, accepting that sometimes they will need to travel to centres of expertise to receive the specialist care they need to ensure they have the best possible chance of a healthy life.

This annual report sets out more about the challenges and our responses to them and we hope it will prove of some reassurance about the level of commitment that now exists across the health and care system in Cumbria to make sure that our services will be among the best.

Hugh Reeve - Clinical Chair
Nigel Maguire - Chief Officer
NHS Cumbria Clinical Commissioning Group (CCG) became a statutory organisation on 1 April 2013. This followed the biggest reorganisation of commissioning in the history of the NHS, which has presented an opportunity. The CCG has a membership of 82 GP practices and is a new type of NHS organisation. This first year has been a period of learning together as we have taken on the baton of commissioning from the Primary Care Trust. We work together through our six localities and also come together through our Full Council of Members to oversee our direction of travel, while devolving most of the governance of the CCG to our Governing Body.

Over the last year, the CCG has worked closely with health and care providers to deliver services that are safe, sustainable, affordable and of high quality. The system has faced some major challenges but is now seeing improvements. The CCG has listened to and acted on the report from NHS England’s national medical director, Sir Bruce Keogh outlining his findings about North Cumbria University Hospitals NHS Trust. These included higher than expected mortality levels. Following concerted efforts by the trust it was able to announce by the year end that mortality levels were now within expected levels. The CCG has also taken into consideration and has acted on the findings of Sir Robert Francis QC following the inquiry into the Mid-Staffordshire NHS Foundation Trust.

There have been ongoing efforts during the year to address the historical financial and recruitment issues that have impacted negatively on our health and care system. There have also been some significant improvements to a range of performance targets that were not being achieved which mean that many patients are now receiving faster access to health care.

One of our key values is that the services we commission are those we would want for ourselves and our families.

In order to achieve this we recognised that a step change was needed in partnership working. In October 2013 we led on the formation of the Cumbria Health and Care Alliance. The Alliance brings together organisations from across the NHS and care services and is planning collectively as a single system to address the issues Cumbria faces.
As part of this there are two important programmes of work: *together for a healthier future* in the north of the county which started in February 2014 and *better care together* in the south of the county which has been running over the past year.

Fundamental to these programmes is engagement with our workforce, patients, the public and our partner organisations which we hope will help build the trust and confidence needed to bring about the required changes for health and care services.

The five year plan now being developed will describe how going forward we will make sure that services are the very best that they can be.

An important element will be providing care that is closer to home that will put services where they are needed within local communities. As part of this we have also spent some considerable time developing a new model of care for out of hospital services - Primary Care Communities. We hope this model will transform the experience of local patients by making sure that they have much better access to GP and other local community health services; that these services are much more joined up with specialist input when needed to reduce avoidable hospital admissions and that they provide the best possible health and care services. We were delighted when our practices in Workington secured a bid for more than £500,000 from the Prime Minister’s Challenge Fund to pilot this work in Workington.

You will also see within this annual report the work carried out by the six localities that form the CCG which is providing real improvements to services. The localities are the places where our member practices work together to deliver changes for their patient populations, with a particular focus on out of hospital services and how these integrate with hospital based services.

While there has been some progress during 2013/14, the CCG does not underestimate the continuing challenges it faces, nor does it shy away from what it needs to do. During 2014/15 we will see the start of the implementation of the five year plan, further improvements to health and care services, more engagement with patients, the public and partner organisations and more innovative ways of working to ensure a truly collaborative approach to health and care provision.

As reflected in this annual report, the CCG has achieved a lot during its first year, and there is growing confidence that the second will see the achievement of even more.

The report also includes information about how the Governing Body has evaluated its performance. This information can be found in the governance statement. The report also presents the CCG’s accounts and financial position.
2.1 NHS Cumbria Clinical Commissioning Group (CCG)

The CCG was established on 1 April 2013 following the passing of the Health and Social Care Act 2012. It took over many of the responsibilities of the former NHS Cumbria Teaching Primary Care Trust (PCT) and was successfully authorised to operate without conditions in the first phase of the Department of Health’s authorisation process for new CCGs.

The CCG is responsible for commissioning approximately 80 percent of the financial value of NHS services in Cumbria, which means the majority of hospital and community health services for local people. It also has a responsibility for developing GP services to the highest standard. NHS England commissions the primary care services provided by GPs, dentists, opticians and pharmacies and specialised services.

The CCG comprises of 81 GP practices in Cumbria and one in North Yorkshire. This membership gives GPs the power to influence commissioning decisions on the planning and purchasing of NHS services to meet the health needs of Cumbria’s residents.

The CCG has six localities (Allerdale, Carlisle, Copeland, Eden, Furness and South Lakes), each with a lead GP. These GPs lead locality executives to ensure that the needs of their local patients are met and also come together at county level to make decisions which affect the whole of Cumbria.

2.2 Health in Cumbria

The CCG operates in a diverse and challenging area. 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 CCG and its partners have the challenge of providing quality services to isolated clusters of population across a very large geographical area.
There are significant differences in the health challenges between the localities. The Cumbria Joint Strategic Need Assessment (JSNA) highlights four key challenges in relation to the health and wellbeing of Cumbria’s population:

- Improving care to respond to the challenges of an **ageing population**
- Improving the health of **children and young people** and the quality and integration of care services
- Improving **mental wellbeing** and reducing **alcohol misuse**
- Reducing health **inequalities and premature mortality** from cancer and cardiovascular disease.

All health and care partners recognise that to address these challenges we need to ensure that local people have access to the best and highest quality possible health and care services which are also safe and sustainable.

### 2.3 The CCG’s vision

The CCG’s vision is: **“We are here to make a real difference to people’s lives”.**

Firstly this is about making a difference by improving the health and wellbeing of individuals and their families. In particular it is about taking serious action to reduce the inequalities in health 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 experience of patients and those working to deliver better healthcare. Working for the health service in Cumbria should be a privilege and 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.

Our key underpinning principles are:

- Doing the right thing for our patients, service users and populations
- Putting ourselves in your shoes – is this the care we would want for ourselves or our families?
- Access to the right healthcare, in the right place, right when you need it
- The Cumbrian health pound is finite and can only be spent once.
To achieve its vision, the CCG will:

- Deliver the standards of care that are already enjoyed across most of the country
- Stop spending other people’s money; return the local NHS system to sustainable financial balance
- Embed continuous service improvement methods across the system, empowering front line clinicians and practitioners
- Work together much more flexibly, where necessary changing which organisation delivers services, where it is delivered, and how it is paid for
- Put the interests of patients and the overall system first, ahead of each organisation’s interests and professional interests.

Going forward, the CCG’s strategic objectives are to:

- Radically increase the scale and integration of out of hospital services, based around Primary Care Communities
- Achieve sustainable, high quality provision, by delivering a programme of hospital services, where necessary, a consolidation of hospital services
- Deliver a modern model of integrated services, ensuring an optimal use of resources for patient pathways across community and hospital services
- Improve population health outcomes, working with all partners.
2.4 Achieving the vision through partnership

As indicated in the member practices’ report there are significant challenges within the health economy. There are quality issues that are being addressed in each of Cumbria’s trusts and the NHS is also responding to national requirements following the publication, during 2013, of reports by Sir Bruce Keogh calling for greater integration across health and care services and a move towards 24 hour working.

There are serious recruitment difficulties which are impacting on the system’s ability to ensure safe and sustainable services. There is a national requirement to make substantial savings over the next five years and the local NHS must address its own financial problems to ensure that in the future it manages within the funding available. In addition, there is the challenge of an increasing number of older people who are living longer and an increasing number of people living with long term conditions.

Against this background the CCG has led the development of the Cumbria Health and Care Alliance. This comprises of local NHS organisations, Cumbria County Council and Healthwatch Cumbria, all of whom firmly believe that to address current and future challenges, the whole system needs to work more collaboratively. This includes a new partnership with the public, patients and partner organisations. The Cumbria Health and Care Alliance will work together to develop a five year plan for the local health economy by 20 June 2014, as required by NHS England.

The Alliance’s development has been led by the CCG Clinical Chair and Chief Officer, with extensive support from the Director of Clinical Innovation and the full participation of the Chief Executive and Medical Director from each of the NHS trusts and the Chief Executive and lead directors from Cumbria County Council.

The Alliance’s ambition is to provide local people with the best possible health and care services ensuring they are:

- More responsive to patients’ needs
- The highest possible quality, including improving safety, outcomes and patient experience
- Clinically and financially sustainable.

The Alliance is driving extensive work programmes in the north and south of the county, both of which will inform the five year plan.
In 2013, under the branding *better care together*, the south of the county started to review local health services in the geographical area covered by University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) – including Furness and South Lakes localities in Cumbria.

The review is being carried out by NHS organisations in the area led by NHS Cumbria CCG, Lancashire North Clinical Commissioning Group (CCG) and UHMBT who run the hospitals in Lancaster, Barrow-in-Furness and Kendal.

More recently, in February 2014, the North Cumbria Programme Board was established, under the branding *together for a healthier future*, again led by NHS Cumbria CCG and comprising of local NHS organisations, Cumbria County Council and Healthwatch Cumbria.

These programmes will ensure that the best possible health services are provided across the county which meet the needs of residents now and well into the future. Their work is being informed by public engagement and independent market research to gain a much better understanding of what is most important to people when they are accessing health and care services.

There is close working with the Cumbria Health and Wellbeing Board which has an important role in not only providing challenge and assurance of the five year plan but in providing leadership and the coordination of joint work with the Cumbria County Council Health Scrutiny Committee. This is to ensure that the NHS fulfils its requirements to involve and consult patients over developments and proposed service changes.
2.5 Locality focus

Our localities provide a vital role in ensuring we respond to local needs, working with local partner organisations, with a close connection with our GP members. Below is a short summary of some of the work each of the localities have led on during the last year.

Allerdale

A key focus for the Allerdale Locality has been meeting the needs of an ageing population, specifically relating to residential care homes. This has included an award winning pilot scheme called Care Home GP and additional training programmes for nurses working in care homes.

Schemes have started in Workington and Keswick on the management of frail elderly patients. This is part of work related to ‘Deciding Right’ which aims to support end of life care. Pilots in Maryport and Keswick are looking at the opportunities Telehealth can have for this group of patients.

The Locality is working with Adult Social Care under the ‘Modernisation Programme’ to improve patient pathways, including a medication review for older patients, particularly those living in care homes. There has also been work with primary care on dementia screening.

Allerdale Locality has been working on several projects to improve the health of children with a number of community based schemes addressing the needs of children with respiratory problems in Maryport, and across the locality.

Allerdale is working closely with Copeland Locality to develop a primary care based mental health service model.

To tackle the issue of premature mortality from cancer and cardiovascular disease it has worked on the Royal College of General Practitioners cancer audit across all practices and with cancer screening defaulters in Workington in a bid to reduce health inequalities.
Carlisle

Carlisle Locality has been developing an innovative project, Mrs Carlisle, to meet the health and social needs of older people living in the city, working closely with Carlisle City Council, Cumbria County Council, Cumbria Partnership NHS Foundation Trust and North Cumbria University Hospitals NHS Trust.

Mrs Carlisle, a Hospital at Home pilot project, aims to provide high-level healthcare, usually provided within an acute hospital setting, at the patient’s home. Following the success of phase one and two, the project is now working on upscaling the scheme to a wider community.

The Locality is working closely with GP member practices, partners and stakeholders in the development of the Primary Care Communities (PCC) model. The focus is on improving patient experience and ensuring the capabilities are developed to allow patients to be looked after within their community.

The Mrs Carlisle project is also working closely with Carlisle Healthy City on Assets Based Community Development (ABCD). The aim is for communities, stakeholders and providers to work together to improve the health of their local communities.
Copeland

Copeland Locality has been working on the development of Community based services as a major part of their work to provide care for the frail older populations and reduce or prevent admissions to hospital.

A pilot project has been implemented in all GP member practices offering a holistic package of care to all over 75's who have been identified as mild or moderately frail. A Care Coordinator has been appointed to work in the community to provide support to enable older people to keep well and live independently.

For patients with more complex health needs, the Locality has developed services including extended operating hours over six days for Short Term Intervention Service (STInT).

Community Matrons have been appointed to manage interim beds, located in care homes across Copeland to provide step-up and step-down nursing care, which aims to prevent or shorten hospital stays for those with complex needs. The Locality has also commissioned training for care home staff, to help them deliver more care within the home.

As well as focusing on the care of the elderly, Copeland Locality has been working closely with NCUHT on alcohol misuse to develop an inpatient pathway that will help prevent repeat detoxifications, which is proven to be harmful to the patient. Further work is planned with partners in the Community Safety Partnership to tackle alcohol misuse and anti-social behaviour.

Eden

Eden Locality worked closely with GP practices on developing sustainable General Practice, based on the implementation of continuous improvement principles and the Productive General Practice (PGP) programme.

The Locality’s Health and Social Care Communities Programme aimed to deliver outcomes that are important to each individual by providing support programmes that are closely aligned to their identified health and social care needs. The programme will be piloted in Upper Eden from April 2014.

In Alston, the Locality worked with colleagues at North West Ambulance Service to secure the future of urgent care support for Eden’s most remote community.
Furness

Furness Locality has successfully developed the plans for a new primary care centre in Barrow-in-Furness. Six member practices will look at joint working to improve efficiency and create additional capacity to help in the recruitment of new GPs which is a significant issue in Cumbria.

An urgent care network was established with social care colleagues enabling seamless care.

The Locality has continued to promote the cancer screening programmes, working with colleagues in South Lakes and North Lancashire to establish a cancer group work plan for 2014/15.

Public engagement has been undertaken with the launch of Maternity Matters in Furness, bringing parents and professionals together to drive quality improvements in maternity.

The Locality also supported the *better care together* programme by developing a planned care network to streamline elective care pathways therefore reducing length of stay, improving day case activity, implementing advice and guidance to reduce unnecessary referrals and increased the speed of referrals for urgent cases; and developing alternative methods of follow up.

South Lakes

The Locality focused on delivering a vision for Frail Elderly Services. This included a new approach to support residents in nursing and care homes and work to improve End of Life services.

 Investment took place in the Urgent Care System to deliver the first part of an integrated discharge/admission prevention service with the rapid development of an enhanced Short Term Intervention Team (STinT) service responding to urgent care pressures over winter.

 Good engagement structures and working relationships with GP member practices have been established with three successful Protected Learning Time events focusing on Cancer, Safeguarding and Supporting Primary Care Development and the CCG Local Incentive Scheme.
2.6 Performance

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 ensures compliance with the constitution by setting performance targets for itself and the services it commissions through providers.

At the end of March 2014 the CCG had achieved the targets in 16 of the 24 Expected Rights and Pledges. Detailed reviews have been carried out and action plans have been implemented with local providers to improve standards in the underachieving or failing standards of the rights and pledges across Cumbria. It is expected that these will improve significantly and in many cases be met by providers throughout 2014/15.

Diagrams 1 and 2, below, indicates how well the CCG is achieving the standards set out in the NHS Constitution Rights and Pledges for 2013/14.

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

NHS Constitution Rights and Pledges 2013-14
CCG Aggregate Performance Referral to Treatment Times (RTT) & Cancer Waiting Times
Performance for March 2014 except* where it is for full year 2013/14

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
The NHS Constitution Rights and Standards 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 standards that are underperforming in Cumbria and are being addressed by the CCG and providers.
Cancer care pathways, particularly in the north of Cumbria, have consistently not achieved the required standards. The CCG has worked with North Cumbria University Hospitals NHS Trust (NCUHT) to develop and share a Recovery Plan that will ensure 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. Currently cancer services are supported by trusts from the North East such as the Newcastle-upon-Tyne Hospitals NHS Foundation Trust.

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. Urgent Care Working Groups have been established in north and south Cumbria, chaired by the CCG but with multi-agency support. These groups have developed plans 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.

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). The CCG has therefore required them to produce effective plans to indicate how they will improve their performance, both in rapidly treating those patients that have been waiting longer than 18 weeks and in then ensuring that there is not a further build-up of patients waiting longer than the standard. The CCG is also exploring ways that treatments that do not require acute hospital facilities could be treated in more suitable locations by alternative providers.

Two of the biggest challenges faced by the CCG and providers are meeting the standards of A&E admissions and health care associated infections. Below are details of how the CCG, working together with its partners, has tackled these challenges.

**A&E Actions**

Both NCUHT and UHMBT had difficulties, particularly during the winter months, in meeting the standard of 95% of patients being treated within four hours of arrival.

This standard has been a challenge nationally and NHS England therefore required all health communities to produce an Urgent Care Plan in May 2013. These plans were centred around acute trusts so UHMBT and NCUHT worked together to produce a plan for the whole of Cumbria. In addition winter funding was available from NHS England for trusts struggling to achieve the 95% target and so was available for both Cumbrian trusts.

A range of initiatives were funded such as a Hospital at Home scheme, a clinical co-ordination centre and improved seven day working including additional transport to take patients home from hospital.

As commissioners, the CCG required both trusts to provide recovery plans identifying their internal plans to improve performance in A&E. The national Emergency Care Intensive Support Team were invited by both the CCG and NCUHT to provide workshops and support
to the Cumbria health community in identifying and implementing best practice in urgent and emergency care.

**Health Care Associated Infections**

The two main Health Care Associated Infections (HCAIs) are Clostridium Difficile infection (C. Difficile) and Meticillin-Resistant Staphylococcus Aureusis (MRSA). The CCG and hospital trusts are monitored on how many patients contract these infections against annual targets. The target for MRSA is zero and C. Difficile is set annually and specifically linked to each individual CCG.

The CCG had a target of 148 cases for C.Difficile in 2013/14 and recorded 185 cases with a majority of the excess cases resulting from UHMBT. The CCG requested a plan from UHMBT as to how it will reduce cases.

Two cases of MRSA were recorded in April 2013; however the CCG has had no more since that date.

The CCG has also appointed an Infection Control and Prevention Nurse to work with healthcare organisations across Cumbria to improve management of HCAIs.

(The source of all of the above data is the North of England Commissioning Support Unit Business Intelligence Service).

**2.7 Quality**

**Quality assurance systems in NHS Cumbria CCG**

Since its inception in April 2013, the CCG developed a number of 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 that are commissioned by the CCG reporting their quality care issues including serious incidents requiring investigation, complaints, patient experience and application of NICE recommendations to the CCG quality team on a bi-monthly basis. These are then 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 (NLRS), NHS England, Healthwatch, the Strategic Executive Information Systems (STEIS) and from feedback the CCG receives from patient experience data, General Practice and CCG localities.

From this intelligence the CCG holds the providers to account at monthly Quality Review Groups held with each provider and CCG representatives, which are led by the CCG GP clinical leads.
In addition to this monthly monitoring the CCG quality team are fully involved in the commissioning processes and this information is used for all commissioning reviews, plans or developments.

The CCG Governing Body receive a bi-monthly report on the quality of care across its provider services based upon all of the information and intelligence outlined above, and includes recommendations made to it by the Sub-Committee of the Board with the remit for quality assurance the NHS Cumbria CCG Quality and Outcomes Assurance Committee.

The CCG is aware that within many NHS commissioning organisations quality failures in providers have often only been highlighted after an event or incident has occurred. As such the CCG has developed and will be further developing a number of systems that act as early warnings for quality failures in commissioned services.

Such a system now operates across nursing homes allowing partner agencies and GPs to alert the CCG to any concerns in the quality of care being provided. In 2014/2015 these systems will be expanded to all services and agencies.

**Processes to help improve quality**

The CCG has prioritised the gathering of real time patient experience through ‘I Want Great Care’ which is a system that will ensure the local population can access user feedback on clinical services across hospitals and primary care in Cumbria.

**2.8 Cumbria Learning and Improvement Collaborative (CLIC)**

During 2013/14 the partners of the Cumbria Health and Care Alliance established the Cumbria Learning and Improvement Collaborative (CLIC).

The purpose of CLIC is to drive a positive transformation in health and social care across Cumbria by leading and embedding a culture of collaboration for continuous learning, continuous improvement, and living within our means. Although CLIC is still in formation and development, it has already begun to deliver on its three key strategies as outlined below:

**Strategy 1: Education and Learning**

*Transforming learning through collaboration and evaluation*

- Training staff in what they need to know to do their jobs as well as possible
- Learning together in teams to improve services and save money
- Involving the people who use our services in our learning
- Training staff to be able to continually improve their jobs and services.
Strategy 2: The Cumbria Production System

*Developing and implementing the Cumbria Production System*

- Helping staff to use and develop the knowledge and skills that they already have
- Giving help to learn, master and apply modern improvement methods
- Understanding and using existing good practice
- Together, developing and agreeing the Cumbrian Production System, using the best of what we know
- Focusing our efforts on our service priorities.

Strategy 3: Leadership

*Embedding talented leadership in all staff*

- Driving the adoption of a common culture by developing staff to be talented leaders
- Nurturing behaviours and embedding a culture of service improvement
- Developing and building leadership talents.

2.9 Children’s Services

A report on the Review of Health Services for Children Looked After and findings by healthcare organisations across Cumbria showed there had been significant progress in improving services for children and young people.

Inspectors noted that there had been significant improvement in the health and well-being of some children. It also acknowledged improvements and investment totalling £2.8 million made by the CCG and Cumbria Partnership NHS Foundation Trust (CPFT) particularly in the Child and Adolescent Mental Health Service (CAMHS), and specialist nurses to work with Children Looked After and health visitors following the last inspection.

The investment in CAMHS included additional staff and an out-of-hours system that has been implemented with feedback from children and young people being used to improve the service. The CCG, NHS England, CPFT, NCUHT, UHMBT and Cumbria County Council (CCC - who are responsible for Public Health) are continuing to work in partnership moving forward as they recognise there is still work to do.

In the report inspectors said: “There is now a strong sense of health visiting, school nursing, specialist and adult mental health teams coming together to identify and meet needs of vulnerable children and their families.”
2.10 Managing Finances

NHS Cumbria CCG’s first financial year was successful in terms of overall financial performance, with the CCG meeting all key financial responsibilities that were to:

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

The CCG ended with an operational surplus of £8.4 million that was consistent with the level of surplus agreed with NHS England. £3.4 million of the surplus is planned to be used as support funding for NCUHT in 2014/15 and the residual balance represents the agreed planned surplus with NHS England to be carried forward. This figure is lower than the 1% CCG’s are advised to plan owing to historic financial support for local NHS providers. This is shown in the CCG’s accounts that have been prepared under direction issued by NHS England under the NHS Act 2006 (as amended).

The establishment of the Health and Social Care Act in 2012 brought about the end of NHS Cumbria Teaching Primary Care Trust and the establishment the CCG. This meant that there could be potential assets and liabilities that would transfer to the CCG, and the CCG was informed by NHS England that there were no assets or liabilities to be transferred at the start of the 2013/14 financial year.

The chart below shows how the CCG’s revenue resources of nearly £700 million were spent in 2013/14.

Diagram 3. Pie chart showing expenditure of the CCG’s revenue resources, of nearly £700 million, in 2013/14
The Full Accounts are included as Part 5 – Annual Accounts and Governance Statement.

In 2014/15 the CCG continues to invest in the improvement of Children’s Services across Cumbria along with significant investment in transformational services in the community to reduce the reliance on the acute hospital sector in future. The CCG continues to work closely together with fellow stakeholder organisations 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. Similarly the CCG is working closely with CCC to develop plans for implementation in 2015/16 for the Better Care Fund to take an integrated approach to the development of health and social care services.

2.11 Regulatory Intervention

During 2012/13 – 2013/14, there have been a number of substantial quality challenges in Cumbria, which have resulted in regulatory intervention. Many of these quality challenges have improved during this time, but have included intervention from the Care Quality Commission (CQC) and/or NHS England regarding:

- NCUHT was included in the Mortality Review led by Sir Bruce Keogh, NHS England Medical Director
- UHMBT was included in Wave 1 of the new Chief Inspector of Hospitals reviews
- The establishment of an inquiry in public, primarily relating to maternity services at Furness General Hospital
- A series of Quality Surveillance Groups, leading to several Risk Summits, relating to specific NHS Trusts across Cumbria
- A wide range of interventions across nursing homes in Cumbria.
2.12 Recruitment and Retention

A key recurring issue is the difficulty of recruiting clinicians and practitioners with the necessary skills, and of enabling those clinicians to continuously improve services within a professionally supportive clinical culture.

The CCG has been working collaboratively to maximise shared resources on a ‘Cumbria wide’ approach for the recruitment and retention of all grades of staff across the county. It has also formed a Recruitment and Retention Steering Group (RRSG) to lead the recruitment drive and partners include lead GPs from the CCG, NCUHT, UHMBT, Cumbria Partnership NHS Foundation Trust (CPFT), Cumbria Health on Call (CHoC) and CCC representing Public Health. The monthly meetings focus upon discussing the here and now to ensure an action focussed attitude.

The RRSG links to other forums including the Cumbrian Learning Improvement Collaborative (CLIC) to make sure there is a consistent and coordinated approach to recruitment. CLIC is a partnership bringing together all those working in health and social care in Cumbria including the NHS, CCC, voluntary and independent (third sector). The RRSG plans to raise effective awareness amongst all NHS staff in Cumbria about CLIC’s transformational plans in relation to training in the future.
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

3.1 Governing Body

The Governing Body ensures that the 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 website: www.cumbriaccg.nhs.uk

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

**Governing Body Members**

**Clinical Chair: Dr Hugh Reeve**

Dr Reeve is Clinical Chair of NHS Cumbria CCG and a GP in Grange-over-Sands. He was elected to the South Lakes Locality in 2007. Previously he was Medical Director and Chair of the Professional Executive Committee at Morecambe Bay PCT. He is also the Chair of the Governing Body, Cumbria Executive (Clinical Leads Group) and the Interim Finance Committee.

**Lay Member Finance and Governance/Vice Chair: Peter Scott**

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 also Chairs the Remuneration and Audit Committees and is a member of the Interim Finance Committee.

**Lay Member Health Improvement: Les Hanley**

Les is a Director of the British Energy Coast Business Cluster, Age UK, West Cumbria and North Country Leisure. He Chairs the Outcomes and Quality Assurance Committee, is a member of the Remuneration Committee, Audit Committee and Interim Finance Committee.

**Lay Member Patient Engagement: Jon Rush**

Jon was a Chief Superintendent with Greater Manchester Police, after spending 24 years working for Cumbria Constabulary where he became Deputy Commander. Jon is also a member of the Remuneration Committee, Audit Committee and Interim Finance Committee.

**Consultant Member: Anthony Woodyer**

Anthony worked in Dorset and London before taking the post of Consultant Surgeon at Tameside General Hospital in 1990. During his time as Medical Director his Trust achieved Foundation Trust status, and Level 2 accreditation in the Clinical Negligence Scheme for Trusts. He is a member of the Outcomes and Quality Assurance Committee.
Nurse Member: Ruth Gildert
Ruth has 40 years experience as a nurse 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 also a member of the Outcomes and Quality Assurance Committee.

GP Member: Dr Geoff Jolliffe
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, Chairs the Furness Locality Executive and is also a member of the Cumbria Executive (Clinical Leads Group).

GP Member: Dr David Rogers
Dr Rogers was appointed Medical Director for NHS Cumbria CCG in February 2014. Prior to that he was the Lead GP for Copeland and for quality at the CCG and he held the position of GP Lead (North) on the CCGs Governing Body. He is also a member of the Cumbria Executive (Clinical Leads Group) and Outcomes and Quality Assurance Committee.

Chief Officer: Nigel Maguire
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. He is also member of the Cumbria Executive (Clinical Leads) and Interim Finance Committee.

Chief Finance Officer: Charles Welbourn
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 Cumbria Executive (Clinical Leads Group) and the Interim Finance Committee.
Locality Lead GPs

**Dr Tom Ickes**

Dr Ickes was welcomed as the Interim Lead GP for Copeland in February 2014. Dr. Ickes is based at Trinity House Surgery in Whitehaven and chairs the Copeland Locality Executive.

![Dr Tom Ickes](image1)

**Dr Geoff Jolliffe**

Dr Jolliffe is the Lead GP for Furness and chairs the Furness Locality Executive. Dr Jolliffe is part of Risedale Surgery in Barrow.

![Dr Geoff Jolliffe](image2)

**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 Alistair MacKenzie](image3)

**Dr Niall McGreevy**

Dr McGreevy is Allerdale’s Interim Lead GP and chairs the Allerdale Locality Executive. Dr McGreevy is a GP in Workington’s James Street Surgery.

![Dr Niall McGreevy](image4)

**Dr Colin Patterson**

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

![Dr Colin Patterson](image5)
Dr Rachel Preston

Dr Preston is the Lead GP for Eden and chairs the Eden Locality Executive. Dr Preston is a GP at the Lakes Medical Practice in Penrith.

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 IT Lead 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 Andrew Rotheray

Dr Rotheray is the Clinical Lead GP for Serious Untoward Incidents (SUls). His role was to ensure all serious case reviews are investigated by the CCG’s quality team and any findings are shared with the relevant providers. Andrew retired at the end of 2013/14 and is thanked for all his wonderful work over many years.
Dr Neela Shabde
Dr Shabde is the Clinical Director for Children and Families. Her role is to learn and contribute to service development of 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 CCG’s Lead Nurse for Quality and Safety and is the Clinical Director for Mental Health and Learning Disabilities. Laura is a member of the Cumbria Clinical Leads Group and Outcomes and Quality Assurance Committee.

Anthony Gardner
Anthony is the lead director for the two south Cumbria localities. He is a member of the Cumbria Clinical Leads Group, Outcomes and Quality Assurance Committee 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 1st 2014 as the Director for Children and Families. Eleanor is a member of the Cumbria Clinical Leads Group.

Caroline Rea
Caroline is the lead director for the four localities in north Cumbria. Caroline is a member of the Cumbria 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 Cumbria Clinical Leads Group and the Interim Finance Committee and attends the Governing Body.

The CCG’s staffing structure as of 31 March 2014 is available at [www.cumbriaccg.nhs.uk/about-us/who-we-are/ccg-structure.aspx](http://www.cumbriaccg.nhs.uk/about-us/who-we-are/ccg-structure.aspx)

3.2 Employee Consultation
The CCG is committed to communicating with and listening to its staff to find out their views and ensure that these are taken into consideration when it is making decisions that are likely to affect their day to day working.

It holds quarterly staff development days, which provide an opportunity for key plans and developments to be presented, so that staff can find out more and make their views known.

The CCG produce fortnightly e-bulletins to ensure staff are up to date on any news or developments and during the year a staff communications and engagement steering group was established, following which planning began for a more substantial newsletter, The Wave, to launch early May 2014.

3.3 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.

Steps are in place to ensure managers address sickness absence issues, both short and long-term, in a fair, consistent and equitable manner. It is recognised however, that all cases must be dealt with on an individual basis because of differing circumstances.

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 advice is sought from appropriate medical professionals when required. All new staff are made aware of the relevant policies and procedures during their induction.

NHS Cumbria CCG’s full Absence Management Policy is available on its website at [www.cumbriaccg.nhs.uk](http://www.cumbriaccg.nhs.uk)

The annual absence rate as at 31 March 2014 for the CCG is 1.76% and the cost of sickness absence during the year amounts to £95,566.
3.4 Employees with disabilities

The CCG has policies in place to ensure all employees, and CCG applicants for employment, are treated fairly and equally. Through the NHS jobs application process all applicants with disabilities are identified and given automatic consideration.

An analysis of how the policies have been applied during the 2013/14 financial year, in relation to applications for employment; employees who have become disabled during the financial year and training, career and development of disabled employees is currently not available.

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

3.5 Complaints

NHS Cumbria CCG aims to improve the health and well-being of all people in Cumbria by ensuring that local people receive the highest standards of healthcare possible.

The views and opinions of patients and families help the CCG to understand when it is doing things well and when it could do something better. Complaints are an essential source of information about the services commissioned by the CCG and the things it does. Complaints provide an opportunity to learn and a chance to put things right when they go wrong.

The CCG has adopted the Principles for Remedy, published by the Parliamentary and Health Service Ombudsmen in 2010.

Its complaints service is in line with the requirements of the Complaint Regulations 2009. Often a problem can be resolved quickly and easily with those directly involved, and this is called local resolution.

Complaints received by the CCG about NHS organisations are directed to the organisation concerned in the first instance. Staff in the CCG can also help to signpost patients to the relevant organisation if they are unsure who to raise their concerns with and to ensure they know about the advocacy service provided through Healthwatch Cumbria.

The North of England Commissioning Support Unit (NECS) Clinical Quality Team handles commissioning related complaints on the CCG’s behalf. Patients can expect their complaint to be acknowledged within three working days. A plan is then agreed with the complainant for how the complaint will be investigated, a timescale for doing so, and how a response will be made.

The majority of complaints received by NHS Cumbria Clinical Commissioning Group were about Continuing Healthcare Funding. These complaints are often about the complexity and duration of the process or the outcome of the funding decision.
These figures do not include complaints that were rejected to another organisation and investigated by them. A joint protocol complaint is a complaint that involves more than one NHS organisation of an NHS organisation and a Local Authority.

Diagram 4. Pie chart showing the number of complaints and enquiries received by NHS Cumbria from April 2013 - March 2014
3.6 Disclosure of Serious Untoward Incidents

The CCG commissions Serious Untoward Incidents (SUls) 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 SUls, 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.

3.7 Information Governance

NHS Cumbria Clinical Commissioning Group Trust’s Information Governance Assessment Report overall score for 2013/2014 was 69% and was graded “Satisfactory” overall as all requirements were met.

Information Governance Incidents

During 2013/14 NHS Cumbria Clinical Commissioning Group has reported zero (0) incidents in line with the HSCIC guidance.
3.8 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 with in the legally binding 20 day period.

The number of FOIs received for 1 April 2013 to 31 March 2014 was 176.

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

3.9 Equality and Diversity

As a statutory organisation, the CCG has a duty to demonstrate ‘due regard’ to the public sector equality duty’s three aims (shown below) and to provide evidence for meeting the specific equality duty, which requires all public sector organisations to publish their equality information annually:

1. Eliminate unlawful discrimination, harassment and victimisation
2. Advance equality of opportunity between different groups
3. Foster good relations between different groups.

Due regard means that the CCG has given consideration to issues of equality and discrimination before making any policy and commissioning decisions that may impact protected groups. Due regard also means the CCG is committed to tackling discrimination, promoting equality of opportunity and having a workforce which reflects the make-up of the population it serves. Training ensures managers and staff understand the importance of equality and diversity and link this to all areas of business, service and policy development.

The CCG is committed to making sure that equality and diversity is a priority when planning and commissioning local health care. To do this it works closely with its localities to understand their needs and how best to commission the most appropriate services to meet those needs.

The CCG has met the Specific Equality Duty by publishing equality information in accordance with section 149 of the Equality Act, further details of which are available at: www.cumbriaccg.nhs.uk/about-us/equality/index.aspx
The CCG is a member of the Cumbria Equality Consortium, which includes a range of public sector and third sector organisations. Member organisations are committed to embedding equality and diversity across the whole of their organisations and share the following equality aims with delivery partners, third sector and community organisations:

- To identify equality priorities
- Provide practical advice and guidance
- Challenge member organisations in their efforts to continually improve.

At the end of March 2014 the male and female breakdown of the CCG was:

<table>
<thead>
<tr>
<th>Body</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Body</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Membership Body</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The CCG is unable to quantify the number of males and females as the membership body is made up of GP Practice representatives which vary from meeting to meeting</td>
<td></td>
</tr>
<tr>
<td>CCG</td>
<td>27</td>
<td>82</td>
</tr>
<tr>
<td>Very Senior Managers</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

### 3.10 Pension Liabilities

Details of how the CCG manages pension liabilities can be found in section 5.5 of the Annual Accounts and Governance Statement.

### 3.11 Sustainability and the Environment

The CCG is committed to promoting environmental sustainability through our actions as a corporate body as well as a commissioner.

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

The CCG have not yet quantified plans to reduce carbon emissions and improve our environmental sustainability. However, covering a county of 2,613 square miles, the biggest direct impact that the CCG can make relates to travel. The CCG is working to minimise journeys and encourages sustainable travel wherever possible in order to reduce the carbon footprint.
Buildings occupied by the CCG are, in the main, owned by NHS Property Services and Cumbria Partnership NHS Foundation Trust. The CCG will be working with these two bodies to ensure that there are robust plans in place to reduce the carbon footprint in line with the recommendations of the Sustainability Development Unit of NHS England.

Where feasible the CCG monitors energy use and encourages staff to be energy efficient. Measures introduced include:

- Thermostatic controlled valves on radiators
- Energy efficient lighting
- Waste management systems for recycling.

Sustainability development monitoring is still being developed.

### 3.12 Emergency Preparedness

The CCG has incident response plans in place which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The CCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

Overall responsibility for emergency preparedness lies with NHS England, and the Cumbria, Northumberland, Tyne and Wear (CNTW) Area Team is therefore responsible for co-ordination of the health response in the event of a major incident.

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 must ensure that contracts with its provider organisations contain relevant emergency preparedness, resilience and response elements.

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.
3.13 Cost Allocation & 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.

3.14 Audit Services
The external auditor appointed by the CCG is:
Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

Services commissioned for 2013/14 were:
- External audit services for NHS Cumbria CCG at a cost of £116,000 and,
- Further work (commissioned at a national level) at a cost of £3,900 – this comprised of a year-end workshop and conflict of interest workshop.

3.15 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 Chief Officer’s Statement of Section 5 - The Annual Accounts and Governance Statement.

3.16 Disclosure to Auditors
At the time this Members’ Report was approved each member, detailed above, confirmed the following:

So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group’s external auditor is unaware; and,

That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group’s auditor is aware of that information.
The Remuneration Committee, established in accordance with NHS Cumbria CCG constitution, held its inaugural meeting on 24 April 2013. It is a non-executive committee of the Governing Body. The remit for the committee is to make recommendations to the Governing Body on the appropriate remuneration and terms of service for the Clinical Chair, Clinical Vice-Chair, GP’s with a CCG role, Chief Officer, Chief Finance Officer and other Very Senior Managers including:

- All aspects of salary
- Provision of other benefits e.g. car allowances
- Advice on and oversight of appropriate contractual arrangements including termination payments, taking into account national guidance.

The Committee membership is as follows:

<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>
</tbody>
</table>
Please note

The Committee meeting dates during 2013/14:

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Members</th>
<th>Attendance</th>
<th>Nature of advice or services</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 April 2013</td>
<td>Peter Scott, Jon Rush, Les Hanley</td>
<td>Hugh Reeve, Nigel Maguire</td>
<td>Present agenda item, Present agenda item</td>
</tr>
<tr>
<td>26 June 2013</td>
<td>Peter Scott, Jon Rush, Les Hanley</td>
<td>Hugh Reeve, Janine Lutz</td>
<td>Present agenda item, HR Advice and support</td>
</tr>
<tr>
<td>9 September 2013</td>
<td>Peter Scott, Jon Rush, Les Hanley</td>
<td>Janine Lutz</td>
<td>HR Advice and support</td>
</tr>
<tr>
<td>5 December 2013</td>
<td>Peter Scott, Jon Rush, Les Hanley</td>
<td>Hugh Reeve, Janine Lutz, Brenda Thomas</td>
<td>Present agenda item, HR Advice and support, Committee Administration</td>
</tr>
</tbody>
</table>

Janine Lutz, Head of Human Resources, North of England Commissioning Support Unit (NECSU) has attended the meetings in an advisory capacity on good HR practice and employment legislation.
4.1 Policy on Remuneration of Senior Managers

The Committee agreed that in recommending remuneration any decision needs to be fair and justifiable, based on evidence and recognising the size and complexity of NHS Cumbria CCG. The principles adopted by the Remuneration Committee were to ensure that the CCG was in a position to attract and retain senior officers; salary levels needed to be fair and justifiable taking into account the previous level of experience of post holders at this level; application of appropriate promotional increases to new appointees whilst recognising 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 2013/14 to the payment of senior managers’ Performance Related Pay.

Policy on Senior Managers Contracts

Very Senior Manager (VSM) contracts of employment apply to the Chief Officer and Chief Finance Officer. All other Directors attract the national Agenda for Change terms and conditions of employment. The CCG has specific GP Contracts for service and employment. Details are given below the contractual summary of VSM and other senior manager contracts, notice periods and termination payments.
## Senior Managers Service Contracts

<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></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 (GP Lead Role)</td>
<td>1 April 2013</td>
<td>31 January 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr David Rogers (Medical Director)</td>
<td>1 February 2013</td>
<td>6 months’ notice</td>
<td>Redundancy payment if applicable</td>
<td></td>
</tr>
<tr>
<td>Dr Fayyaz Chaudhri (left GP Lead role 31 March 2013)</td>
<td>1 April 2013</td>
<td>30 September 2015</td>
<td></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></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)</td>
<td>1 February 2014</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigel Maguire</td>
<td>1 April 2013</td>
<td>6 months’ notice</td>
<td></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>
</tbody>
</table>

## Payments to past Senior Managers

No payments have been made to past senior managers in 2013/14.
Salaries & 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>Start Date</th>
<th>Leaving Date</th>
<th>Salary (bands of £5,000)</th>
<th>Taxable Benefits</th>
<th>Annual Performance Related Bonuses (bands of £5,000)</th>
<th>Long-term Performance Related Bonuses (bands of £5,000)</th>
<th>All Pension Related Benefits (bands of £2,500)</th>
<th>Total (bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governor Body Members</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nigel Maguire</td>
<td>Chief Officer</td>
<td>01-Apr-13</td>
<td></td>
<td>135-140</td>
<td>5,500</td>
<td></td>
<td></td>
<td></td>
<td>122.5-125</td>
</tr>
<tr>
<td>Charles Welbourn</td>
<td>Chief Finance Officer</td>
<td>01-Apr-13</td>
<td></td>
<td>110-115</td>
<td>7,900</td>
<td></td>
<td></td>
<td></td>
<td>15-17.5</td>
</tr>
<tr>
<td>Dr Hugh Reeve</td>
<td>Clinical Chair</td>
<td>01-Apr-13</td>
<td></td>
<td>115-120</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>375-377.5</td>
</tr>
<tr>
<td>Ruth Gildert</td>
<td>Clinical Member: Nurse</td>
<td>01-Apr-13</td>
<td></td>
<td>10-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10-15</td>
</tr>
<tr>
<td>Dr Anthony Woodyer</td>
<td>Clinical Member: Secondary Care Clinician</td>
<td>01-Apr-13</td>
<td></td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5-10</td>
</tr>
<tr>
<td>Les Hanley</td>
<td>Lay Member: Health Improvement</td>
<td>01-Apr-13</td>
<td></td>
<td>10-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10-15</td>
</tr>
<tr>
<td>Peter Scott</td>
<td>Lay Member: Finance &amp; Governance</td>
<td>01-Apr-13</td>
<td></td>
<td>15-20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15-20</td>
</tr>
<tr>
<td>Jon Rush</td>
<td>Lay Member: Public Engagement</td>
<td>01-Apr-13</td>
<td></td>
<td>10-15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>10-15</td>
</tr>
<tr>
<td>Dr Geoff Jolliffe</td>
<td>Lead GP (South) / GP Lead: Furness</td>
<td>01-Apr-13</td>
<td></td>
<td>60-65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>55-60</td>
</tr>
<tr>
<td>Dr David Rogers</td>
<td>Lead GP (North) / GP Lead: Copeland / Medical Director 1.2</td>
<td>01-Apr-13</td>
<td></td>
<td>115-120</td>
<td>200</td>
<td></td>
<td></td>
<td></td>
<td>300-302.5</td>
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<tr>
<td><strong>Other Senior Managers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Peter Rooney</td>
<td>Director of Strategic Planning &amp; Performance</td>
<td>01-Apr-13</td>
<td></td>
<td>80-85</td>
<td>4,700</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Anthony Gardner</td>
<td>Network Director</td>
<td>01-Apr-13</td>
<td></td>
<td>100-105</td>
<td>7,500</td>
<td></td>
<td></td>
<td></td>
<td>22.5-55</td>
</tr>
<tr>
<td>Caroline Rea</td>
<td>Network Director</td>
<td>01-Apr-13</td>
<td></td>
<td>100-105</td>
<td>6,700</td>
<td></td>
<td></td>
<td></td>
<td>20-22.5</td>
</tr>
<tr>
<td>Laura Carr</td>
<td>Lead Nurse (Quality &amp; Safety) / Clinical Director for Mental Health</td>
<td>01-Apr-13</td>
<td></td>
<td>75-80</td>
<td>6,200</td>
<td></td>
<td></td>
<td></td>
<td>(853)-(87.5)</td>
</tr>
<tr>
<td>Diane Eden</td>
<td>Programme Director: Long Term Conditions &amp; Primary Care</td>
<td>01-Apr-13</td>
<td>28-Sept-13</td>
<td>35-40</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>20-22.5</td>
</tr>
<tr>
<td>Dr Tom Ickes</td>
<td>GP Lead: Copeland</td>
<td>01-Feb-14</td>
<td></td>
<td>5-10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5-10</td>
</tr>
<tr>
<td>Dr Rachel Preston</td>
<td>GP Lead: Eden</td>
<td>01-Apr-13</td>
<td></td>
<td>60-65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15-17.5</td>
</tr>
<tr>
<td>Dr Fayyaz Chaudri</td>
<td>GP Lead: Allerdale</td>
<td>01-Apr-13</td>
<td>30-30-Sep-13</td>
<td>30-35</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0-2.5</td>
</tr>
<tr>
<td>Dr Niall McGreevy</td>
<td>GP Lead: Allerdale</td>
<td>01-Oct-13</td>
<td></td>
<td>35-40</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>35-40</td>
</tr>
<tr>
<td>Dr Colin Patterson</td>
<td>GP Lead: Carlisle</td>
<td>01-Apr-13</td>
<td></td>
<td>60-65</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>15-17.5</td>
</tr>
<tr>
<td>Dr Alistair MacKenzie</td>
<td>GP Lead: South Lakes</td>
<td>01-Apr-13</td>
<td></td>
<td>45-50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>190-192.5</td>
</tr>
</tbody>
</table>

1. David Rogers was lead GP North representative of the Governing Body until he was appointed Medical Director wef 1st February; a process has commenced to appoint a replacement in accordance with the CCG’s constitution.
2. David Rogers was appointed Medical Director wef 1st February 2014 and Tom Ickes took over the GP Lead role for Copeland Locality.
3. Diane Eden left 28th September 2013 and following a managerial review the post was removed from the management structure.
4. Fayyaz Chaudhri stepped down wef 30th September 2013 and Niall McGreevy 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 Fayyaz for April to June and then he was paid via payroll. Service Level Agreement payments to James St Group Practice for Niall’s services as GP Lead.
5. Taxable benefits of lease car.
6. The amount included here in the annual increase in pension entitlement and not actual remuneration received by individual during the year. This is a notional figure calculated by a formula directed by the CCG Annual Reporting Guidance based on figures provided by the NHS Pensions Agency.

The content of this Table has been 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

The content of this Table has been audited by our external auditor.

Certain members do not receive pensionable remuneration and there are no entries in respect of pensions for those 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 pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Pay Multiples

The banded remuneration of the highest paid member of the Governing Body in the clinical commissioning group in the financial year 2013-14 was £142.5k. This was 3.5 times the median remuneration of the workforce, which was £41k.

In 2013-14 one employee received remuneration in excess of the highest paid member of the Governing Body. Remuneration packages ranged from £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

There were no off pay-roll engagements during the year ended 31 March 2014.

4.2 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 or conflicts.

Part 5: Annual Accounts and Governance Statement 2013/14
<table>
<thead>
<tr>
<th>Note</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement of the Accountable Officer’s Responsibilities</td>
<td>i</td>
</tr>
<tr>
<td>Annual Governance Statement</td>
<td>ii-xii</td>
</tr>
<tr>
<td>Independent Auditor’s Report</td>
<td>xiii-xv</td>
</tr>
</tbody>
</table>

### The Primary Statements:

<table>
<thead>
<tr>
<th>Description</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement of Comprehensive Net Expenditure for the year ended 31 March 2014</td>
<td>1</td>
</tr>
<tr>
<td>Statement of Financial Position as at 31 March 2014</td>
<td>2</td>
</tr>
<tr>
<td>Statement of Changes in Taxpayers’ Equity for the year ended 31 March 2014</td>
<td>3</td>
</tr>
<tr>
<td>Statement of Cash Flows for the year ended 31 March 2014</td>
<td>4</td>
</tr>
</tbody>
</table>

### Notes to the Accounts:

<table>
<thead>
<tr>
<th>Description</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounting policies</td>
<td>5-9</td>
</tr>
<tr>
<td>Financial performance duties</td>
<td>10</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>10</td>
</tr>
<tr>
<td>Revenue</td>
<td>10</td>
</tr>
<tr>
<td>Employee benefits and staff numbers</td>
<td>10-12</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>13</td>
</tr>
<tr>
<td>Better payment practice code</td>
<td>13</td>
</tr>
<tr>
<td>Operating leases</td>
<td>14</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>14-15</td>
</tr>
<tr>
<td>Cash</td>
<td>15</td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>15</td>
</tr>
<tr>
<td>Provisions</td>
<td>15</td>
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</table>

### Other Notes:

<table>
<thead>
<tr>
<th>Description</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingencies</td>
<td>16</td>
</tr>
<tr>
<td>Commitments</td>
<td>16</td>
</tr>
<tr>
<td>Financial instruments</td>
<td>16-17</td>
</tr>
<tr>
<td>Operating segments</td>
<td>17</td>
</tr>
<tr>
<td>Events after the end of the reporting period</td>
<td>17</td>
</tr>
<tr>
<td>Pooled budgets</td>
<td>17</td>
</tr>
<tr>
<td>Intra-government and other balances</td>
<td>17</td>
</tr>
<tr>
<td>Related party transactions</td>
<td>18</td>
</tr>
<tr>
<td>Losses and special payments</td>
<td>18</td>
</tr>
<tr>
<td>Impact of IFRS</td>
<td>18</td>
</tr>
</tbody>
</table>
STATEMENT OF THE ACCOUNTABLE OFFICER’S RESPONSIBILITIES

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

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

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

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

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

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

Nigel Maguire
Accountable Officer

4 June 2014
Annual Governance Statement by the Accountable Officer

Introduction & Context
The 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.

The CCG operated in shadow form prior to 1 April 2013 to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the CCG taking on its full powers.

As at 1 April 2013, the CCG was licensed without conditions.

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

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

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

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 the Accountable Officer I worked with the Membership, Governing Body and CCG officers to ensure that NHS Cumbria’s Constitution was created in line with the accepted principles of good governance and the CCG’s vision to commission safe, secure, high quality services across Cumbria and reduce inequalities across the whole healthcare system.

As well as defining the CCG’s governance arrangements the Constitution also defines the
Membership (specifying all 82 Member Practices), who the CCG is accountable to and the CCG’s functions and general duties. It is the responsibility of all the CCG employees, Member Practices, Governing Body, its committees, sub-committees and anyone else acting on behalf of the Group to ensure compliance with the Constitution. As a whole, the CCG works 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 Council has specific responsibility for:

- Approving the CCG’s Constitution and proposed changes to the constitution
- The arrangements for members joining and leaving the CCG
- The arrangements for appointment of the Clinical Chair and Chief Officer (Accountable Officer)
- Ensuring the publication of the Annual Report and Accounts by the Governing Body

The membership is comprised of a representative from each of the 82 GP member practices which cover the whole of Cumbria and 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 the last year the Full Council of Members has met to approve the changes to the CCG’s governance arrangements prior to submission to NHS England for approval in July 2013.

<table>
<thead>
<tr>
<th>Attendance at Full Council of Members 2013/14:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>82</td>
</tr>
<tr>
<td>Total number of meetings held</td>
<td>1</td>
</tr>
<tr>
<td>% attendance</td>
<td>56%</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 delivery of better outcomes
- Develops constructive and meaningful relationships with its partners and stakeholders in order to deliver high quality, continuously improving services.

It also provides assurance that the CCG is compliant with its statutory obligations and that it meets the key national requirements for governance in order to be a public organisation. The Governing Body 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 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 is 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 Vice-Chair, GP’s with a CCG role, Chief Officer, Chief Finance Officer and other Very Senior Managers (VSM).
The Governing Body membership consists of Clinical Chair (Chair), Chief Officer, Chief Finance Officer, Lead GP for the north of the County, Lead GP for the south of the County, Lay Member for Finance & Governance (Vice-Chair), Lay Member for Public & Patient Engagement, Lay Member for Health & Innovation, CCG’s Registered Nurse and the CCG’s Secondary Care Specialist Doctor. Initially there was a Local Authority representative. However, after independent advice from North of England Commissioning Support Unit, the Local Authority representative was removed from the membership of the Governing Body and is now in attendance only. The Local Medical Committee has observer status which was also extended to Cumbria Healthwatch once it had re-formed.

Assurance in support of the above responsibilities has been regularly presented to the Governing Body in the following key areas:

- PCT handover documents and associated action plan
- Quality reports identifying issues in provision of services and detailing actions taken to mitigate risks
- Performance reports including highlighting risks in key performance areas, where they are occurring and action plans put in place to mitigate risk
- Monthly finance update reports which details expenditure to date, areas of concern, actions being taken to mitigate risk
- Francis Report and associated action plan
- Keogh Review and associated action plan
- Winterbourne View and associated action plan.

In addition the Governing Body has considered specific issues concerning the review of services at University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT) and the better care together programme and the ongoing review of Children’s Services in Cumbria.
Committees of the Governing Body

NHS Cumbria CCG Executive (Clinical Leads Group) - The Clinical Leads Group is constituted to enable senior commissioning clinicians to provide an overarching shared clinical direction to the whole organisation. Its primary function provides a forum for the CCG clinical leads to determine clinical strategies and advise the Governing Body, provide clinical oversight to major strategic programmes (e.g. Primary Care, Cancer), enable appropriate peer challenge, support and joint problem solving and learning between localities and to ensure a formal peer review system is developed and implemented. In particular it:

- Leads the development of the county-wide vision and strategy
- Tackles health inequalities across Cumbria assessing the extent to which inequalities are being reduced and quality and outcomes are improving
- Supports the development county-wide commissioning plans and standards
- Supports the management of the overall CCG clinical and financial performance against plans
- Oversees service and pathway redesign where this takes place across the county or a number of Localities
- Ensures the quality of services commissioned from providers is of a high quality and continuously improving
- Ensures that process and compliance issues for all serious incidents and ‘never events’ are met and that complaints are effectively responded to with lessons learnt built into the commissioning strategy
- Co-ordinates the delivery of effective safeguarding arrangements
- Maintains effective relationships with county-wide partners, providers and key stakeholders across Cumbria and NHS England.
- Considers business cases for investment in county-wide schemes
- Provides an informal opportunity to arbitrate in disputes between Localities
- Manages Cumbria-wide strategic risks
- Manages the continuing care budget and other county-wide risk budgets on behalf of the Localities
- Responds to decisions on specialised commissioning made by NHS England.

<table>
<thead>
<tr>
<th>Attendance at Governing Body 2013/14:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
</tr>
<tr>
<td>Total number of meetings held</td>
</tr>
<tr>
<td>% attendance</td>
</tr>
</tbody>
</table>

(Note: average membership with removal of Local Authority Representative)
The membership of the Committee consists of the CCG Clinical Chair, six GP leads elected by each Locality, Clinical Director - Children & Families, Interim Clinical Director of Innovation and Integration, Lead Nurse - Quality & Safety, Chief Officer, Chief Finance Officer, the Locality Network Directors and the Director of Planning & Performance. In addition, when necessary, there are a number of additional clinicians and officers in attendance to provide additional expertise on specific agenda items.

Its main focus of work in 2013/14 has been supporting the CCG through the transition process and ensuring safeguarding improvements are being implemented for both vulnerable adults and children. The Committee has also paid particular attention to the improvement of care within the three main Provider Trusts in Cumbria which have faced a number of significant issues during 2013/14. Another key objective this year has been to highlight and address growing concerns regarding resources both in the hospital and Primary Care systems.

<table>
<thead>
<tr>
<th>Attendance at Cumbria executive (Clinical Leads Group) 2013/14:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
</tr>
<tr>
<td>Total number of meetings held</td>
</tr>
<tr>
<td>% attendance</td>
</tr>
</tbody>
</table>

**Locality Executives** - The CCG has six Locality Executives: Allerdale, Carlisle, Copeland, Eden, Furness, and South Lakes. Each Locality Executive (which is accountable to the Governing Body) is responsible for leading the setting of the Locality vision and strategy, developing Locality commissioning plans, driving improvements in quality and outcomes and reducing inequalities. A key area for the localities is engaging with patients, communities and third sector organisations and maintaining effective relationships with partners, providers and key stakeholders in the Locality.

The membership of each Locality consists of the elected GPs for the locality (NB 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, there are nine in Copeland, there are six in Allerdale), the Network Director and Senior Commissioning Lead for that Locality.
The Governing Body receives assurance of work being undertaken by the Localities through the receipt of the locality minutes. Presentations have also been made to members of both the Governing Body and the Cumbria Executive detailing how commissioning functions are being undertaken and how each locality is monitoring and addressing issues in provision of health care locally.

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

### Attendance at Locality Executive Meetings 2013/14:

<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>8</td>
<td>7</td>
<td>11</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Total number of</td>
<td>12</td>
<td>11</td>
<td>12</td>
<td>12</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>meetings held</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% attendance</td>
<td>74%</td>
<td>83%</td>
<td>74%</td>
<td>83%</td>
<td>82%</td>
<td>79%</td>
</tr>
</tbody>
</table>

### Audit Committee

- The Audit Committee (which is accountable to the Governing Body) provides the Governing Body with an independent and objective view of the CCG’s financial systems, financial information and compliance with laws, regulations and directions governing the CCG finances. It also reviews the effectiveness of the system of governance including the Standing Orders, Reservation and Delegation of Powers and Prime Financial Polices, CCG Polices, 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 the Lay Member for Finance and Governance (Chair), the Lay Member for Public & Patient Engagement and the Lay Member for Health & Innovation. 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).

### Attendance at Audit Committee 2013/14:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>3</td>
</tr>
<tr>
<td>Total number of</td>
<td>3</td>
</tr>
<tr>
<td>meetings held</td>
<td></td>
</tr>
<tr>
<td>% attendance</td>
<td>100%</td>
</tr>
</tbody>
</table>
Remuneration Committee - The Remuneration Committee (which is accountable to the Governing Body) considers and makes recommendations to the Governing Body on the determination of salaries and conditions 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 role includes:

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

The membership consists of the Lay Member for Finance and Governance (Chair); Lay Member, Public & Patient Engagement and Lay Member, Health & Innovation. In support of the membership of the Committee the following officers are in attendance: Head of Human Resources (North of England Commissioning Support) and the Clinical Chair (as required).

Work coverage to date has included the consideration of the remuneration of the following posts: The CCG’s Clinical Chair; Chief Officer; Chief Finance Officer; and Medical Director.

<table>
<thead>
<tr>
<th>Attendance at Remuneration Committee 2013/14:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
</tr>
<tr>
<td>Total number of meetings held</td>
</tr>
<tr>
<td>% attendance</td>
</tr>
</tbody>
</table>
Outcomes & Quality Assurance Committee - This Committee (which is accountable to the Governing Body) was initially established to support and focus on innovation and integration and ensure that the CCG was achieving its core aim of improving health and reducing health inequalities and ensuring quality services were being provided to the patients in Cumbria. However, as detailed in the PCT handover documents, the CCG inherited a wide range of issues in terms of the quality of health care provision in Cumbria. As a result this Committee was re-focused to examine, in detail, the areas of concern and monitor how improvements were being achieved.

There has been a high volume of work undertaken by this Committee to ensure that the assurance to the Governing Body is robust in terms of the Quality report and to ensure progress and improvements are made in the provision of health care across Cumbria.

The membership consists of the Lay Member with responsibility for Health Improvement (Chair), the Governing Body registered nurse, the Governing Body secondary care specialist doctor, the GP Lead for quality, the Network Director with lead responsibility for quality, the Lead Nurse - Quality & Safety, the Quality and Safety Manager and the Clinical Pharmacy Lead.

The coverage of work includes monitoring infection control issues, the Winterbourne View report and associated action plan, outcomes from the Care Quality Commission review, non-medical prescribing medicines, Cumbria Area Prescribing Committee Terms of Reference, outcomes of Hospital site visits and commissioning issues raised by the findings of external reports.

<table>
<thead>
<tr>
<th>Attendance at Outcomes and Quality Assurance Committee 2013/14:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
</tr>
<tr>
<td>Total number of meetings held</td>
</tr>
<tr>
<td>% attendance</td>
</tr>
</tbody>
</table>

Interim Finance Committee - In September 2013 the Governing Body approved the creation of an Interim Finance Committee (which is accountable to the Governing Body). The remit of this Committee was to consider the in-depth and performance issues facing the CCG and provide additional assurance to the Governing Body.

The membership consists of the CCG Clinical Chair (Chair), Chief Officer, Chief Finance Officer, Director of Planning and Performance and the three Lay Members. All other Governing Body members are also invited to attend.
The minutes of all the above committees are submitted to the Governing Body.

The key relationships between the constitutional committees, which are critical to NHS Cumbria CCG’s delivery is set out below:
Review of Governance Arrangements

As Accountable Officer I considered it prudent after six months to review and seek assurance that the governance arrangements were in line with the CCG’s objectives and current working practices. With the support of the Governing Body I procured the Company Secretary of North of England Commissioning Support to undertake an independent review which commenced in September 2013. This included ensuring our working practices were aligned to the CCG’s Constitution, Standing Orders, Reservation and Delegation of Powers and Prime Financial Policies.

A total of 34 recommendations were made from the Governance review which ranged from minor operational issues to some suggested changes to the current committee structures. As a result, and in order to ensure there was clarity of responsibilities across the organisation, a draft ‘NHS Cumbria CCG Working Arrangements’ document was created. On the 5 December 2013 a development session was held for the Governing Body to consider the outcomes of the review, discuss its performance to date and consider the draft ‘Working Arrangements’ document with a view to improving the governance arrangements of the CCG. This document was subsequently approved at the Governing Body on 19 December 2013 and the following committee structure will be embedded into the CCG:

- Governing Body
- Locality Executives
- Outcomes & Quality Assurance Committee
- Finance & Performance Committee
- Audit Committee
- Remuneration Committee
- Clinical Leads Group
- Director Group

In light of the above changes the CCG has drafted revised/new terms of reference (ToR’s) where required. These changes will be embedded into the CCG’s Constitution and other governance framework documents. Once independent legal advice has been sought to confirm that the CCG is legally compliant with the recommendations in the Harris Review, these will then be presented to the Governing Body, the Full Council of Members and NHS England for approval.

The CCG has also been working actively with partnership organisations and stakeholders across the whole of the Cumbrian Health Economy to ensure that, where possible, services and provision of care can be integrated to deliver higher quality care closer to home and in a more timely and cost effective manner for the benefit of patients. Further details of this are contained in the Annual Report.
The Assurance Framework and the Risk Register have been developed in consultation with the Governing Body and Directors team. A risk management development session was held in September 2013 for the Governing Body, and then a further review of the Risk Register undertaken in November 2013 to identify trends in risk potentially affecting delivery of the priority areas which also led to enhanced critical scrutiny. This work has been supplemented by direct support from North of England Commissioning Support Unit to review individual risks in detail with the Directors team. It is also noteworthy that the Governing Body has, throughout the year, received monthly reports on key operational risks and mitigating actions on the key areas of service quality, NHS constitutional target performance and financial issues. The final Risk Register and Assurance Framework have been reviewed in detail by the Audit Committee. Directors, senior managers and clinical leads will continue to review the Risk Register on an on-going basis, using the Safeguard Incident & Risk Management System (SIRMS) as a means of maintaining the information electronically. The Assurance Framework and Risk Register will be reviewed by the Governing Body bi-annually through its sub-committee structure and the assurance on the underlying processes will be provided through Audit Committee review.

The CCG has also established effective systems to support whistleblowing and for receiving and investigating complaints from staff. This is done by:

- having a confidential reporting process which clearly documents the procedure for staff to report matters of concern, which is regularly updated and communicated to staff
- having an annually updated Anti-Fraud, Theft and Corruption Policy
- maintaining an effective internal audit function
- having a clear complaints procedure
- using complaints and compliments as a positive improvement tool.

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.
**Information Governance**

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

High importance is placed on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have ensured that all staff undertake annual information governance training and have implemented a staff information IG Code of Conduct that has been issued to staff to ensure they are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We share learning of serious incidents with staff who are consistently being encouraged to apply risk assessment and management procedures when handling data. As an organisation we are currently striving to fully embed an information risk aware culture throughout.

**Pension Obligations**

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the scheme are in accordance with the scheme rules and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

**Equality, Diversity & Human Rights Obligations**

Control measures are in place to ensure that the CCG complies with the required public sector equality duty set out in the Equality Act 2010. In February 2014 further assurance on the CCG’s commitment to Equality was received when the Governing Body was asked to consider and approve the CCG’s Report ‘Ensuring Equality for All 2013/14’ which has now been published on the CCG website.

**Sustainable Development Obligations**

The CCG is required to report its progress in delivering against sustainable development indicators.

Plans are being developed to assess risks, enhance our performance and reduce our impact, including carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.
The CCG will ensure it complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012 and will be setting out our commitments as a socially responsible employer.

Risk Assessment in Relation to Governance, Risk Management & Internal Control

The CCG approach to risk management encompasses the breadth of the organisation by considering financial, organisational, and reputational and project risks, both clinical and non-clinical and for all parts of the organisation involved. The CCG was established with a Risk Register on 1 April 2013 identified as part of the corporate handover document from the former Cumbria Teaching PCT. This has been reviewed during the year taking account of risks identified from a variety of sources including:

- Quality reviews
- Agreed action plan on legacy and transition issues
- Complaints and incidents
- Internal investigations
- Internal/external audit reports
- Performance reviews
- Financial reporting
- National policy initiatives (e.g. Winterbourne View, CCG allocations).

In updating and developing the Risk Register a number of issues were identified and have been addressed through specific actions and therefore mitigated to a level where the risk is manageable in an organisation context. Therefore the principal risks at the end of the year were identified as follows:
• Non-achievement of key constitutional targets for Cumbria patients
• Quality of services for children
• The sustainability of maternity services in Cumbria
• The overall clinical and financial sustainability of local NHS provider organisations
• Effective services outside of hospital to prevent unnecessary admission to hospital services
• Safeguarding
• Effectiveness of the Child & Adolescent Mental Health Services CAHMS
• The ability to develop a sustainable 5-year commissioning plan in the context of the Cumbria Health Economy.

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 key financial targets, have been a high risk during the first year of the CCG. Key elements in managing the risk have been the implementation of the new national financial ledger, the establishment of an effective finance team, working closely with NHS England on resource allocation and co-commissioning issues, and implementing measures to reduce costs in the context of over-performance on secondary care contracts. Reports on the financial position are provided to the Governing Body and Executive Committee at each meeting with remedial action identified where necessary.

A review of the organisation’s Risk Management systems and processes, and the Assurance Framework, was undertaken by the CCG’s Internal Auditors. The objectives of the assurance framework review were to identify whether a framework had been established which was designed and operates to meet the requirements of the annual governance statement, and to provide reasonable assurance that there was an effective system of internal control to manage the principal risks identified by the organisation.

The audit review concluded that key controls had been adequately designed and were operating effectively to deliver the key objectives of the system, functions and processes. As a result, significant assurance was given that the Assurance Framework had been developed to meet the organisation’s objectives on an on-going basis.

The CCG has implemented robust procedures for its key financial systems which have been reviewed as appropriate in line with the annual audit plan and reviewed and reported to the Audit Committee.
Review of the Effectiveness of Governance, Risk Management & Internal Control

During the year the CCG has undertaken a formal governance review to ensure that at all levels management resources are aligned and focused to deliver on the CCG’s strategic objectives and the associated risks. The CCG has developed a focused organisational development programme (including use of techniques such as Rapid Process Improvement Workshops). In addition, all staff have experienced objective setting and have established personal development plans to support delivery. In addition, all staff have completed training on key operational risk related issues including information governance, standards of business conduct (e.g. bribery & fraud), health and safety and safeguarding.

Capacity to Handle Risk

During the year the CCG has undertaken a formal governance review to ensure that at all levels management resources are aligned and focused to deliver on the CCG’s strategic objectives and the associated risks. The CCG has developed a focused organisational development programme (including use of techniques such as Rapid Process Improvement Workshops). In addition, all staff have experienced objective setting and have established personal development plans to support delivery. In addition, all staff have completed training on key operational risk related issues including information governance, standards of business conduct (e.g. bribery & fraud), health and safety and safeguarding.

Review of Effectiveness

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

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the Internal Auditor and the 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. I have been advised on the implications of the result of my review by the Governing Body, the Audit Committee and the Outcomes & Quality Assurance committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.
Managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with 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 from the CCG’s internal audit throughout the year. Other sources of evidence include:

- External Audit via their Annual Audit Letter which provides a high level summary of audit work carried out
- Regular team meetings
- Reports to Audit Committee by the Local Counter Fraud Specialists
- Information Governance Toolkit submission
- Review of the Assurance Framework corporate risk register by the CCG Governing Body and Audit Committee
- Regular meetings with Area Team (Quality Surveillance Groups/Quarterly checkpoints)
- Attendance at the main providers of acute, community and mental health services quality committees/meetings
- Outcome of the Authorisation Process which resulted in the CCG being authorised without conditions.

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issues an independent and objective opinion on the adequacy and effectiveness of the CCG system of risk management, governance and internal control. The Head of internal Audit concluded 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/or inconsistent application of controls, put the achievement of particular objectives at risk.”

During the year the Internal Audit issued the following audit reports with a conclusion of limited assurance:

“Contracts and SLAs – non-healthcare services: Limited re what is in place; Significant re process to finalise and put in”

“IT operational security – Q4 Server Configurations”

There were no conclusions issued by the Internal Audit during the year of no assurance.
**Business Critical Models & Data Quality**

The CCG has undertaken work to ensure all business critical models have been identified and that associated data quality assurance issues are addressed to ensure that the CCG is able to function effectively. It is noteworthy that the majority of such models are provided externally to the CCG and therefore the CCG also seeks formal assurance of the effectiveness of the controls environment from those system providers. While the CCG acknowledges that data quality is robust at the CCG Governing Body level it will continue to work to improve systems and data quality to enhance work at a locality level.

**Data Security**

Information Governance (IG) is the framework for which information, in particular personal identifiable data of patients, staff and corporate information, is handled in a confidential, secure, ethical and legal manner. The CCG provides formal assurance of its compliance with Information Governance requirements annually through the Information Governance Toolkit (IGT). We have submitted a satisfactory level of compliance (level 2) with the information governance toolkit assessment.

The CCG recognises the importance of appropriately managing information and keeping it secure. Information Governance feeds into the Executive Committee as part of the CCG Integrated Governance structure. The CCG’s Chief Finance Officer has executive responsibility for Information Governance and is the Senior Information Risk Officer (SIRO) with responsibility for ensuring that information risk is assessed and managed within the organisation.

The CCG is continually reviewing its information governance provision to ensure it provides excellence to its staff, patients, suppliers, partners, local community and the wider NHS.

Until the 31 March 2014 the GP Lead for SUI’s was the Caldicott Guardian for the CCG. These duties transferred to the Medical Director on 1 April 2014. 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 NHS Cumbria CCG are individually responsible for making their own IGT submission. This is monitored by the Information Governance Department.

As a result of high profile data breaches nationally and the CCG’s commitment to embed the IG agenda across the CCG, staff awareness of the importance of reporting all information security incidents has been raised. This has resulted in the CCG being aware of a number of minor breaches in provider organisations and these have been communicated appropriately to the relevant organisations.
Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG and explained within the Corporate Governance Framework were developed to ensure compliance with all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG’s statutory duties.

Conclusion

A system of internal control has been in place in the CCG for the year ended 31 March 2014, and up to the date of approval of the annual report and accounts. Based on the work undertaken in 2013/14, 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.

Nigel Maguire
Accountable Officer

4 June 2014
INDEPENDENT AUDITOR’S REPORT
TO THE MEMBERS OF NHS CUMBRIA
CLINICAL COMMISSIONING GROUP (CCG)
We have audited the financial statements of NHS Cumbria CCG for the year ended 31 March 2014 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 approval of the Secretary of State.

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 office holders together with the related narrative notes on page 29;
- table of pension benefits and related narrative notes on page 30; and
- narrative notes on the pay multiple on page 31.

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 as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of the Accountable officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG’s circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the CCG; 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 Member Practices’ Introduction, Strategic Report, Members’ report, Remuneration report, Statement of Accountable Officer responsibilities, and 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.

**Opinion on regularity**

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

**Opinion on financial statements**

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Cumbria CCG as at 31 March 2014 and of its net operating costs for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

**Opinion on other matters**

In our opinion the:

- part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State; and

- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we report by exception**

We report to you if:

- in our opinion the governance statement does not reflect compliance with NHS England’s Guidance;

- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or

- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.
Conclusion on the CCG’s arrangements for securing economy, efficiency and effectiveness in the use of resources

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 any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

• our review of the Governance Statement; and
• the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the CCG.

As a result, we have concluded that there are no matters to report.

Certificate

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

Karen Murray
Director - for and on behalf of Grant Thornton UK LLP, Appointed Auditor
4 Hardman Square
Spinningfields
Manchester
M3 3EB

5 June 2014
### Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

<table>
<thead>
<tr>
<th></th>
<th>Note</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Administration Costs and Programme Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross employee benefits</td>
<td>5</td>
<td>6,029</td>
</tr>
<tr>
<td>Other costs</td>
<td>6</td>
<td>671,024</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>3</td>
<td>(1,781)</td>
</tr>
<tr>
<td><strong>Net operating costs for the financial year</strong></td>
<td></td>
<td><strong>675,272</strong></td>
</tr>
</tbody>
</table>

Of which:

**Administration Costs**

<table>
<thead>
<tr>
<th></th>
<th>Note</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross employee benefits</td>
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<td>5,590</td>
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<tr>
<td>Other costs</td>
<td>6</td>
<td>6,408</td>
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<tr>
<td>Other operating revenue</td>
<td>3</td>
<td>(100)</td>
</tr>
<tr>
<td><strong>Net administration costs</strong></td>
<td></td>
<td><strong>11,898</strong></td>
</tr>
</tbody>
</table>

**Programme Expenditure**

<table>
<thead>
<tr>
<th></th>
<th>Note</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross employee benefits</td>
<td>5</td>
<td>439</td>
</tr>
<tr>
<td>Other costs</td>
<td>6</td>
<td>664,616</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>3</td>
<td>(1,681)</td>
</tr>
<tr>
<td><strong>Net programme expenditure</strong></td>
<td></td>
<td><strong>663,374</strong></td>
</tr>
</tbody>
</table>

**Total comprehensive net expenditure for the financial year**

|                                |      | **675,272**  |

The notes 1-8 on pages 5-14 form part of this statement.
## Statement of Financial Position as at 31 March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>9</td>
</tr>
<tr>
<td>Cash</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total Assets Employed</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Financed by Taxpayers’ Equity**
- General fund | (29,945)
- **Total taxpayers’ equity:** | (29,945)

The notes 9-22 on pages 14-18 form part of this statement.

The financial statements on pages 1 to 4 were approved by the Governing Body on 4 June 2014 and signed on its behalf by:

**Nigel Maguire**  
Accountable Officer
### Statement of Changes In Taxpayers’ Equity for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted CCG balance at 1 April 2013</td>
<td>-</td>
</tr>
<tr>
<td>Changes in CCG taxpayers’ equity for 2013-14</td>
<td>(675,272)</td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(675,272)</td>
</tr>
<tr>
<td>Net Recognised CCG Expenditure for the Financial Year</td>
<td>645,327</td>
</tr>
<tr>
<td>Net funding</td>
<td>645,327</td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>(29,945)</td>
</tr>
</tbody>
</table>

### Statement of Cash Flow for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(675,272)</td>
</tr>
<tr>
<td>Increase in trade &amp; other receivables</td>
<td>(3,639)</td>
</tr>
<tr>
<td>Increase in trade &amp; other payables</td>
<td>33,591</td>
</tr>
<tr>
<td><strong>Net Cash Outflow from Operating Activities</strong></td>
<td>(645,320)</td>
</tr>
<tr>
<td><strong>Net Cash Outflow before Financing</strong></td>
<td>(645,320)</td>
</tr>
<tr>
<td><strong>Cash Flows from Financing Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Net funding received</td>
<td>645,327</td>
</tr>
<tr>
<td><strong>Net Cash Inflow from Financing Activities</strong></td>
<td>645,327</td>
</tr>
<tr>
<td><strong>Net Increase in Cash</strong></td>
<td>7</td>
</tr>
<tr>
<td><strong>Cash at the Beginning of the Financial Year</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Cash at the End of the Financial Year</strong></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 2013/14 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.

In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

The accounting arrangements for balances transferred from predecessor PCTs (“legacy” balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG was nil as no legacy balances were transferred to the CCG. The CCG’s arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 12 to these financial statements.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the Financial Statements are prepared on the going concern basis.
1.2 Accounting Convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Acquisitions and Discontinued Operations
Activities are considered to be ‘acquired’ only if they are acquired from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

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

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

For transfers of assets and liabilities from those NHS bodies that closed on 31 March 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.5 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.

1.6 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.

1.6.1 Critical Judgements in Applying Accounting Policies

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

• Determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets;
• Due to the high turnover of consumables and the low value, the clinical commissioning group does not value inventories on the Statement of Financial Position but charges all items directly to the Operating Cost Statement when purchased.

1.6.2 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:

• Impairment of Receivables: details of the clinical commissioning group’s policy are disclosed in note 9.2
• Provisions/Contingencies: 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.

1.7 Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

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

1.8 Employee Benefits

1.8.1 Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the 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.

1.9 Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.
1.10 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The Clinical Commissioning Group as Lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate 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.

1.11 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.

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%
When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

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

1.13 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.

1.14 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.

1.15 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.
1.16 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.16.1 Financial Assets at Fair Value Through Profit and Loss

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

1.16.2 Held to Maturity Assets

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

1.16.3 Available For Sale Financial Assets

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

1.16.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise in accordance with generally accepted pricing models based on discounted cash flow analysis.

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

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

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

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

1.17 Financial Liabilities

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

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

1.17.1 Financial Guarantee Contract Liabilities

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

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.
1.17.2 Financial Liabilities at Fair Value Through Profit and Loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group’s surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

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

1.18 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.

1.19 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 including losses which would have been made good through insurance cover had clinical commissioning groups not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 Joint Operations
Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.
1.21 Accounting Standards that have been issued but have not yet been adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013/14, all of which are subject to consultation:

- IAS 27 Separate Financial Statements
- IAS 28 Investments in Associates and Joint Ventures
- IAS 32 Financial Instruments - Presentation (amendment)
- IFRS 9 Financial Instruments
- IFRS 10 Consolidated Financial Statements
- IFRS 11 Joint Arrangements
- IFRS 12 Disclosure of Interests in Other Entities
- IFRS 13 Fair Value Measurement.

The application of the Standards as revised would not have a material impact on the accounts for 2013/14, were they applied in that year.

2. Financial performance duties

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 in 2013/14 was as follows:

<table>
<thead>
<tr>
<th>NHS Act Section Duty</th>
<th>Maximum £000</th>
<th>Performance £000</th>
<th>Duty Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>223H (1) Expenditure not to exceed income</td>
<td>685,538</td>
<td>677,053</td>
<td>Yes</td>
</tr>
<tr>
<td>223I (2) Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>223I (3) Revenue resource use does not exceed the amount specified in Directions</td>
<td>683,757</td>
<td>675,272</td>
<td>Yes</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>
<td>Yes</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>
<td>Yes</td>
</tr>
<tr>
<td>223J (3) Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>12,800</td>
<td>11,898</td>
<td>Yes</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 2013/14 and incurred no capital expenditure.

3. Other operating revenue

<table>
<thead>
<tr>
<th>Charitable and other contributions to revenue expenditure: non-NHS</th>
<th>2013-14 Total £000</th>
<th>2013-14 Admin £000</th>
<th>2013-14 Programme £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>166</td>
<td>97</td>
<td>69</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>1,613</td>
<td>1</td>
<td>1,612</td>
</tr>
<tr>
<td>Other revenue</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>1,781</strong></td>
<td><strong>100</strong></td>
<td><strong>1,681</strong></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>2013-14</th>
<th>Admin</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total £000</td>
<td>Permanent Employees £000</td>
<td>Other £000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>4,963</td>
<td>4,851</td>
</tr>
<tr>
<td>Social security costs</td>
<td>462</td>
<td>462</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension Scheme</td>
<td>604</td>
<td>604</td>
</tr>
<tr>
<td><strong>Net employee benefits</strong></td>
<td><strong>6,029</strong></td>
<td><strong>5,917</strong></td>
</tr>
</tbody>
</table>

5.2 Average number of people employed

<table>
<thead>
<tr>
<th>2013-14</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number</td>
<td>Permanently employed Number</td>
<td>Other Number</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>96</td>
</tr>
</tbody>
</table>

5.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th>2013-14 Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
</tr>
<tr>
<td>Total Staff Years</td>
</tr>
<tr>
<td>Average working Days Lost</td>
</tr>
</tbody>
</table>

The data provided is only for the 9 months to 31st December 2013 as this is the only data available.

No people retired on ill-health grounds nor took early retirement.

5.4 Exit packages agreed in the financial year

The clinical commissioning group did not agree any exit packages during 2013/14.
5.5 Pension costs

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

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

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

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

5.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of Pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

5.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.
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) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

5.5.3 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;

• 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 statement of comprehensive net expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment; 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.

5.6 Severance payments

The clinical commissioning group made no severance payments during 2013/14.
6. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2013-14 Total £000</th>
<th>2013-14 Admin £000</th>
<th>2013-14 Programme £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>5,535</td>
<td>5,096</td>
<td>439</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>494</td>
<td>494</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>6,029</td>
<td>5,590</td>
<td>439</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>6,255</td>
<td>3,062</td>
<td>3,193</td>
</tr>
<tr>
<td>Services from NHS foundation trusts</td>
<td>307,234</td>
<td>375</td>
<td>306,859</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>200,095</td>
<td>156</td>
<td>199,939</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>54,170</td>
<td>214</td>
<td>53,956</td>
</tr>
<tr>
<td>Chair and lay membership body and governing body members</td>
<td>215</td>
<td>215</td>
<td>-</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>351</td>
<td>-</td>
<td>351</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>281</td>
<td>34</td>
<td>247</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>326</td>
<td>188</td>
<td>138</td>
</tr>
<tr>
<td>Establishment</td>
<td>1,368</td>
<td>146</td>
<td>1,222</td>
</tr>
<tr>
<td>Transport</td>
<td>14</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Premises</td>
<td>1,446</td>
<td>1,180</td>
<td>266</td>
</tr>
<tr>
<td>Audit fees</td>
<td>116</td>
<td>116</td>
<td>-</td>
</tr>
<tr>
<td>Other auditor’s remuneration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other services</td>
<td>4</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>86,793</td>
<td>-</td>
<td>86,793</td>
</tr>
<tr>
<td>GMS/PMS/APMS and PCTMS</td>
<td>11,461</td>
<td>-</td>
<td>11,461</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>674</td>
<td>554</td>
<td>120</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Education and training</td>
<td>219</td>
<td>153</td>
<td>66</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>671,024</td>
<td>6,408</td>
<td>664,616</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>677,053</td>
<td>11,998</td>
<td>665,055</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

7.1 Measure of compliance

<table>
<thead>
<tr>
<th></th>
<th>2013-14 Number</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the year</td>
<td>15,595</td>
<td>79,014</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>15,496</td>
<td>78,828</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>99.37%</td>
<td>99.76%</td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the year</td>
<td>2,710</td>
<td>505,088</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>2,703</td>
<td>505,014</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>99.74%</td>
<td>99.99%</td>
</tr>
</tbody>
</table>

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

8.1 As lessee

The CCG leases cars typically on 3 year leases. The CCG, as lessee, has determined, based on an evaluation of the terms and conditions of the arrangements, that the lessor retains a significant portion of the risks and rewards of ownership. As such the CCG accounts for them as operating leases.

The CCG occupies property owned and managed by Community Health Partnerships Ltd and NHS Property Services Ltd and, although there are no contracts in place, the transactions involved do convey the right to use property assets. As such the CCG accounts for them as operating leases.

8.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Buildings</td>
</tr>
<tr>
<td>Minimum lease payments</td>
<td>1,182</td>
</tr>
<tr>
<td>Total</td>
<td>1,182</td>
</tr>
</tbody>
</table>

8.1.2 Future minimum lease payments

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Buildings</td>
</tr>
<tr>
<td>Payable:</td>
<td></td>
</tr>
<tr>
<td>No later than one year</td>
<td>-</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
</tr>
</tbody>
</table>

The CCG occupies property owned and managed by Community Health Partnerships Ltd and NHS Property Services Ltd. For 2013/14, a transitional occupancy rent based on annual property cost allocations was agreed. This is reflected in Note 8.1.1 above.

While our arrangements with Community Health Partnerships Ltd and NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.
9. Trade and other receivables

<table>
<thead>
<tr>
<th>Current 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: revenue</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
</tr>
<tr>
<td>Non-NHS receivables: revenue</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
</tr>
<tr>
<td>VAT</td>
</tr>
<tr>
<td>Operating lease receivables</td>
</tr>
<tr>
<td>Other receivables</td>
</tr>
<tr>
<td><strong>Total</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>31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

£1,353,261 of the amount above has subsequently been recovered post the statement of financial position date.

The CCG did not hold any collateral against receivables outstanding at 31 March 2014.
9.2 Provision for impairment of receivables

No provision for impairment of receivables was made at 31 March 2014 as all receivables were less than 3 months overdue and deemed recoverable.

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

Made up of:
- Cash with the Government Banking Service 7

No patients’ money were held by the clinical commissioning group.

11. Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td></td>
<td>7,780</td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td></td>
<td>4,032</td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td></td>
<td>3,105</td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td></td>
<td>18,204</td>
</tr>
<tr>
<td>Social security costs</td>
<td></td>
<td>67</td>
</tr>
<tr>
<td>Tax</td>
<td></td>
<td>88</td>
</tr>
<tr>
<td>Other payables</td>
<td></td>
<td>315</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>33,591</td>
</tr>
</tbody>
</table>

Other payables include £97,898 outstanding pension contributions at 31 March 2014.

The CCG had no provisions as 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 CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £8,675,421.

13. Contingencies

The CCG had no contingencies as 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 CCG 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 2014.

15. Financial instruments

15.1 Financial risk management

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

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

15.1.1 Currency risk

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

The CCG has no borrowings and therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the CCG’s revenue comes from parliamentary funding, the CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note 9.

15.1.4 Liquidity risk

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

15.2 Financial assets

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

15.3 Financial liabilities

<table>
<thead>
<tr>
<th>Other</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payables</td>
<td></td>
</tr>
<tr>
<td>• NHS</td>
<td>11</td>
</tr>
<tr>
<td>• Non-NHS</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td><strong>33,121</strong></td>
</tr>
</tbody>
</table>
16. Operating segments

The CCG considers it has only one segment: commissioning of healthcare services.

17. Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the CCG.

18. Pooled budgets

The CCG operates 3 pooled funds in partnership with Cumbria County Council under section 75 of the Health Act 2006. All 3 funds are hosted by Cumbria County Council.

The Locality pooled fund consolidates the former Generic Care, Intermediate Care and Prevention pooled funds. 6 District based Health and Social Care Joint Management teams use funds flexibly across these 3 services to develop local services that 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 pooled fund jointly commissions services to improve general well-being and life chances of adults with a learning disability.

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

<table>
<thead>
<tr>
<th>Contributions</th>
<th>Locality £000</th>
<th>ICES £000</th>
<th>Learning Disability £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

Share of Expenditure

<table>
<thead>
<tr>
<th>Contributions</th>
<th>Locality £000</th>
<th>ICES £000</th>
<th>Learning Disability £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

Overspend

<table>
<thead>
<tr>
<th>Overspend</th>
<th>Locality £000</th>
<th>ICES £000</th>
<th>Learning Disability £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(436)</td>
<td>(18)</td>
<td>(789)</td>
<td>(1,243)</td>
</tr>
</tbody>
</table>

Share of overspend

<table>
<thead>
<tr>
<th>Contributions</th>
<th>Locality £000</th>
<th>ICES £000</th>
<th>Learning Disability £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<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>
### 19. Intra-government and other balances

<table>
<thead>
<tr>
<th></th>
<th>Current Receivables</th>
<th>Current Payables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Balances with NHS bodies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• NHS bodies outside the Departmental Group</td>
<td>1,265</td>
<td>230</td>
</tr>
<tr>
<td>• NHS Trusts and Foundation Trusts</td>
<td>1,619</td>
<td>11,582</td>
</tr>
<tr>
<td><strong>Total of balances with NHS bodies:</strong></td>
<td><strong>2,884</strong></td>
<td><strong>11,812</strong></td>
</tr>
<tr>
<td>Balances with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Other Central Government bodies</td>
<td>62</td>
<td>260</td>
</tr>
<tr>
<td>• Local Authorities</td>
<td>388</td>
<td>2,466</td>
</tr>
<tr>
<td>• Bodies external to Government</td>
<td>305</td>
<td>19,053</td>
</tr>
<tr>
<td><strong>Total balances at 31 March 2014</strong></td>
<td><strong>3,639</strong></td>
<td><strong>33,591</strong></td>
</tr>
</tbody>
</table>
20. Related party transactions

During the year none of the Department of Health Ministers, NHS Cumbria CCG Governing Body members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the CCG.

The Department of Health is regarded as a related party. During the year the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:
• NHS England (including commissioning support units);
• NHS Foundation Trusts; and,
• NHS Trusts;

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Cumbria County Council.

21. Losses and special payments

The clinical commissioning group had no losses or special payments cases during 2013/14.

22. Impact of IFRS

Accounting under IFRS had no impact on the results of the CCG during the 2013/14 financial year.
Contact Us

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Penrith Hospital, Bridge Lane
Penrith, Cumbria
CA11 8HX

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Email: enquiries@cumbriaccg.nhs.uk
Website: www.cumbriaccg.nhs.uk