NHS
Newcastle West
Clinical Commissioning Group

Annual report and accounts 2014/15

Transforming lives together

Contents

Foreword

NHS Newcastle West Clinical Commissioning Group (CCG) is the body responsible for planning and commissioning healthcare in the local area. Established in 2013, the CCG is made up of 18 GP practices that look after the health of the 130,000 population in the Newcastle West area.

As a clinically-led organisation run by a team of doctors, nurses and healthcare professionals, we have the knowledge and experience to understand the needs of our patients our local community.

Here in the West of Newcastle we face a number of healthcare challenges. We have an ageing population and increasing numbers of people living with multiple, long-term healthcare conditions at a time where patient needs and expectations are higher than ever before. At the same time there is more pressure than ever on our finances and resources. Despite this, we have worked hard to meet some of our ambitious targets.

This year has seen a reduction in the number of early deaths from heart disease, stroke and cancers, but there is still a lot of work to be done.

We recognise the importance of strengthening links with a wider range of health and social care organisations in order to improve our services further. By working together we can combine expertise, resources and services. Over the last twelve months we have worked with local partners on a number of schemes including the Better Care Fund, which was set up to improve the links between adult social care and health services. Starting with older people and those with long term conditions, the fund provides targeted services for some of the most vulnerable members of our community.

As part of our commitment to strengthening public engagement, we have been working with local partners, including Newcastle North and East CCG, to gather patient opinions on a range of services including diabetes education provision, musculoskeletal services, mental health services and the Chronic Obstructive Pulmonary Disease (COPD) pathway. Following these reviews, feedback from around 350 users is being collated, considered and used to shape our plans for future delivery.

This year we have also undertaken a series of reviews into our secondary care provision, with a view to offering more targeted, joined-up care, supported by our primary and community-based care services. In urgent care we are reviewing walk-in centre provision in the city. We are also examining children’s use of A&E services to ensure each child gets the most appropriate treatment to meet their needs, whilst simultaneously analysing use of NHS resources.

We are proud of the progress we are making with our care home support programme. Together with Newcastle North and East CCG this new service will link a GP practice to each of the city's care homes, working alongside the nursing home support team to achieve a more consistent, efficient and higher quality of service. We hope the project will lead to a reduction in acute care admissions and alleviate pressure on out-of-hours services.

For the last year we have been working towards providing a more joined up support service, and April 2015 saw the merger of the three local CCGs - Newcastle North and East, Newcastle West and Gateshead, which is now known as NHS Newcastle Gateshead CCG.

The three areas, comprising 65 GP practices, have always benefitted from a close working relationship, and the merger gives us the opportunity to make services safer, deliver better health outcomes and meet the need of patients in light of an increasingly constrained financial outlook.

Dr Guy Pilkington
Chair

Strategic report

Introduction

This annual report outlines how the members of the Clinical Commissioning Group (CCG) and its Governing Body have performed in promoting the success of the CCG in delivering against its objectives.

It provides a fair review of the CCG's business and a description of the principal risks and uncertainties facing the group, and the ways in which these are being addressed.

CCG discharge of duties

The CCG has discharged its duties under the National Health Service Act 2006 (as amended), as required by the CCG Assurance Framework.

The CCG is subject to the NHS England CCG assurance process, including the completion and submission of the 'balanced scorecard' latterly called the Assurance Framework Delivery Dashboard. The CCG has regular dialogue with the NHS England Area Team, and participates in the formal quarterly assurance process. The outcome of this is reported to the Governing Body.

About us

NHS Newcastle West Clinical CCG is the statutory body responsible for planning and commissioning healthcare for 130,000 people in the Newcastle West area.

The CCG is made up of 18 GP practices, and was granted responsibility for commissioning in April 2013. Together with NHS Newcastle North and East CCG we plan the healthcare delivery for the people of Newcastle.

Our responsibilities include:

- Planned hospital care
- Urgent and emergency care
- Rehabilitation care
- Community health services
- Mental health and learning disability services

Our mission is 'to build a better health service for the local population that is safe, accessible and cost effective'. To deliver our mission and responsibilities effectively, we are committed to working with local people and health and social care professionals in the region. Because the CCG is made up of doctors, nurses and healthcare professionals, we are already very close to our patients so we are well placed to develop quality health services that are responsive to our patients' needs.

Central to the success of this vision is the involvement of our partners and the public. Over the past year, we have continued to make strong progress in engaging with local partners including healthcare providers, the local authority, the Wellbeing for Life Board, Healthwatch Newcastle and other community and voluntary sector groups. The development of our increasingly close joint working with neighbouring CCGs through the Newcastle Gateshead Alliance is set out in the section below.

Hospital and community services are largely provided by the Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTHFT). Primary care services are provided from GP surgeries, NHS dentist practices, optometric practices, and pharmacies across Newcastle, and are commissioned by NHS England's Local Area Team for Cumbria, Northumberland, Tyne and Wear. As the year came to a close, we have been preparing to take on a co-commissioning role with NHS England.

Newcastle Gateshead Alliance

When the CCG was established in April 2013, we recognised the similarities in demographics and healthcare needs between our communities and our neighbours in Newcastle North and East and Gateshead, as well as the significant flow of patients between the three areas.

As a result, the three CCGs - Gateshead, Newcastle North and East and Newcastle West - have worked together under a partnership agreement as Newcastle Gateshead Alliance. The Alliance focuses on shared issues that affect local people, taking advantage of common opportunities and making best use of our combined expertise, knowledge and resources.

During 2014, the Alliance consulted with member practices, stakeholders and the public on a proposal for the three CCGs to merge and form a single statutory body, NHS Newcastle Gateshead Clinical Commissioning Group, on 1 April 2015.

The extensive consultation exercise received a positive response and the merger plan was subsequently approved by NHS England after practices in all three areas voted in favour of the change.
Feedback from NHS England highlighted that all three CCGs are performing well, and that by moving to a merged organisation we have an even greater potential to do more for public and patients. NHS England's panel also took the time to feedback about the passion and commitment of our people, and the strong clinical and managerial leadership in all three CCGs.

The new organisation will formalise the close working arrangements that are already in place, and we anticipate a seamless transition with no interruption to the services we provide.

A single CCG will be better placed to face the challenges for the NHS in the future, and strengthens our ability to bring improvements in outcomes for patients – for example by making more efficient use of clinical leadership time, and recognising the flow of patients between the three areas.

With 65 member GP practices, the new CCG will operate with two localities – Newcastle and Gateshead, with its chair rotating annually between these two areas. The CCG's Clinical Chair for 2015-16 will be Dr Guy Pilkington, with Dr Mark Dornan as Assistant Clinical Chair.

Focusing on our priorities

Over a five-year period, our agreed priorities are to:

- Prevent people from dying prematurely
- Enhance quality of life for people with long-term conditions
- Help people to recover from episodes of ill health or following injury
- Ensure that people have a positive experience of care
- Treat and care for people in a safe environment and protect them from avoidable harm

While health is generally improving in Newcastle, significant healthcare challenges remain, with higher levels of deprivation and slightly lower life expectancy than the average for England. Substantial inequalities can be seen between the most affluent parts of Newcastle and its more disadvantaged areas, with life expectancy varying by up to 12 years for men and nine years for women.

Despite a reduction in the number of early deaths from heart disease, stroke and cancers, we still have a higher than average death rate from cardiovascular diseases, with coronary heart disease and stroke rates as significant causal factors.

Smoking remains the greatest reason for premature death and disease in Newcastle, with alcohol-related harm and obesity also contributing. A key focus for us is therefore to encourage people to take control of their own health and the health of those around them. Working with the people who use our services, we have a better chance to focus on prevention methods and intervene earlier when problems do occur. This work is set within the partnership context of the Newcastle Gateshead Alliance and joint working with Newcastle City Council and healthcare partners.

A further key strand of activity involves raising awareness of services to encourage patients to use the best service for their individual needs. This activity can encourage more appropriate use of pharmacies, GPs and walk-in centres, which in turn can reduce the reliance on acute care services.

Targets and performance

Improving performance

During 2014/15 we have worked hard to continue as an effective commissioner of healthcare services, improve the quality of the care available to patients and meet our local and national performance targets.

Our performance as a CCG is reviewed by NHS England to ensure that we are delivering quality outcomes for patients, both locally and as part of the national standards.

The following pages set out a few of our highlights.

Due to the different timetables for reporting, the period for the indicators described below is as follows:

- A&E 4 hour waits – March 2015
- Ambulance response times – February 2015
- Ambulance handovers – February 2015
- Healthcare associated infections – March 2015 (Clostridium Difficile), February 2015 (MRSA)
- Referral to treatment times – February 2015
- Cancer waiting times – January 2015
- Avoidable emergency admissions – January 2015

A rating has been assigned to all key targets, defined as follows:

Performance target is currently expected to be achieved 

Achievement of performance target is currently at risk 

Performance target is currently not expected to be achieved 

A&E and Ambulance Targets

Four hour waits 

In 2014/15, both Gateshead Health NHS Foundation Trust and Newcastle upon Tyne Hospitals NHS Foundation Trust (NUTH) have met the four hour waiting time standard in A&E, although system pressures nationally and across the North East have seen NUTH marginally fall short of the required standard in the latter half of 2014/15.

Ambulance handovers 

CCGs and North East Ambulance Service (NEAS) are working collectively to improve ambulance turnaround times at hospitals in the North East. Regionally Newcastle upon Tyne Hospitals NHS Foundation Trust is a good performer, and delays have been kept to a minimum, although there have been some pressures over the winter months.

Ambulance response times 

Ambulance response times have been under pressure throughout the later part of 2014/15, and NEAS are not currently achieving this annual target for 2014/15. Pressures are largely down to a national shortage of paramedics and NEAS are working to recruit additional staff as part of their recovery action plan.

Reduction in avoidable emergency admissions 

Good management of long-term conditions requires effective collaboration across the health and care system to support people in managing conditions and to promote recovery after acute illness. There should be shared responsibility across the system so that all parts of the NHS improve the quality of care and reduce the frequency and necessity for emergency admissions. CCGs are required to achieve an annual reduction in the emergency admissions for those conditions (sometimes referred to as ‘ambulatory care sensitive conditions’) that could usually have been avoided through better management in primary or community care. Local performance data shows that Newcastle is not yet achieving the required reduction in emergency admissions in 2014/15, but initiatives through the Better Care Fund have been identified to improve this position going forward.

Cancer waits

Cancer waiting times 

The NHS Constitution sets out that CCGs are to achieve nine cancer waiting times standards in 2014/15. We are currently expected to meet all of these standards in 2014/15.

Healthcare associated infections

MRSA 

Clostridium Difficile 

Organisations across the North East have struggled to meet the healthcare associated infection thresholds set for 2014/15, although it has been acknowledged nationally that there have been significant improvements over recent years. Organisations are required to meet national standards for Clostridium Difficile and MRSA.

We have not had any incidences of MRSA over the period April – February 2014/15. The annual threshold for the maximum number of cases of C Diff has been exceeded.

A Healthcare Acquired Infection Reduction Partnership continues across Gateshead, Newcastle and Northumbria to closely monitor the trend and identify potential mitigating actions, and lessons learned, and establish closer working relationships between providers and commissioners.

Referral to treatment 

Due to different timetables for reporting, the period used for the indicator is described as below

- Referral to treatment times – February 2015

The NHS Constitution states that patients should be treated within 18 weeks from referral to treatment and we are currently performing within these standards.

Mental health - parity of esteem

The CCG recognises mental health as being important and the Mental Health Programme Board is well established across Newcastle and Gateshead, involving providers, both acute and community, as well as users and carers.

Improving Access to Psychological Therapies (IAPT) 

The CCG is working to develop a single delivery model across Newcastle involving a major transformation in relation to the service model and workforce. Whilst this transformational work is ongoing, the CCG is working with both providers to implement actions that will expediate the delivery of the national IAPT standards.

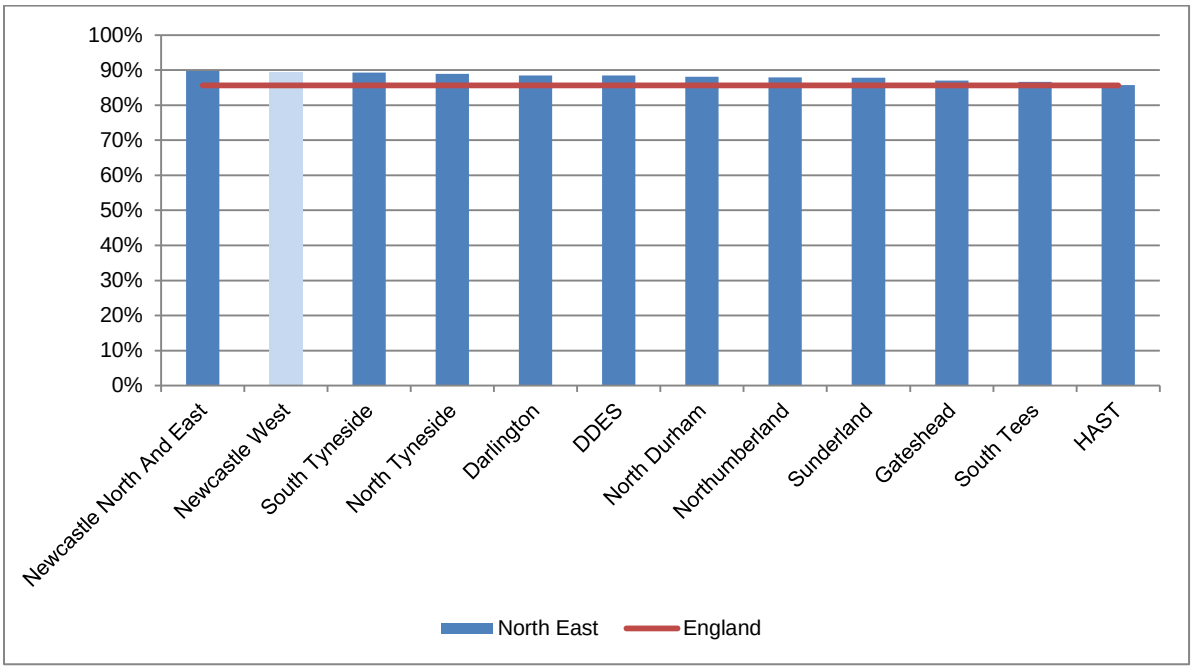
Dementia 

Particular focus has been given on ensuring patients are diagnosed with dementia where appropriate to ensure they receive the care required. The CCG has shown significant improvement throughout 2014/15 but is below the required standard at this point in time.

GP experience

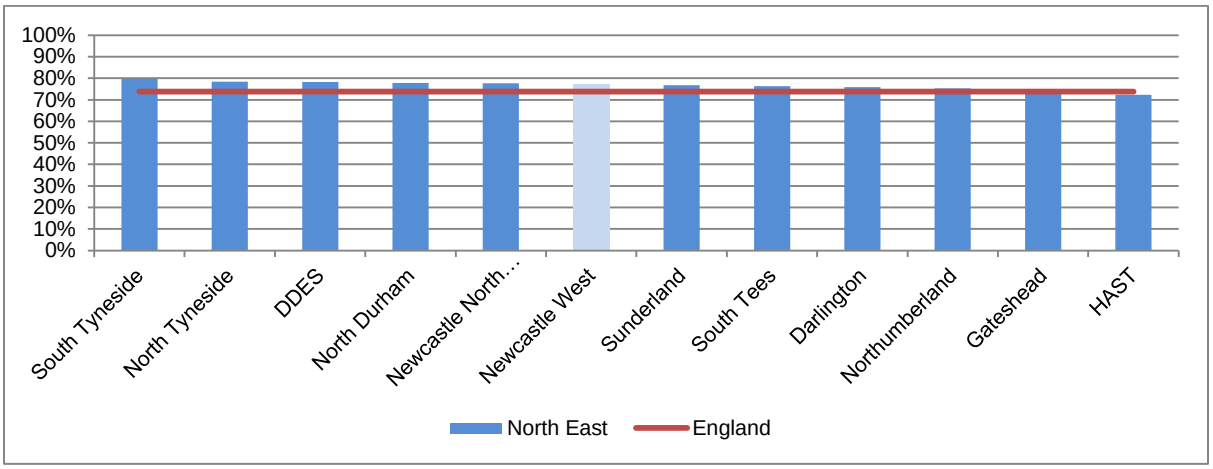
Source: GP Patient Survey – December 2014 Results are published for every CCG in the country and the national results, using aggregated data collected during January-March 2014 and July-September 2014.

GP experience – quality of consultation



The CCG is a top performer both nationally and regionally in terms of positive responses to five questions in relation to quality of their consultation with a GP.

GP experience - access



The CCG is performing above average in terms of positive responses to the question “Overall how would you describe your experience of making an appointment”.

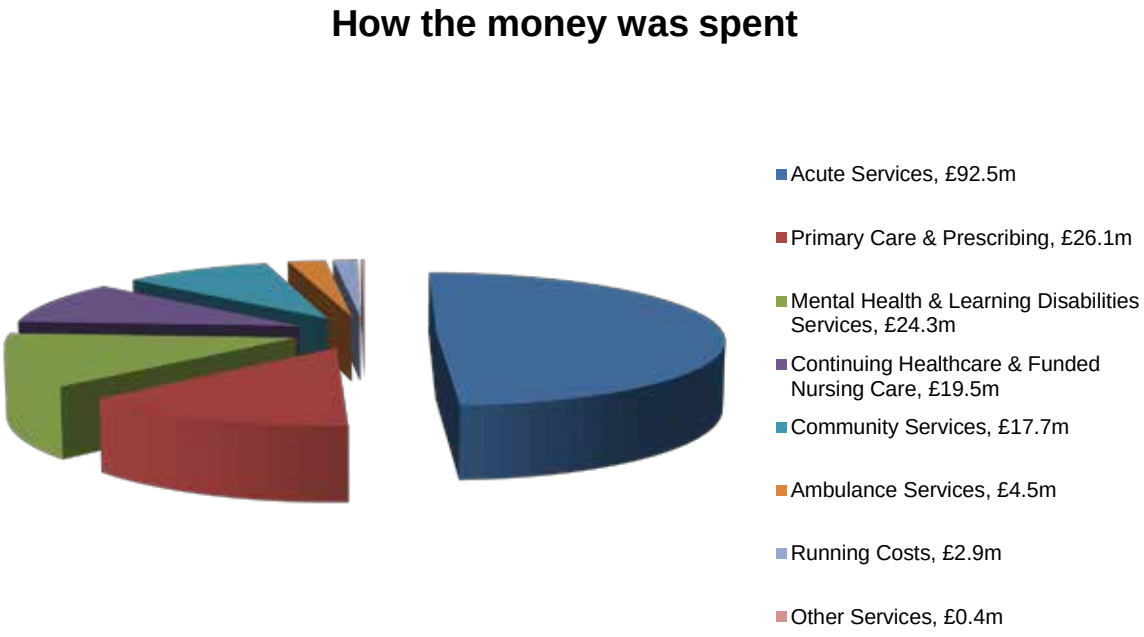
Financial performance

The Governing Body approved a commissioning budget for 2014/15 based upon an initial allocation of £187.3m, excluding the running costs allowance of £2.9m. Within this budget approval was a planned surplus of £1.9m, consistent with the financial planning framework for CCGs.

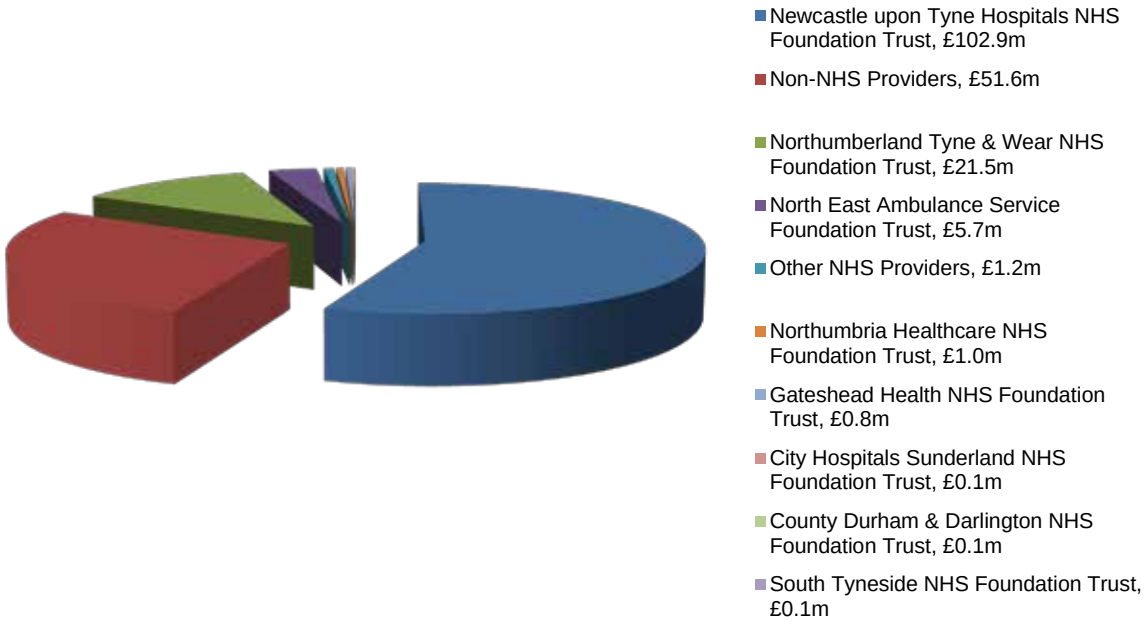
An actual surplus of £2.4m was achieved for the reporting period; £0.5m in excess of that planned due to the reduced contributions to the national risk share arrangements for CHC restitution cases. This surplus was achieved having successfully managed some in-year cost pressures of which the most notable, where expenditure was significantly above budgeted levels, were:

- £0.7m on general and acute hospital episodes of care
- £2.7m on continuing and funded nursing care
- £0.9m on prescribing of drugs

Full resource allocation for the CCG was £190.2m, against which expenditure in 2014/15 totalled £187.8m and was applied in the following way:



Health care spend by provider



Looking ahead

On 1 April 2015 Newcastle West CCG joined with Newcastle North and East CCG and Gateshead CCG to form NHS Newcastle Gateshead CCG, covering the area of the three former separate organisations.

For 2015/16, and in future years, the new CCG will receive one allocation to commission healthcare services and one for running costs to cover the practice populations of the whole of Newcastle and Gateshead.

In 2015/16 the funding formula for CCGs - adopted by the NHS England Board in December 2013 (including a specific adjustment for unmet need and inequalities of 10%, alongside the equivalent 15% adjustment for primary care) - continues to be used. This gives a total 2.46% increase in the commissioning budget, which includes £3.5m for investment in system resilience. Together with the national planned 10% reduction in running cost allocations, the change in allocation is as follows:

Newcastle Gateshead CCG	2014/15 £'000	2015/16 £'000	% Change
Running Cost Allocation	11,942	10,716	-10.27%
Programme Cost Allocation	648,667	664,611	2.46%
Total Funding Allocation	660,609	675,327	2.23%

Based on the new funding formula, NHS Newcastle Gateshead CCG receives £25m or 3.72% in excess of its weighted capitation share of national funding as determined by the NHS funding formula.

For the immediate future the Newcastle Gateshead CCG has set an initial budget, including the BCF allocation of £12m, for 2015/16 for the following commissioned services:

	£m
Acute Services	336.5
Mental Health and Learning Disabilities Contracts	75.0
Community Contracts	89.2
Ambulance A&E Contracts	14.8
Continuing Healthcare and Funded Nursing Care	53.7
Primary Care Prescribing	84.4
Other Services	23.0
Total	676.6

A finance and activity plan has been formulated that brings together the commissioning plans of the CCG with the delivery of national business rules/planning guidance, and the expected contract activity and costs for 2015/16, whilst maintaining the financial obligation of the CCG.

Key assumptions within the plan meet the national business rules and include:

- Provision of 0.5% contingency, totalling £3.5m
- Provision of 1% headroom for non-recurrent spend, totalling £6.6m
- A control total of £8.4m surplus
- Net acute tariff reduction of 0.9%
- Overall non-acute tariff reduction of 0.6%.
- Anticipated QIPP plans at 0.7% of the total CCG revenue resource limit

Budgeted commissioning spend has also been adjusted for demographic growth where appropriate, as well as the impact of planned investments and efficiency saving delivered through improved quality, innovation, productivity and prevention (QIPP).

For 2015/16, the CCG financial plan includes investment in Mental Health that equals a 1.9% increase in line with the CCG allocation increase, excluding seasonal resilience funding.

Our QIPP plans total £4.7m, which represents 0.7% of the total CCG revenue resource limit. They include a range of specific schemes, including £1m led by medicines management to reduce costs in primary care prescribing. Other QIPP savings are anticipated from a range of interventions, to shift activity from secondary to primary care which, combined with benefits from initiatives negotiated within contracts, are expected to deliver circa £2m.

In this way we are confident that we can demonstrate our plans are clear and credible and meet the efficiency challenge in 2015/16, and provide the basis for further medium term efficiency savings.

Moving forward we are developing our ambitions for future evidence based planning, with work led by the Clinical Director of Transformation and utilising information from a range of benchmarking sources, including Commissioning for Value and the expertise of our clinical leads and directors.

Plans will be put into practice via the two units of delivery for Gateshead and for Newcastle, where business cases and internal governance processes are utilised to support robust implementation. This is supported by well-developed practice engagement led by the two delivery teams, and by contracting, performance and finance staff.

The NHS Forward View has outlined the financial challenge to the NHS for the next five years, highlighting a £30billion funding gap. This document and supporting work has outlined the ways in which new models of care across the service can support the delivery of significant efficiencies, while continuing the drive towards better, high quality care for patients.

Key financial performance indicators

Revenue resource limit
The CCG's performance for 2014/15 is as follows:

Revenue resource limit	2014/15 £000
Total net operating cost for the financial year	187,817
Final revenue resource limit for year	190,183
Underspend against revenue resource limit	2,366

Better Payment Practice Code

There is a further financial obligation under the Better Practice Payment Code to pay 95% of creditors within 30 days of invoicing or receipt of invoice or goods, whichever is the later.

Overall performance for the year was that 99.36% of correctly addressed and undisputed invoices were paid within the required 30 days as a percentage of the total value of invoices paid, and 97.60% as a percentage of the total number of invoices paid in the year.

Better Payment Practice Code	2014/15 Number	2014/15 £000
Non-NHS creditors		
Total bills paid in the year	4,271	25,452
Total bills paid within target	4,168	24,942
Percentage of bills paid within target	97.59%	97.99%
NHS creditors		
Total bills paid in the year	1,267	136,479
Total bills paid within target	1,237	135,955
Percentage of bills paid within target	97.63%	99.62%

Running costs

The CCG is required to maintain running costs within an allowance of £24.73 per head of population, equating to £3.142m. The broad definition of running costs is that it will include any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services.

Running costs	**2014/15**
Running costs (£000)	2,905
Population (number)	127,052
Running cost per head of weighted population (£)	22.86

Annual accounts

The annual accounts and primary financial statements for the reporting period have been approved by the Governing Body as being prepared under directions issued by the NHS Commissioning Board, and represent a true and fair view of the financial standing of the CCG.

Overview of the year

In our second year of operation, we have made further progress in delivering on our long-term strategic aims and objectives, working in close partnership with partners including local hospitals and healthcare providers, Newcastle City Council, local communities, the third sector, the Wellbeing for Life Board and Healthwatch Newcastle.

Working with our partner CCGs in Gateshead and Newcastle North and East, we have taken steps to align and plan our engagement activity. This includes a shared set of principles for all engagement activity:

- Placing patients and the public at the centre of informing, influencing and shaping CCG commissioning and development
- Agreeing to align engagement mechanisms, share best practice where appropriate and find common solutions to problems
- Trusting each other, sharing resources, ideas and enthusiasm
- Ongoing engagement and involvement, using new and innovative methods as well as tried and tested techniques
- Changing the culture about the value of engagement and involvement and how it will influence the 'we asked, you said and this is how it was changed' campaign
- Ensuring key issues are always considered and acted upon in strategic planning
- Communication about patient experiences should always be honest, open and transparent
- Actively listening to opinions, asking communities once, using plain language
- Agreeing to work on issues together whenever possible in a planned and timely manner.
- Valuing the differences in our communities and ensuring work is locality driven

This section outlines our progress on a number of areas over the past year:

Better Care Fund

We have continued to progress the Better Care Fund, working with NHS Newcastle North and East CCG and Newcastle City Council to improve services through pooled budgets and greater integration. The initiative, which aims to improve the way adult social care and health services work together, will initially concentrate on services for older people and people with long term conditions. The £21.8m is allocated to improve the lives of some of the most vulnerable members of our community, giving them more control, placing them at the centre of their own care and providing the right care, in the right place, at the right time.

A successful joint stakeholder event was the first step towards putting the plan into action, and new service solutions have since been designed to deliver the Newcastle vision for integrated health and social care outside hospital.

Engagement and participation

We are committed to active community engagement, to ensure that the services we buy are targeted to, and informed by the needs of local people. Over the past year, we have progressed a wide range of events and activities to ensure the voice of patients is heard and acted upon.

COPD engagement work

Newcastle West CCG in conjunction with Newcastle North and East CCG have carried out engagement work to hear about people's experiences of the COPD (Chronic Obstructive Pulmonary Disease) pathway, including pulmonary rehabilitation courses to ensure patients receive the best possible care and treatment. This work was supported by our involvement partners, Involve North East, HAREF and Deaflink.

Currently, patients access pulmonary rehabilitation at the Royal Victoria Infirmary (RVI) or, for patients in the north and east of the city, at Benfield Park Medical Group. However, uptake of the pulmonary rehabilitation courses is currently low and we would like to improve access to the course.

127 people contributed to the consultation, which aimed to gauge the level of awareness of pulmonary rehabilitation classes and understand the patient experience of the COPD pathway. Comments centred on the need for a simpler diagnosis process, information sharing and help with understanding symptoms.

As a result, a new course is being proposed, to take place in a community setting over six weeks, with sessions available at different times throughout the day. The course content would include education about managing COPD, lung health and dealing with breathlessness. It would also include a programme of light physical activity tailored to suit each patient's ability. At the end of the course, the patient would be given an individual plan to help manage their condition in the future.

Listening to patients with diabetes

The Newcastle CCGs have also engaged with patients to hear about their experiences and views of diabetes education.

Currently, newly diagnosed patients living in the city are able to access two main courses – DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed), which takes place at the Diabetes Centre, located at the Campus for Ageing and Vitality on Westgate Road, and 'Living well, taking control', a pilot provided by HealthWORKS Newcastle.

Almost 100 people gave their views, offering an insight into uptake of diabetes education courses, barriers to attendance and how future courses could be improved. Valuable comments included a preference for delivery in the

community, improved information to support self-management of the condition, and accessibility.

The CCGs have drafted options for a new service specification for diabetes education which the engagement will help inform. Three options have been developed, though the service design is likely to include elements of all of them.

Review of speech and language services

Newcastle's CCGs have come together with Newcastle City Council to review the city's speech and language therapy services, which offer expert guidance to help children improve their communications skills.

With special educational needs and disabilities (SEND) services set for reform following the Children and Family Act 2014, we are reviewing the service to bring it in line with the new legislation and take the opportunity to improve services for all children with communication difficulties.

We are listening to views and ideas from parents and families, and plan to redesign the service between now and April 2016.

Musculoskeletal services (MSK) review

Another area under review is the musculoskeletal service. The three Newcastle Gateshead Alliance CCGs initiated a review of the Musculoskeletal (MSK) care pathway to ensure that patients receive the best possible care.

An engagement exercise in April gathered views from over 100 patients who have used MSK services, to find out about their experiences and how their treatment has affected their lives.

A range of comments and recommendations on areas like the communication of treatment options, information about waiting times and continued communication after treatment have helped us to shape our plans for future delivery.

Infant emotional health review

The Newcastle CCGs have also initiated a review to better understand parents' experience of current services to identify gaps in current provision and identify what further support or services would be useful for parents.

The key objectives of the project are to explore parents' experience of current infant emotional health services, their views about early access to the services, and the outcomes they have seen, as well as identifying gaps in service provision and options for improvement.

The project is currently talking with parents of children under 5 years old who have accessed infant emotional health services within the last 12 months.

Caring about carers

In February, the Newcastle CCGs held a Caring about Carers Conference in partnership with Newcastle City Council and partners from the community and voluntary sector.

The overall purpose of this conference was to raise awareness of the work of carers and their contribution to the health and social care agenda, as well as identifying ways in which we can work together to tackle the issues and concerns faced by carers in their everyday lives.

Over 130 people attended the conference, considering a range of key themes. This included looking at ways to provide a supportive environment for young carers and ensure that education establishments help in identifying and supporting young carers by referring to relevant support agencies.

Discussions around the issues and needs of adult carers focused on providing support for adult carers by giving them timely information, breaks to have a life of their own and providing tailored support. The session also highlighted practical steps to improve support for carers of older people, people with mental health concerns, and how primary care services can better serve carers.

Ongoing participation

A significant part of our partnership approach was the completion of a new compact setting out the relationship between the voluntary and community sector in Newcastle and a range of public sector partners including the two Newcastle CCGs.

This was followed by an open meeting which brought together the Newcastle West Executive with representatives from Involve North East, HAREF (Health and Race Equality Forum), Healthwatch Newcastle, and Newcastle Council for Voluntary Service, to consider how the CCG could further develop its approach to involvement.

Most of the 18 practices in the area have established patient participation groups (PPGs), which offer local people a chance to influence local GP services. In addition, we provide ongoing support to practices to develop their Patient Participation Groups, which meet on a regular basis to discuss the services on offer from their practice, and how improvements can be made. Patient groups from across the area come together four times each year to share views and ideas through the Newcastle West Patient Forum.

Our website, along with others in the Newcastle Gateshead Alliance, was updated and refreshed during the year, to make it more user-friendly, give key information on our work, and to encourage people to have their say and get

involved. We have also established our presence on Twitter and Facebook, and have combined these accounts with the other Alliance social media feeds as a result of the organisational merger.

The MY NHS membership programme has become fully established during the past year, providing access to regular updates about our work, opportunities to provide feedback, and invitations to take part in events and focus groups.

Members of the public are encouraged to attend our Governing Body meetings, which are held in partnership with the other Alliance CCGs and feature a 'Question Time' element in which members of the public can ask questions and make comments on our work.

Newcastle West Patient Forum brings together representatives from all the Practice Patient Groups across the area on a quarterly basis. Meetings are structured by theme, and are planned and directed by a smaller sub group of the Forum, who also work with us to support patient representation and engagement across the broader work of the CCG.

The first joint Newcastle Community Forum meeting took place in July, including an update on mental health services from Dr Guy Pilkington, Chair of NHS Newcastle West CCG and the Mental Health Programme Board.

In addition, we support an Involvement Forum, which is a meeting of representatives from the umbrella voluntary and community sector organisations in Newcastle, contracted involvement partners, CCG lay members, PPI leads and officers to regularly meet and discuss issues at a strategic level, share information, and cascade information back through organisational networks.

Another positive step was the creation of a school assembly package, so that GPs can now visit local schools to talk with young people about when to see your GP, and how to make an appointment, as well as reassuring them about issues like confidentiality.

Community engagement is at the heart of our work, and significant engagement work has also underpinned all of the initiatives set out below.

Mental health

With significant changes taking place in mental health nationally, we have launched Deciding Together - a major listening exercise so that service users and local people can help to shape the future of services in our area.

With a clear focus on prevention and early identification of mental illness, improving the quality and efficiency of services, and avoiding hospital admissions

unless it is absolutely necessary, we are carrying out a comprehensive review across the Newcastle Gateshead area.

Service users, families and stakeholders came together through a series of events and engagement activities to consider how patients can have more control over the services they use. This includes looking at the ways people access services as well as potentially relocating the current adult in-patient units to more modern settings.

Also under consideration are the best arrangements for section 136 suites, services for people with especially complex mental health needs, support for older people and transport issues.

Review of walk-in centres

With NHS services nationally under increasing pressure from demographic change and shifting patterns of demand, Newcastle West CCG and Newcastle North and East CCG initiated a review of NHS Walk in Centres (WICs) operating within the city.

In Newcastle there are three NHS Walk in Centres – at Ponteland Road Health Centre, Blakelaw, Westgate Walk in Centre, and Molineux Walk in Centre, Byker. The aim of this project was to explore patients' awareness and experiences of WICs in Newcastle, to inform decisions on the future service delivery model.

Over 300 people gave their views face-to-face or via online questionnaires and focus groups. This demonstrated high awareness of WICs, with the vast majority of people rating their overall experience of using a WIC as very good or good, citing the speed with which they were seen and treated, the friendly and helpful staff and the good quality care and treatment they received.

However, the report also highlighted some recommendations about future promotion, for example within the deaf community, as well as a number of practical suggestions for improving services or facilities at each of the three centres.

Review of children's attendances at Accident and Emergency

Newcastle North and East CCG and Newcastle West CCG are focussing on A&E attendance within their 2013/14-2015/16 commissioning plans, with a view to reducing the number of inappropriate or avoidable attendances.

Part of this work is a project is to examine inappropriate attendance of children and young people at A&E through the development of the Newcastle Sick and Injured Children's and Young People's pathway. This will enable each child and

young person gets the most appropriate advice and treatment in the right place, at the right time, and will enable NHS resources to be used appropriately.

The project is working to identify reasons for accessing A&E over other suitable health services and find out more about people's experiences, along with any perceived barriers to accessing alternative services.

It is working to engage with the parents or guardians accompanying children or young people aged 0-16 attending A&E or, if attending independently, the young person themselves.

Award-winning health campaign

With NHS services nationally facing additional pressures every winter, the region's CCGs have revived the successful 'Keep calm and look after yourself' campaign, which initially ran for seven weeks last winter.

The campaign, which was delivered by North of England Commissioning Support (NECS), won a prestigious award its success in saving public resources.

As Healthcare Campaign of the Year at the Chartered Institute of Public Relations (CIPR) Pride Awards in the North East, it drew praise as research showed that it had persuaded 24,000 people across the North East to use A&E more appropriately, saving £1.4m in public money.

For every £1 invested in the campaign in the previous winter, an estimated £16 was saved on inappropriate use of NHS services.

Details of the campaign can be found at www.keepcalmthiswinter.org.uk.

Winter pressures

During the winter, NHS services locally, regionally and nationally all faced unprecedented levels of demand. Winter is always a time of pressure for NHS services, but a range of factors including an increase in respiratory illnesses and a spike in demand for admissions among patients who are frail, elderly, or have chronic and long-term conditions, created an exceptional set of challenges for NHS bodies in the area.

CCGs and trusts across the region came together to coordinate the NHS' response to these pressures; exchanging mutual aid between areas, sharing information about available beds and maintaining daily contact through the joint system resilience group.

In addition, a regional 'Keep calm and look after yourself' campaign encouraged patients to choose the right NHS service for their need, with additional proactive

and reactive communications via media and partner organisations helping to reinforce winter campaign messages.

Funding was also secured from NHS England, with the aim of strengthening the urgent care system at a local level, with a package put in place to support the urgent care system as a whole. This included direct investment in A&E, extra beds on wards to free up space in A&E, and more staff to enable timely and well supported discharge from hospital. This package also supported extra community nursing staff to reduce the number of unnecessary admissions, and provided GPs to work alongside A&E staff handling the less urgent cases.

Further funding was provided by NHS England to assist with delivery of A&E services and support mental health trusts to assist with patients who come to A&E in crisis, helping A&E to operate as efficiently as possible.

Primary care co-commissioning

In November 2014, NHS England released 'Next steps towards primary care co-commissioning'. In it, CCGs were offered the opportunity to take on additional responsibilities for the commissioning of primary care services, ie Primary Care Co-commissioning.

Co-commissioning has a number of benefits for patients and the public including:

- Improved access to primary care and wider out-of-hospitals services, with more services available closer to home
- High quality out-of-hospital care
- Improved health outcomes, equality of access, reduced inequalities
- A better patient experience through more joined up services

In order to identify its preferred level of co-commissioning, and to ensure the decision was clinically driven, the CCG undertook a formal voting process. The process itself was agreed with member practices and LMC representatives prior to being put in place. This was a two-stage process which asked firstly for a decision on whether or not the member practices wished to be engaged in an increased level of co-commissioning, and secondly for the preferred level of involvement depending on the outcome of the first stage.
The outcome was an agreement to opt for Level 2 involvement, which provides for co-commissioning arrangements with NHS England and the creation of a joint primary care committee.

Medicines optimisation

Throughout the year we have been developing systems to provide online e-learning so that all of our healthcare professionals are kept-up-to-date about

medicine usage and have developed a website to enable access to guidelines across the area.

We have also produced regional wide antibiotics guidelines and an app to support the HCAI reduction agenda. We have also issued prescribing guidelines to support uptake of best practice to improve patient care.

Research and development

We recognise that to deliver the best outcomes for our users, we need to work on new ways to deliver targeted care.

During the year, many of our practices joined forces to undertake a large research study into the prevention of falls. Over 1,500 patients were involved in the project, which identified a range of further opportunities for patients across the Newcastle area.

Commissioning intentions

Newcastle West CCG has worked closely with key stakeholders, patients and the local community to establish a number of strategies that will help provide more targeted services in our local community, improve health outcomes for our patients and public and reduce inequalities across the region.

To achieve this we will prioritise the following key areas:

- Early intervention to prevent the onset of many health conditions
- Integrating and coordinating health and social care services to support patients in their own home or community wherever possible
- Providing timely access to secondary care services for those requiring hospital admission

Primary care strategy for Newcastle and Gateshead

Over the past year we have met with patients, GPs and other health organisations, to develop our primary care strategy for Newcastle and Gateshead. From these discussions, we have suggested that the overarching aim for the primary care strategy should be to ‘maximize the quality, capacity, capability and resilience of primary care provision for patients.’

In order to achieve this, we recognised that we should prioritise three primary objectives:

- Out of hospital care (proactive management of patients at home to reduce the need for and frequency of hospital intervention)

- Enhanced access (teams of healthcare professionals that deliver care in the community to a registered practice population, facilitated through shared IT systems, seven days a week)
- A sustainable workforce (motivated, engaged, contented, competent, valued and positive GPs, pharmacists, nurses, managers and administrators wanting to work in primary care)

Through our work with groups, we identified five key themes as the focus for our transformational work. These are quality, models of care, system infrastructure and process, sustainable workforce, and co-commissioning. The next step is to work in three dedicated groups to focus on models of care, system infrastructure and process, and workforce (in partnership with Health Education North East).

DVT pathway

We recently began working with Newcastle North and East CCG to develop a deep vein thrombosis (DVT) pathway that allows diagnosis and management in the community, bringing care closer to home.

Under the present system, everyone is referred to secondary care for assessment at the cost of £500 per referral, yet statistics show that 80% of these patients don't have a DVT.

Still in the early stages, work is currently focused upon developing and then costing a pathway to deliver a service in a primary care setting. Only those with a confirmed DVT will then be referred to secondary care. If the service is viable, efficiency gains could be significant.

NHS health check programme

The health check programme continues to be an important focus for our preventive work, helping to assess patients' risk of serious health conditions such as heart disease, stroke, diabetes, kidney disease and dementia, and providing appropriate support to reduce or manage their risk.

Exploring new ways to stay healthy

Another positive development was the award of funds from the Big Lottery Fund to support Ways to Wellness – an organisation working in partnership with the CCG – to provide vital social support to people with long term health conditions. Ways to Wellness aims to fund link workers to work with up to 5,000 people with long term conditions in the west end of Newcastle to motivate and support them and, where appropriate, signpost them to community activities to help them manage their health more effectively. This could include advice on healthy eating, physical activity and social interaction.

Community activities can make a real difference in helping people with long term conditions to improve their quality of life, build their confidence and stay better for longer.

Support for care homes

We are making progress with Newcastle North and East CCG in rolling out a new service which will link a GP practice to each of the city's care homes, working alongside the existing nursing home support team.

This will enhance consistency, efficiency and quality of service and is also likely to reduce admissions to acute care and pressure on out-of-hours services. After the initial focus on nursing homes, we aim to extend the scheme to residential homes.

Sustainability and the environment

We are committed to working in ways that maximise the health, social and economic benefits of our activities, and minimise our impact on the environment. This approach requires us to be mindful of the environmental impact of all our decisions.

Wherever possible, we aim to take opportunities to contribute positively to the local economy and community, reduce waste and utilities consumption, and minimise any negative impact on the environment.

By building sustainability considerations into both our strategic decision making and the way we go about our daily business, we can save money, eliminate unnecessary waste in the system and reduce our carbon footprint.

Travel

We encourage sustainable travel wherever possible, through initiatives like a reduced cost public transport initiative and a cycle to work scheme. We also offer shower facilities and cycle parking where this is possible. In addition, we promote home working opportunities.

Waste

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

Workforce development

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

Utilities

Where possible, we try and reduce electricity, gas and water consumption. For example, we have a policy to make sure that we switch off our lights and close down computers when they are not being used and we're looking to reduce our carbon footprint as much as possible. We also have a recycling policy in place and we have indicated our figures for domestic waste, recycling and confidence waste. In summary, for 2014/15, our usage has been as follows:

		Cost
Electricity	Usage – 99,031.33 Carbon emissions – 48,947.72 *(Conv. Factor 0.494265)*	£12,715.62
Gas	Usage – information unavailable Carbon emissions – information unavailable *(Conv. Factor 0.184973)*	£ information unavailable
Water usage		£1,285.70
Domestic waste		£651.37
Recycling		£305.41
Confidential waste		£892.06

Notes:

- Information provided by NHS Property Services
- Water consumption calculation - water consumption has been calculated from costs on the basis of using a conversion factor of £2.55696 per cubic meter. This conversion figure is an average of ten water company charges for both Fresh Water supply and Sewerage processing from 2013 and 2014 that supply NHS Property Services properties
- Electric consumption calculation - where no details are available for electric consumption the consumption figures have been estimated using a conversion factor of 12.8 pence per unit. This conversion figure is based on an average taken from a representative sample of NHS Property Services properties
- Gas consumption calculation – no information was available from NHS Property Services properties

Equality and diversity

We comply with the Equality Act 2010 and the Public Sector Equality Duty. We take equality and human rights into account in everything we do, whether commissioning services, employing people, developing policies, communicating, consulting or involving people in our work.

We embed equality into all our core business functions and see it as an

opportunity to raise equality in service commissioning and performance for the community, patients, carers and staff.

This year we refreshed our Equality Analysis (EA) toolkit and guidance, which covers all equality groups offered protection under the Equality Act 2010. This ensures that we can identify the effect of our policies, procedures and functions on various sections of the population we serve. We will take immediate steps to deal with any negative impact and make sure equity of service delivery is available for all.

Workforce

Our workforce is our most valuable asset, therefore the way we develop our organisation and our staff is extremely important to us. Our focus must be on developing our capacity and capability to balance the challenges of providing high quality, safe services with the efficiencies necessary for re-investment in order to achieve our financial plans.

We have a robust appraisal process in place which is the system we use to manage people development and as a platform for managing talent and succession planning in the organisation. We are committed to the education and training of our staff and want to support staff to maximise their potential through the wide range of learning opportunities available

The sickness absence rate in the CCG is one of the lowest across the North East. However, we will continue to carefully monitor the rates and reasons why staff are absent to ensure that the appropriate management interventions and support functions are in place. We will be looking at what actions we need to implement in light of the emphasis in the NHS Five Year Forward View to improve the physical and mental health and wellbeing of our staff.

Organisational change is known to be stressful for staff, and given that we have just been through a major change process for the merger of the CCGs we are pleased therefore to report that the sickness absence rate has remained low throughout the merger timeline which is a good indication of the success of the engagement process used.

Staff and recruitment

Equality and diversity training is a mandatory requirement for our staff. Anyone involved in recruitment is required to undertake recruitment and selection training which includes awareness of equality and diversity legislation as it relates to the recruitment process.

All members of staff receive a copy of the quarterly newsletter, produced by our Commissioning Support Unit, which contains up-to-date information on equality diversity and human rights legislation and developments.

We can also demonstrate fair recruitment, workforce engagement and employment terms and conditions for staff.

We have earned the two tick 'positive about disabled people' symbol which demonstrates our commitment to employ, retain and develop the abilities of disabled staff. It terms of our gender split for the CCG are as follows:

NHS Newcastle West CCG	Male	Female
Governing Body members	7	3
Very senior managers	0	1
CCG employees	8	27

Working relationships

Engagement and partnership is embedded into our culture. Our partnerships with local NHS trusts, local voluntary sector organisations and community groups enable us to identify the needs of the diverse community we serve in Newcastle.

We actively seek the views of patients, carers and the public through consultations, community events, activities, surveys, focus groups and via Healthwatch.

Through our Commissioning Support Unit, we have continued to work closely with other local NHS organisations to support the regional working that has been a legacy of the Equality, Diversity and Human Rights Regional Leads Meetings.

An open approach

We have an open, accessible approach and work hard to ensure our services are inclusive and accessible to all. Our public buildings are accessible for people with a disability and have had disability access audits.

When it comes to accessing information, we strive to use everyday language wherever possible, including interpreting services. Our public information is offered in other languages and formats such as large print or Braille and audio.

We welcome feedback, positive or negative, about people's experience of local NHS services as this helps us to improve services for patients.

Certification

We certify that the clinical commissioning group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

Mark Adams
Accountable Officer, 27 May 2015

Members report

Details of members of the Membership Body and Governing Body

The Member Practices of the Clinical Commissioning Group are:

- Betts Avenue Medical Centre
- Broadway Medical Centre
- Cruddas Park Surgery
- Denton Park Health Centre
- Denton Turret Medical Centre
- Dilston Medical Centre
- Fenham Hall Surgery
- Grainger Medical Group
- Holmside Medical Group
- Newburn Surgery
- Parkway Medical Centre
- Ponteland Road Health Centre
- Prospect Medical Group
- Roseworth Surgery
- Scotswood GP Practice
- Throckley Primary Care Centre
- West Road Medical Centre
- Westerhope Medical Group

The Chair of the Clinical Commissioning Group is Dr Guy Pilkington and the Chief Officer (Accountable Officer) is Mark Adams.

Membership Body (Practices Board)
The composition of the Membership Body is:

Member Representative	Job Title	Practice
Dr Neil Kerry	GP	Betts Avenue Medical Centre
Julie Wade	Practice Manager	
Dr Chaudhary	GP	Broadway Medical Centre
Razia Chaudhary	Practice Manager	
Dr Carol Brougham	GP	Cruddas Park Surgery
Susan Wilson	Practice Manager	
Dr Michael Meinen	GP	Denton Park Health Centre
Diane Wallace	Practice Manager	
Dr David Howarth	GP	Denton Turret Medical Centre
Martin Bell	Practice Manager	

Dr Gopal Munisamy	GP	Dilston Medical Centre
Tracey Gardener	Practice Manager	
Dr Carolyn Burton	GP	Fenham Hall Surgery
Helen Gunn	Practice Manager	
Dr Nasreen Mowla	GP	Grainger Medical Group
Patricia Urwin	Practice Manager	
Dr Rachel Cooper	GP	Holmside Medical Group
Michael Foster	Practice Manager	
Dr Mike Scott	GP	Newburn Surgery
Malcolm Smith	Practice Manager	
Dr Nicola Weaver	GP	Parkway Medical Centre
Donna Aydon	Practice Manager	
Dr Dietrich Reimold	GP	Ponteland Road Health Centre
Sharon Russell	Practice Manager	
Dr Joe Kelliher	GP	Prospect Medical Group
Amanda Bargewell	Practice Manager	
Dr Steve Turley	GP	Roseworth Surgery
Christine Ramsey	Practice Manager	
Dr Kate Cushing	GP	Scotswood GP Practice
Diane Carr	Practice Manager	
Dr Brigid Joughin	GP	Throckley Primary Care Centre
Marie Bottomley	Practice Manager	
Dr Barbara Palmer	GP	West Road Medical Centre
Tracy Huitson	Practice Manager	
Dr Alison Smith	GP	Westerhope Medical Group
Paul Waters	Practice Manager	

Governing Body

The composition of the Governing Body is:

Chair	Dr Guy Pilkington
Chief Officer (Accountable Officer)	Mark Adams
Chief Finance Officer and Operating Officer	Joe Corrigan
Executive Director of Nursing and Patient Safety	Chris Piercy
Medical Director	Dr Neil Morris
Secondary Care Specialist Doctor	Bill Cunliffe
Lay Member: **To lead on audit, remuneration and conflict of interest matters**	Jeff Hurst
Lay Member: **To lead on patient and public participation matters**	Mandy Taylor
Member Practice Representatives	Dr Rachel Cooper Dr Alison Smith
	Director of Public Health: Prof. Eugene Milne, Newcastle City Council Director of Commissioning: Jackie Cairns Head of Corporate Affairs: Jeffrey Pearson Minute taker: Louise McAndrew

Audit Committee
The composition of the Audit Committee is:

Membership:

- The lay member of the Clinical Commissioning Group who leads on audit and conflict of interest matters
- At least one other lay member of the Clinical Commissioning Group
- One other member with the relevant skills and experience as nominated by the Governing Body

In attendance:

- The chief finance officer is the lead officer for the committee
- The accountable officer attends at least annually to discuss with the committee the process for assurance that supports the Annual Governance Statement. He also attends when the committee considers the draft internal audit plan and the annual accounts.
- The External Auditor and Internal Audit attend the committee as necessary

Details of members of other committees and sub-committees can be found in Section 4 of the Governance Statement.

The Membership Body and Governing Body declaration of interests can be found in the Remuneration Report.

Pension liabilities

Treatment of pension liabilities in the accounts is outlined in Note 4.5 to the accounts. In addition page 48 of the Remuneration Report outlines the Cash Equivalent Transfer Values.

Sickness absence data

A table is included in note 4.3 of the accounts.

External audit

The Audit Commission appointed Mazars LLP as the CCG's external auditor for the years 2013/14 to 2016/17. The 2014/15 audit fee was £60,000 plus VAT.

The auditors did not perform any non-audit work for the CCG during the 12 month period beginning April 2014.

Disclosure of serious untoward incidents

Information on the disclosure of serious untoward incidents is referenced in the Governance Statement which can be found on page 40.

Cost allocation and setting of charges for information

We have complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

Principles for remedy

'Principles for Remedy' published by the Parliamentary and Health Service Ombudsmen in May 2010 have been adopted by the CCG as part of best practice recommendations within the Complaints Policy and Procedure.

Employee consultation

Staff engagement is a key factor in ensuring we deliver our organisational objectives and meet the range of current challenges that we face. By involving staff in decisions and communicating clearly with them, we are able to maintain and improve staff morale, especially during periods of difficulty and change.

As part of our journey to become NHS Newcastle Gateshead CCG we have worked with our HR Partners to ensure we used appropriate organisational change processes with our staff. This has included a number of staff engagement sessions around developing the new organisation, developing our mission vision and values and for example during the HR consultation process on the organisational structure.

We undertook a local staff survey to seek opinions from staff on how to improve our organisation to take us from 'good' to 'great' in order to improve and join work up across the organisation our wider geography and work streams.

The survey focussed on understanding from staff:

- What works really well
- What we wouldn't want to change
- What things we know work less well
- Where we could do things better
- Working in partnership

Feedback from the survey was used throughout the merger process to continuously engage with staff, share opinions and solutions and demonstrate to staff how their feedback was used. Outcomes from this work continue to be implemented including the development of a compact for our internal values and behaviours. Some examples of feedback from the staff survey included:

> "I've found the internal culture to be very friendly and everyone appears to enjoy their job, have high job satisfaction and a real commitment to making a difference and doing things better. The passion is great to see. If this could somehow be communicated to providers and practices it would be great for the CCG. I think sometimes external stakeholders under-estimate just how much work commissioners do and how dedicated and passionate the staff are."

> "We need to ensure that the whole working environment works for every member of staff, and that people must be valued for the work which they do. Staff must also be encouraged to make things happen, and for 'new' things to come not just from senior management or clinicians."

Organisational change is known to be stressful for staff, we are therefore pleased to report that the sickness absence rate has remained low throughout the merger timeline, which is a good indication of the success of the engagement process used.

Disabled employees

We have policies in place to ensure all employees are treated fair and equally. All staff undertake mandatory training, which includes equality and diversity legislation.

Emergency preparedness, resilience and response

We have an incident response plan in place, which is fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. We regularly review and make improvements to our major incident plan and we have a programme for regularly testing this plan, the results of which are reported to the Governing Body.

Statement as disclosure to auditors

The Governing Body is not aware of any relevant audit information that has been withheld from the Clinical Commissioning Group's external auditors and members of the Governing Body take all necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

Mark Adams
Accountable Officer, 27 May 2015

Remuneration report

Remuneration committee

The remuneration committee was established to advise the Governing Body about pay, other benefits, and terms of employment for the Chief Officer and other senior staff.

The composition of the remuneration committee is:

- All of the lay members of the CCG

The committee is chaired by the lay member for patient and public involvement.

The chair has the responsibility to ensure that the Committee obtains appropriate advice in the exercise of its functions.

The Accountable Officer is the lead officer for the committee and will be invited to attend all meetings. He or she will withdraw for discussions relating to his or her own remuneration.

Other officers, employees, and practice representatives of the CCG may be invited to attend all or part of meetings of the committee to provide advice or support particular discussion from time to time. They will not be in attendance for discussions about their own remuneration or terms of service. Those invited to attend are not entitled to vote.

During the year the remuneration committee has met on one occasion. The two lay members, the Accountable Officer and the chief finance and operating officer all attended this meeting.

For the purpose of this remuneration report, the definition of ‘senior managers’ is as per the CCG Annual Reporting Guidance published by NHS England:

“Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Clinical Commissioning Group.”

This means those who influence the decisions of the CCG as a whole, rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.

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

Senior manager contracts

Contracts of employment in relation to all senior managers employed by the CCG are permanent in nature and subject to six months' notice of termination by either party. Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the NHS Pension Scheme Regulations for those who are members of the scheme. No awards have been made during the year to past senior managers.

Three of the GP Governing Body members are not directly employed by the CCG, with their services provided through separate agreements between the CCG and the respective GP practices with which they are employed or partners thereof.

The following tables and pay multiples have been audited. Remuneration committee, senior manager contracts and off payroll engagements are not subject to audit.

Comparative information for the prior year is disclosed in the tables below

Newcastle West CCG senior officer's salaries and allowances 2014/15

Name	Title	Salary and Fees (bands of £5,000) £000	Taxable Benefits (Rounded to the nearest £00) £00	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Dr Guy Pilkington	Chair	105-110	0	0	0	0	105-110
Mark Adams	Chief Officer	130-135	0	0	0	2.5-5	135-140
Joe Corrigan	Chief Finance Officer and Operating Officer	120-125	0	0	0	0	120-125
Chris Piercey	Chief Nursing Officer	100-105	0	0	0	0	100-105
Dr Neil Morris	Medical Director	85-90	0	0	0	0	85-90
Bill Cunliffe	Secondary Care Specialist Doctor	25-30	0	0	0	0	25-30
Jeff Hurst	Lay member, audit, remuneration and conflict of interest matters	20-25	0	0	0	0	20-25
Mandy Taylor	Patient and public participation matters	5-10	0	0	0	0	5-10
Dr Rachel Cooper	Clinical Vice Chair	40-45	0	0	0	0	40-45
Dr Alison Smith	Member practice representative	5-10	0	0	0	0	5-10
Jeffrey Pearson	Head of Corporate Affairs	55-60	20	0	0	12.5-15	70-75
Jackie Cairns	Locality Director of Commissioning	85-90	10	0	0	0	85-90

Newcastle West CCG senior officer's salaries and allowances 2013/14

Name	Title	Salary and Fees (bands of £5,000) £000	Taxable Benefits (Rounded to the nearest £00) £00	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Dr Guy Pilkington	Chair	105-110	0	0	0	0	105-110
Mark Adams	Chief Officer	130-135	0	0	0	97.5-100	230-235
Joe Corrigan	Chief Finance Officer and Operating Officer	120-125	0	0	0	85-87.5	210-215
Chris Piercey	Chief Nursing Officer	85-90	0	0	0	0	85-90
Dr Neil Morris	Medical Director	70-75	0	0	0	0	70-75
Bill Cunliffe	Secondary Care Specialist Doctor	20-25	0	0	0	0	20-25
Jeff Hurst	Lay member, audit, remuneration and conflict of interest matters	10-15	0	0	0	0	10-15
Mandy Taylor	Patient and public participation matters	5-10	0	0	0	0	5-10
Dr Rachel Cooper	Clinical Vice Chair	45-50	0	0	0	25-27.5	70-75
Dr Alison Smith	Member practice representative	5-10	0	0	0	0	5-10
Jeffrey Pearson	Head of Corporate Affairs	50-55	28	0	0	25-27.5	75-80
Jackie Cairns	Locality Director of Commissioning	85-90	15	0	0	32.5-35	115-120

Notes:

The Chief Officer, Chief Finance Officer and Operating Officer, Chief Nursing Officer, Medical Director and Secondary Care Specialist Doctor work on a cluster basis across Gateshead CCG, Newcastle North and East CCG and Newcastle West CCG. The figures above relate to total remuneration for this cluster work.

Taxable benefits are shown in £00 and all relate to lease cars.

Pension values are provided by NHS Pensions. Clarification and confirmation of reported values has been provided by NHS Pensions.

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

Dr Guy Pilkington
Dr Neil Morris
Dr Alison Smith
Dr Rachel Cooper (for the period April 2013 to August 2013 only. Directly employed from September 2013)

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

Professor Eugene Milne, Director of Public Health, Newcastle City Council

The Chief Officer, Chief Finance Officer and Operating Officer, Chief Nursing Officer, Medical Director and Secondary Care Specialist Doctor and Head of Corporate Affairs work on a cluster basis across Gateshead CCG, Newcastle North and East CCG and Newcastle West CCG. The figures below relate to the cost of the staff sharing arrangements relating to Newcastle West CCG. The staff sharing arrangement calculation is apportioned based upon CCG recurrent running cost allocation.

Staff sharing arrangements for Newcastle West CCG senior officer's salaries and allowances 2014/15

Name	Title	Salary and Fees (bands of £5,000) £000	Taxable Benefits (Rounded to the nearest £00) £00	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related Bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
Mark Adams	Chief Officer	35-40	0	0	0	0-2.5	35-40
Joe Corrigan	Chief Finance Officer and Operating Officer	30-35	0	0	0	0	30-35
Chris Piercy	Chief Nursing Officer	25-30	0	0	0	0	25-30
Dr Neil Morris	Medical Director	20-25	0	0	0	0	20-25
Bill Cunliffe	Secondary Care Specialist Doctor	5-10	0	0	0	0	5-10
Jeffrey Pearson	Head of Corporate Affairs	10-15	5	0	0	2.5-5	15-20

Staff sharing arrangements for Newcastle West CCG Senior Officers Salaries and Allowances 2013/14:

Mark Adams	Chief Officer	35-40	0	0	0	25-27.5	60-65
Joe Corrigan	Chief Finance Officer and Operating Officer	30-35	0	0	0	22.5-25	55-60
Chris Piercy	Chief Nursing Officer	20-25	0	0	0	0	0
Dr Neil Morris	Medical Director	15-20	0	0	0	0	0
Bill Cunliffe	Secondary Care Specialist Doctor	5-10	0	0	0	0	0
Jeffrey Pearson	Head of Corporate Affairs	10-15	7	0	0	5-7.5	20-25

Newcastle West CCG senior officer's pension benefits 2014/15

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in Pension Lump Sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £000	Lump Sum at aged 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to partnership pension £000
Mark Adams, Chief Officer	0-2.5	2.5-5	25-30	80-85	486	531	32	19
Joe Corrigan, Chief Finance Officer and Operating Officer	0-2.5	0-2.5	40-45	130-135	732	781	29	17
Rachel Cooper, Clinical Vice Chair	0-2.5	0-2.5	10-15	30-35	144	151	4	6
Jeffrey Pearson, Head of Corporate Affairs	0-2.5	2.5-5	5-10	20-25	149	0	0	8
Jackie Cairns, Locality Director	0-2.5	0-2.5	25-30	75-80	452	485	20	12

Newcastle West CCG Senior Officers Pension Benefits 2013/14

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in Pension Lump Sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Lump Sum at aged 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to partnership pension £000
Mark Adams, Chief Officer	5 - 7.5	15 – 17.5	25-30	75 - 80	372	486	106	19
Joe Corrigan, Chief Finance Officer and Operating Officer	2.5 - 5	12.5 – 15	40 - 45	125 - 130	624	732	95	17
Rachel Cooper, Clinical Vice Chair	0 – 2.5	2.5 - 5	5 - 10	25 - 30	128	144	12	3
Jeffrey Pearson, Head of Corporate Affairs	0 – 2.5	2.5 - 5	5 - 10	15 - 20	112	149	34	7
Jackie Cairns, Locality Director	0 – 2.5	5 – 7.5	20 - 25	70 - 75	397	452	46	12

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 benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not 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 cash equivalent transfer values

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

Pay multiples

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

The mid-point of the banded remuneration of the highest paid director in Newcastle West CCG in the financial year 2014/15 was £107,500 (2013/14, £107,500). This was 7.2 times (2013/14, 8.1 times) the median remuneration of the workforce, which was £14,866 (2013/14, £13,278).The reduction in the ratio is due to an increase in the median remuneration in 2014-15.

In 2014/15, no employee (2013/14, no employee) received a full time equivalent remuneration in excess of the highest paid director. Full time equivalent remuneration for employees ranged from £4,585 to £106,704 (2013/14, £4,483 to £106,704).

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.

	2014/15	2013/14
Band of Highest Paid Director's Total Remuneration (£'000)	105 -110	105-110
Median Total Remuneration (£)	14,866	13,278
Ratio	7.2	8.1

Off-payroll engagements

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

	2014/15	2013/14
Number of existing arrangements as of 31 March	3	3
Of which, the number that have existed:		
· For less than one year at the time of reporting	0	3
· For between one and two years at the time of reporting	3	0
· For between two and three years and the time of reporting	0	0
· For between three and four years at the time of reporting	0	0
· For four or more years at the time of reporting	0	0

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

	2014/15	2013/14
Number of new engagements, or those that reached six months in duration, between 1 April and 31 March	0	4
Number of new engagements which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations	0	0
Number for whom assurance has been requested	0	4
Of which:		
• assurance has been received	0	4
• assurance has not been received	0	0
• engagements terminated as a result of assurance not being received	0	0

Assurances were obtained in writing in all cases.

	2014/15	2013/14
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	3	4
Number of individuals that have been deemed " Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements)	12	12

Of the three off-payroll engagements in this financial year:

Three remain off payroll as at 31 March 2015 due to partnership arrangements in the individuals GP practice's that prevent the individual becoming an employee

Governing Body – declarations of interest

Name	Position Held on Governing Body	Declarations of Interest	Identified Conflicts of Interest
Dr Guy Pilkington	Chair	Partner at Cruddas Park Surgery.	None identified
Mark Adams	Chief Officer	Director, Beverley Leisure LTD – Residents holding company for Beverley Park Tennis Club. Director GLSKR.com Ltd.	None identified
Joe Corrigan	Chief Finance and Operating Officer	Sibling is a GP Partner and a member of NHS Cumbria Clinical Commissioning Group	None identified
Dr Neil Morris	Medical Director	None	None identified
Mr Bill Cunliffe	Secondary Care Specialist Doctor	None	None identified
Chris Piercy	Executive Director of Nursing and Patient Safety	Chair of Clarke Lister BHF Peterlee. Chair of Trustees Clarke Lister Feel Good Centre. Trustee Royal College of Nursing Foundation	None identified
Jeff Hurst	Lay Member (Governance)	Chief Executive Officer Newcastle YMCA. Newcastle YMCA is commissioned by Newcastle City Council to deliver an obesity prevention programme with children in East Newcastle. Close personal friendship with Dr D Howarth, Senior Partner, Denton Turret Medical Group. Friendship started 10 years ago.	None identified
Mandy Taylor	Lay Member (Patient and Public Involvement)	Chief Executive at Streetwise.	None identified
Dr Rachel Cooper	Clinical Vice-Chair	GP partner Holmside Medical Group Husband consultant radiologist at South Tyneside Foundation Trust	None identified
Dr Alison Smith	Practice Representative	GP partner at Westerhope Medical Group	None identified
Jackie Cairns	Director of Delivery and Transformation.	None	None identified
Jeffrey Pearson	Head of Corporate Affairs	Brother works for NHS Business Services Authority	None identified

Membership Body and Governing Body profiles

Practices Board
Our Practices Board is the Membership Body of the CCG. It comprises a GP representative from each of the 18 member practices, acting on behalf of the practice in dealings with the CCG and representing the member practice at meetings of the Practices Board. The Practices Board is chaired by Dr Guy Pilkington.

Governing Body
The Governing Body is responsible for reviewing decisions, approving plans and is responsible for our £190.2 million budget. Individual members of the Governing Body bring different perspectives, drawn from their background and experience. These differing insights ensure that we take a balanced view to decisions.

Dr Guy Pilkington, Chair
Dr Guy Pilkington is Clinical Chair of NHS Newcastle West Clinical Commissioning Group and has been Chair of the CCG and its preceding Practice Based Commissioning Group (PBC) for the last seven years.

Mark Adams, Chief Officer (Accountable Officer)
Mark's role as Accountable Officer is to ensure that the CCG functions effectively, efficiently and economically with the aims of improving the safety and quality of services provided for patients, the health of the local population and the delivery of value for money. He also ensures that the working arrangements of the CCG reflects good practice.

Another part of his role is to ensure that the CCG conducts itself in an environment that is well governed and that they make prudent decisions in an open and transparent way to secure continuous improvements in service quality and outcomes.

Mandy Taylor, Deputy Chair and Lay Member
Mandy brings a wealth of experience of working within the community and voluntary sector to her role as Lay Member for Public and Patient Involvement. She has been involved with the CCG since shadow form as a voluntary and community representative of the CCG Consortium Board.

She is a passionate advocate for young people and has vast experience of successful stakeholder engagement from her working life

Mandy is currently employed as the Chief Executive Officer at Streetwise Young People's Project, which delivers specialist sexual health, counselling, information, advice and support services to young people.

Dr Rachel Cooper, Clinical Vice-Chair
Rachel is clinical vice-chair of NHS Newcastle West CCG. She has been in this role for over two years, and was previously involved in Newcastle West Practice Based Commissioning Group.

Her areas of responsibility are long-term conditions and the older person, working with, and supporting, clinical leads who work in these areas. She is specifically involved in implementing a chronic obstructive pulmonary disease (COPD) pathway and leading work around services outside of hospital, including community nursing and care homes.

In the past she has worked for Macmillan as the GP facilitator for Newcastle, and also worked for NHS North of Tyne, the former primary care trust, as a clinical governance and performance lead.

Rachel is a partner at Holmside Medical Group in the west end of Newcastle and has been for almost 13 years. The practice has the oldest population in Newcastle and covers some of the most deprived areas of the city. She is a GP trainer; training GP registrars in the practice and from August will also be involved in the training of junior doctors.

In addition to training in the practice Rachel has expertise in women's health, fitting contraceptive implants and intra uterine devices, and also palliative and end of life care.

Jeff Hurst, Lay Member Governance
Following 24 years in the public sector, working within the defence sector, Jeff spent the last ten years working in the community and voluntary sector specifically with organisations providing services to young people with multiple needs who live in the deprived areas of Newcastle. He read law at Northumbria University and has recently completed a Master's in Business Administration at Durham University.

Jeff's approach as lay member for governance is to ensure that the needs and wishes of member practices are accurately represented, to make certain that services meet the needs of their patients.

Jeff has a keen interest in research and has recently established a research partnership between Newcastle CCG's and FUSE, the region's Public Health Research Centre of Excellence. The aim of the partnership is to create research capability and capacity within Newcastle by supporting the appointment, development and retention of key staff undertaking, or supporting, people and patient-based research.

Chris Piercy, Executive Director of Nursing and Patient Safety
As Director of Nursing, Chris' role is statutory as the chief nurse for the CCG. He also assures the delivery of the highest levels of service quality, patient safety and value for money in all commissioned services whilst ensuring that patients/carers are central to all decision-making and that their voices can be heard across the CCG.

Chris is also the CCG lead for Safeguarding Children and Adults and also lead for Infection Prevention and Control.

Bill Cunliffe, Secondary Care Specialist Doctor
Bill's role brings a broader view, on health and care issues to underpin our work, with particular focus on patient care in the secondary care setting.
Bill formally worked as a consultant surgeon for Gateshead Health NHS Foundation Trust for 21 years, and was also the Trust's Medical Director from 2004 until 2010. This background provides an understanding of secondary care settings which enables him to give an independent strategic clinical view on all aspects of our business.

Dr Neil Morris, Medical Director
Neil offers medical leadership on all aspects of quality and safety relating to the patients of Gateshead and Newcastle. There is a particular focus on the services the CCG commissions (acute and mental health providers, as well as community health services). He also supports primary care in maintaining or raising the quality of GP services for the benefit of patients, practices and CCG practice membership.

Joe Corrigan, Chief Finance and Operating Officer
Joe's role as Chief Finance and Operating Officer means that he is the Governing Body's professional expert on finance with responsibility for ensuring, through robust systems and processes, that the regularity and propriety of expenditure is fully discharged. His responsibilities include ensuring that the CCG's functions and resources support achievement of their strategies.

Dr Alison Smith, Member Practice Representative
Alison originally moved to Newcastle in 1982 to attend Medical School and then went straight into GP training after qualifying and has been at Westerhope Medical Group for the past 21 years.

Alison's areas of special interest are mental health and substance misuse. Alison has provided clinician input through various committees/boards through different NHS administrations and has been the Independent Chair of the Practice Board since April 2013.

Declarations of interest: Member Practice Representatives

Member Representative	Practice	Declarations of Interest	Identified Conflicts of Interest
Dr Neil Kerry	Betts Avenue Medical Centre	General Practitioner	None identified
Dr Chaudhary	Broadway Medical Centre	General Practitioner	None identified
Dr Carol Brougham	Cruddas Park Surgery	General Practitioner	None identified
Dr Michael Meinen	Denton Park Health Centre	General Practitioner	None identified
Dr David Howarth	Denton Turret Medical Centre	Lead GP for liaising with CCG, GP Trainer, GP Partner	None identified
Dr Gopal Munisamy	Dilston Medical Centre	General Practitioner	None identified
Dr Carolyn Burton	Fenham Hall Surgery	General Practitioner	None identified
Dr Nasreen Mowla	Grainger Medical Group	General Practitioner	None identified
Dr Rachel Cooper	Holmside Medical Group Scotswood GP Practice	Husband is a Consultant Radiologist at NHS South Tyneside Foundation Trust	None identified
Dr Mike Scott	Newburn Surgery	General Practitioner	None identified
Dr Nicola Weaver	Parkway Medical Centre	General Practitioner	None identified
Dr Dietrich Reimold	Ponteland Road Health Centre	General Practitioner	None identified
Dr Jane Carman	Prospect Medical Group	General Practitioner	None identified
Dr Steve Turley	Roseworth Surgery	General Practitioner	None identified
Dr Brigid Joughin	Throckley Primary Care Centre	GP Partner	None identified
Dr Barbara Palmer	West Road	General Practitioner	None identified
Dr Alison Smith	Westerhope Medical Group	General Practitioner	None identified

Statement by the Accountable Officer

Statement of Accountable Officer's responsibilities

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

The responsibilities of an Accountable Officer include 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 CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare for the financial year, financial statements in the form and on the basis set out in the Accounts Direction.

The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG, and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

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

Mark Adams
Accountable Officer, 27 May 2015

Governance statement

Introduction

The CCG was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the NHS 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 clinical commission group taking on its full powers.

During the course of 2014/15 the CCG has been engaged in a process which has culminated in a merger with NHS Gateshead CCG and NHS Newcastle North and East CCG, producing a single clinical commissioning group, NHS Newcastle Gateshead CCG, to be established on 1 April 2015. This process has been facilitated and overseen by colleagues in NHS England.

Scope of responsibility

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

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

Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the clinical commissioning group's compliance with the principles set out in the code.

For the financial year ending 31 March 2015, and up to the date of signing this statement, we had regard to the provisions set out in the code, and applied the principles of the code.

The Clinical Commissioning Group Governance Framework

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

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

The CCG has a Constitution based on the Department of Health's Model Template and it has been amended and approved to take into account subsequent guidance. Review of the CCG's Constitution confirms that it complies with the elements of the self-certification checklist, including:

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

Practices Board

The CCG has a Practices Board, comprising the elected members of each general practice within the group. Each practice has elected two representatives, one health care professional and one practice manager, to represent their commissioning interests.

The practices board has met on four occasions during 2014-15 in order to discharge its responsibilities as determined by the scheme of reservation and delegation and its terms of reference.

The Practices Board is chaired by a clinician who is also a member of the Governing Body. The Chair of the CCG is a voting member of the group.

The Practices Board has determined to delegate the majority of the decision-making responsibility to the Governing Body and its sub-committees.

Governing Body

The Governing Body is constituted in accordance with the Health and Social Care Act 2012 and the National Health Service (Clinical Commissioning Groups) Regulations 2012. There are no separate terms of reference for the Governing Body, as they are set out in the CCG constitution and include the membership.

During the year 2014/15, Newcastle West CCG Governing Body met on six occasions both in private and public, and for which there was an annual cycle of business.

Agendas are structured to deal with Public and Patient Involvement, Quality, Finance, Performance, Strategic, Governance and Public Health issues. The arrangements meet the requirements of best practice guidance in respect of risk management and ensure that a strong accountability framework has been established. They reflect the public service values of accountability, probity and openness and specify as Accountable Officer my responsibility for ensuring that these values are met within the Clinical Commissioning Group.

The meetings of the Governing Body were held jointly with the governing bodies of Gateshead CCG and Newcastle North and East CCG.

Members of the Governing Body completed a self-assessment questionnaire (Figure 1), which provides a profile of the effectiveness of the Governing Body during 2014-15. This has highlighted some areas which the Governing Body needs to address in order to be more effective, and they will form the basis for some of the developmental work of the Governing Body during 2015-16.

Figure 2 provides information on the attendance of members at the Governing Body meetings, and at meetings of its sub-committees.

Figure 1: Governing Body self-assessment questionnaire

Governing Body – Self-assessment Questionnaire

	YES / %	NO / %	DON'T KNOW / %
Q1 Are you clear about the Terms of Reference for the Governing Body?	18 / 95	0 / 0	1 / 5
Q2 Are you clear about the roles and responsibilities of members of the Governing Body?	18 / 95	0 / 0	1 / 5
Q3 Is there clear division of responsibilities in the leadership of the group, between the Accountable Officer and the Chair	14 / 74	1 / 5	4 / 21
Q4 Does the Chair display leadership of the Governing Body, to support it being effective in all aspects of its role?	15 / 79	0 / 0	4 / 10.5
Q5 The Governing Body can clearly explain why the current balance of skills, experience and knowledge amongst members is appropriate to effectively govern the CCG	17 / 89.5	0 / 0	2 / 9
Q6 Do all members have clearly set out objectives and mechanisms in place for appraisal/ annual review	6 / 32	6 / 32	7 / 36
Q7 Has the Governing Body received assurance on the development process for the OD strategy?	11 / 58	1 / 5	7 / 37
Q8 Are the matters reserved to the Governing Body (as set out in the constitution) still suitable?	17 / 89.5	0 / 0	2 / 9
Q9 Are the committees effective in discharging the duties delegated to them? Would we be able to articulate this?	15 / 79	0 / 0	4 / 10.5
Q10 Does the Governing Body have the appropriate balance of skills, experience, and knowledge to ensure the responsibilities are managed effectively?	17 / 89.5	0 / 0	2 / 9
Q11 Do all the members of the Governing Body provide sufficient time to discharge their responsibilities effectively?	12 / 63	1 / 5	6 / 32
Q12 Is Governing Body supplied with information and support in a timely manner, in a form and of a quality appropriate to enable it to discharge its duties?	18 / 95	0 / 0	1 / 5
Q13 Do the Governing Body lay members provide constructive challenge and help develop proposals on strategy?	15 / 79	1 / 5	3 / 16
Q14 Is the Governing Body development programme appropriate?	15 / 79	0 / 0	4 / 10.5
Q15 Does the Governing Body make a difference in the management of the CCGs?	13 / 68	1 / 5	5 / 27
Q16 Is the Governing Body presented with a balanced and an understandable assessment of the organisations position and prospects?	18 / 100	0 / 0	0 / 0
Q17 Does the Governing Body carry out a review of the effectiveness of the organisations risk management and internal control systems?	15 / 83	0 / 0	3 / 17
Q18 Key information is triangulated to enable the Governing Body to make decisions and have assurance about the quality of care it commissions	18 / 100	0 / 0	0 / 0
Q19 The papers and information the Governing Body receives are accessible but comprehensive enough to provide assurance.	17 / 94	0 / 0	1 / 6
Q20 Is there a formal and transparent procedure on executive remuneration?	18 / 100	0 / 0	0 / 0
Q21 Is the governing body assured with progress on the communication and engagement strategy implementation?	13 / 72	2 / 11	3 / 17
Q22 Is the Governing Body committed to hearing the views of stakeholders?	17 / 100	0 / 0	0 / 0
Q23 Does the Governing Body encourage participation of stakeholders?	17 / 94	0 / 0	1 / 6
Q24 Does the Governing Body make the most constructive use of its AGM?	6 / 33	3 / 17	9 / 50

Figure 2: Governing Body and Committee Meetings Attendance Record

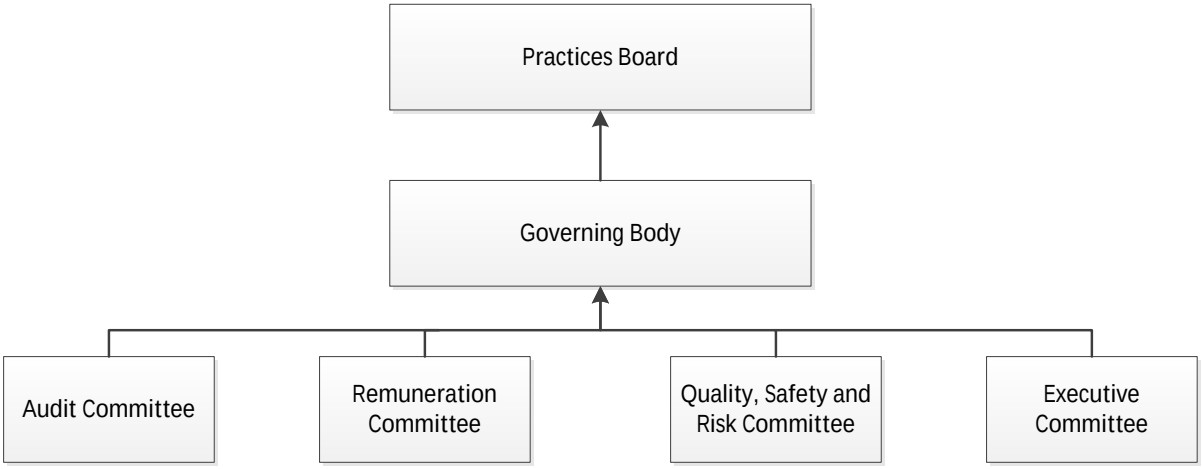
Members' Attendance Record: NHS Newcastle West Clinical Commissioning Group 2014/15						
Name	Title	Governing Body	Audit Committee	Remuneration Committee	Quality, Safety and Risk Committee	Executive Committee
Guy Pilkington	Chair	5/5				10/11
Mandy Taylor	Deputy Chair and Lay Member for PPI	4/5		1/1	3/5	
Jeff Hurst	Lay Member	4/5	7/7	1/1		6/11
Rachel Cooper	Clinical Vice Chair	2/5				5/11
Alison Smith	Practice Representative	5/5				
Neil Morris	Medical Director	4/5			5/5	2/5
Bill Cunliffe	Secondary Care Doctor	2/5	4/7[1]		1/5	1/5
Chris Piercy	Director of Nursing	3/5	3/7[2]		5/5	3/5
Mark Adams	Chief Officer	5/5			0/5	7/11
Joe Corrigan	Chief Finance and Operational Officer	5/5				6/11
Jackie Cairns	Commissioning Director	5/5			0/5	10/11

It should be noted that whilst Mark Adams is listed in the terms of reference as a member of the Quality, Safety and Risk committee, a decision was taken that the Executive Director of Nursing, Quality and Patient Safety should take a lead in relation to this group.

Bill Cunliffe and Chris Piercy were nominated to the Audit Committee by the Governing Body and between them have ensured attendance, and therefore quoracy.

We have continued to operate with a committee structure which reflects guidance and best practice, including an Audit Committee incorporating the business of the former Finance and Performance Committee, Remuneration Committee, Quality, Safety and Risk Committee, and Executive Committee terms of reference have been agreed for these committees which support the organisation in the delivery of effective governance. The organisational structure including key committees is set out below.

[1] Bill Cunliffe was nominated by the Governing Body in January 2014 as a member of the audit committee.
[2] Chris Piercy was nominated by the Governing Body in January 2014 as a member of the audit committee.



Description of the Established Governing Body Committees

The roles of each of the Governing Body committees are set out broadly below.

The Governing Body Committees have authority under the Scheme of Delegation to establish sub-committees or sub-groups to enable them to fulfill their role. Each of the Governing Body committees has detailed terms of reference. Each committee is authorised by the Governing Body to pursue any activity within their terms of reference and within the scheme of reservation and delegation.

Audit Committee

The Audit Committee was operational throughout the 2014-15 financial year, and has continued to operate after that period. In accordance with the terms of reference, meetings of the Audit Committee will normally be held bi-monthly, and not less than 5 times per financial year. The Audit Committee met on seven occasions during 2014-15.

In line with the requirements of the NHS Audit Committee Handbook and NHS Codes of Conduct and Accountability, the committee provides the organisation with an independent and objective review of their financial systems, financial information and compliance with laws, guidance, and regulations governing the NHS.

The committee's cycle of business includes review of the Clinical Commissioning Group Assurance Framework and corporate risk register.

The committee is a non-executive committee of the Governing Body and has no executive powers, other than those specifically delegated in its terms of reference. Annually, the committee also carries out a self-assessment of its effectiveness and addresses any issues raised as part of the committee's development process.

The committee's terms of reference are described in a document separate to the CCG's constitution and are available on the CCG's website.

The Audit Committee, as part of its terms of reference, provides an annual report of its work to the Governing Body. The most recent report available covers the year to 2014/15. The principal purpose of the report is to give the Governing Body an assurance as to the work carried out to support the Accountable Officer's review of the internal control arrangements.

The committee's cycle of business enables the Audit Committee to carry out its key objectives necessary to support its assurances regarding the effectiveness of the organisation's internal controls.

Remuneration Committee

The Remuneration Committee was operational throughout the 2014-15 financial year and has continued to operate after that period. In accordance with the terms of reference, meetings of the Remuneration Committee will be held as and when required, but not less than once per financial year. The Remuneration Committee met on one occasion during 2014-15.

The Remuneration Committee is established to advise/recommend to the Governing Body the appropriate remuneration and terms of service for the Chief Officer and other staff paid through the Very Senior Manager Pay Framework. The committee also advises/recommends to the Governing Body remuneration for the role of chair, remuneration and terms of service of any independent lay members and reviews any business cases for early retirement and redundancy.

The committee's terms of reference are described in a document separate to the CCG's constitution and are available on the CCG's website.

Quality, Safety and Risk Committee

The Quality, Safety and Risk Committee was operational throughout the 2014-15 financial year and has continued to operate after that period. In accordance with the terms of reference, meetings of the Quality, Safety and Risk Committee will be held not less than six times per financial year. The Quality, Safety and Risk Committee met on five occasions during 2014-15.

The Quality, Safety and Risk Committee assists the Governing Body in its duty to secure continuous improvement in the quality of services, improve the quality of primary medical services and promote research and use of research. It provides assurance to the Governing Body about the quality, safety and risks of the services being commissioned, and the overall risks to the organisation's strategic and operational plans.

The committee's terms of reference are described in a document separate to the CCG's Constitution and are available on the CCG's website.

Significantly during the year through its cycle of business, the Quality, Safety and Risk Committee and its associated sub-committee has considered the following issues:

- Quality monitoring reports on provider commissioned services, including the reporting of serious untoward incidents
- Complaints, claims and untoward incidents (through a report from the Quality, Patient Safety and Clinical Governance Committee)
- Healthcare acquired infections
- Provision of nursing home care
- Corporate and top risks register
- Risk Management Strategy and Governance Framework

During 2014-15 there were no never events reported to the CCG.

Whilst never events should not happen, in the event of an occurrence the important message is to be open and ensure lessons learned become embedded into everyday clinical practice.

Finance and Performance Committee

The function and business of the Finance and Performance Committee was reviewed in March 2014. The outcome of this review proposed that the business of the committee be incorporated into the function of the Audit Committee, as there was a clear overlap between the two committees. The proposal was approved and was implemented from 1April 2014.

Executive Committee

The Executive Committee was operational throughout the 2014-15 financial year and has continued to operate after that period. In accordance with the terms of reference, meetings of the Executive Committee will normally be at least monthly, and not less than 8 times per financial year. The Executive Committee met on 12 occasions during 2014-15.

The Executive Committee is a management committee which supports the CCG, its Governing Body and the Accountable Officer in the discharge of their functions. It assists the Governing Body in its duties to promote a comprehensive health service, reduce inequalities and promote innovation. Its remit includes development and implementation of strategy, monitoring and delivery of delegated duties, operational, financial, contractual and clinical performance as well as ensuring the coordination and monitoring of risks and internal controls. It has authority to make decisions as set out within its terms of reference and the CCG's scheme of delegation.

In preparation for the merger of NHS Gateshead CCG, NHS Newcastle North and East CCG and NHS Newcastle West CCG from 1 April 2015, the Executive Committee met as a joint committee which managed the points above for all three CCGs.

The Clinical Commissioning Group Risk Management Framework

A Risk Management Strategy is in place which takes into account current guidance on risk management best practice and incorporates guidance provided by ISO 31000:2009 (formerly AZ/NZ Standard 4360:2004) and the former National Patient Safety Agency in its approach to assessing risk.

The Risk Management Strategy sets out the CCG's approach to the assessment and management of clinical and non-clinical risk in fulfilment of our overall objective to commission high quality and safe services. It provides guidance for the systematic and effective management of risk. Key elements of the Risk Management Strategy include:

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

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

Initial risks are rated according to impact and likelihood. Controls and assurances are then identified to ensure risks are being managed and mitigated. Residual risk ratings are then agreed and recorded, with a review date. The risk management policy sets out the arrangements for the escalation of risk.

The Quality, Safety and Risk Committee formally received a paper on risk appetite at its meeting in May 2014. This led to a change in the CCG's approach to risk management, with training sessions being arranged for members of staff.

An assurance framework has been developed and reviewed by the Audit Committee. It has been approved by the Governing Body and is actively reviewed. The assurance framework enables the Governing Body to be sighted on the risks to the delivery of the organisation's principal objectives and to ensure that effective controls and assurance are in place.

The Clinical Commissioning Group Internal Control Framework

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the clinical commissioning group, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

A system of internal control has been in place in the clinical commissioning group for the year ended 31 March 2015, which continues to be developed as the organisation matures.

The Internal Audit service is an important aspect of assurance on the system of internal control through a risk based programme of work. This provides assurance on key systems of control within the CCG through formal reporting to Audit Committee. The Head of Internal Audit also has direct access to the Audit Committee Chair as required.

The CCG relies on several external support services providers in respect of some of its business functions, including the North of England Commissioning Support Unit (NECS), the NHS Shared Business Service (SBS), Electronic Staff Records (ESR – via McKesson) and the NHS Business Services Authority (BSA). These organisations provide service auditor reports as part of the evidence of assurance on their internal system of controls as required by their customers. In addition, Northumbria Healthcare NHS Foundation Trust provides the CCG with its payroll service.

An assurance letter is provided to the CCG at the year-end which summarises the internal audit work carried out on the controls reporting the outcomes of such audits.

A wide range of support services were commissioned in 2013/14 by the CCG from the North of England Commissioning Support Unit (NECS). Commissioning Support Units were introduced in the NHS as part of the commissioning reforms to provide commissioning support at scale to a number of CCGs under a service level agreement. CCGs receive periodic Service User Reports prepared in accordance with guidance set out in the International Standards on Assurance Engagements 3000 and 3402 highlighting weaknesses in the controls environment within NECS.

Statutory and mandatory training has been undertaken by all members of staff during 2014-15, including compliance with health and safety requirements and information governance requirements. The CCG is committed to a process of continuing professional development which will be directed through the formal appraisal system.

The CCG has a range of policies in place which contribute to the system of internal control. The three policy areas are corporate, human resources and information governance with a suite of standard operating procedures to support them. Policies will be reviewed and revised on a regular basis determined by their revision date.

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG has an Information Governance Framework in place comprising an approved Strategy, a suite of approved policies and procedures, a programme of mandatory training, information risk management, incident management and has also adopted and implemented the Health and Social Care Information Centre's (HSCIC), 'Checklist for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigating'.

The organisation has in place a standard operating procedure for the reporting of level 2 Information Governance incidents to the Information Commissioner. This procedure outlines the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach. There have been no Information Governance serious breaches in year.

The Information Governance agenda is heard at the Quality, Safety and Risk Committee which reports to the Governing Body. We have also appointed a Caldicott Guardian and Senior Information Risk Owner.

The Information Governance Toolkit has been provided by the HSCIC to support performance monitoring of progress on Information Governance in the NHS. The CCG has published the HSCIC Information Governance Toolkit and has been assessed as achieving Level 2 (66%) for Version 12 (2014/15).

Freedom of Information and Subject Access Requests

We comply with our statutory duty to respond to requests for information. During the year we received 235 requests under the Freedom of Information Act 2000, and one request under the Data Protection Act 1998. All of the requests were responded to within the statutory timescales.

We have adopted and implemented the Department of Health Guidance, 'Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents'. The organisation has in place a standard operating procedure for the reporting of level 3 Information Governance incidents to the Information Commissioner.

This procedure outlines the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach.

There have been no Information Governance breaches in year.

Counter fraud

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

There were no reported incidents of fraud.

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's 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 and human rights

Control measures are in place to ensure that we comply with the required public sector equality duty set out in the Equality Act 2010.

Responsibility for equality and diversity has been delegated to the Quality, Safety and Risk Committee, which provides assurance to the Governing Body on statutory obligations. The Head of Corporate Affairs is the CCG lead for equality and diversity matters, and links with colleagues in NECS who provide specialist support in relation to the Equality Duty and Equality delivery system.

Sustainable development obligations

We are required to report our progress in delivering against sustainable development indicators.

We are developing plans to assess risks, enhance our performance and reduce our impact, including against 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.

To assist with this, the CCG has leased an electric vehicle which is available for use by all staff who need to need to attend external meetings during the normal working day.

We will ensure that we comply with our obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

We are also setting out our commitments as a socially responsible employer.

We are committed to both environmental and social sustainability and will work with our partner organisations, during 2014 and beyond, to deliver this. We will work through the Wellbeing for Life Board, and the implementation of the Wellbeing for Life Strategy, to identify and pursue opportunities, and with local providers in our approach to commissioning of services that are responsible and sustainable.

Risk assessment in relation to Governance, Risk Management and Internal Control

Risk assessment

Risk is assessed in accordance with the processes and procedures set out in our Risk Management Strategy and Risk Management Policy.

Risk is identified and embedded in the organisation via a number of mechanisms, including a risk register which identifies current and prospective risks to the CCG.

The risk register is initially reviewed by the Quality Safety and Risk Committee and the Audit Committee before being reported to the Governing Body. Active steps are taken to ensure that it is regularly updated. In addition, all CCG policies and reports are assessed for equality impact.

Risks were identified in relation to all of the corporate objectives set for 2014-15, but with the exception of the three (identified below) none of these risks were considered to be major. There have been no risks identified in relation to compliance with our licence.

The following in-year and future risks have been identified:

In-year risks

The major risks to the CCG in 2014/15 were firstly in relation to the systems and processes which were implemented to manage Continuing Health Care, and the establishment of contracts for providers who deliver domiciliary care to people receiving continuing health care.

Secondly, a risk was identified in relation to potential deprivation of liberty safeguards for people receiving continuing health care following a Supreme Court ruling relating to a case in Cheshire West.

Thirdly, the risk of financial overspend was identified arising from increased demand for NHS Services.

Future risks

The financial risks in relation to the Better Care Fund arrangements with Newcastle City Council and Gateshead Council will remain a concern until the relevant processes are fully implemented and evaluated.

There is a potential risk in relation to the co-commissioning of primary care in conjunction with NHS England as this is a new and untried process which will impact on the relationship between the CCG and member practices.

Review of economy, efficiency and effectiveness of the use of resources

The CCG has well developed internal systems and processes in place for managing resources, underpinned by the governance structure that includes the Audit Committee, with terms of reference as noted above.

The financial standing of the CCG enabled the Governing Body to agree a balanced budget for the financial year, meeting all of the national financial planning assumptions including delivery of the efficiency requirement of £7.0m and further local efficiency savings of £1.5m. Primarily delivery of the national target was through the NHS QIPP programme where provider cost efficiencies were to be achieved through improved quality, innovation, productivity and prevention. The additional efficiency savings were delivered through focused work on:

- Demand management and peer review within practices supported by a practice engagement scheme
- Improvements in planned care pathways including ambulatory care
- Urgent care and non-elective demand for health care services
- Improved risk share arrangements in maternity and diagnostic pathways and productivity gains in outpatient activity
- Adoption of clinical guidelines

Member practices, as ‘gatekeeper’ to wider NHS services, played a pivotal role in delivering the efficiency savings, supported by dedicated CCG staff who undertook regular practice visits throughout the year to review performance against specific practice plans.

It is important that our financial reporting supports collective and comprehensive assurance on patient safety, quality and performance which is critical to ensuring economy, efficiency and effectiveness in the use of CCG resources. The ‘Integrated Delivery Report’ has become the vehicle for corporate reporting throughout the organisation and crucially gives visibility and enables triangulation of patient safety, quality performance and financial matters arising from commissioned services.

Review of the effectiveness of governance, risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group. The effectiveness of the Governing Body, Audit Committee, Remuneration Committee, Quality, Safety

and Risk Committee, Executive Committee and Internal Audit as outlined above in the section relating to the CCG's Governance Framework.

Capacity to handle risk

As Accountable Officer I have overall responsibility for:

- Ensuring the implementation of an effective risk management strategy, including effective risk management systems and internal controls
- The development of the corporate governance and assurance framework
- Meeting all the statutory requirements and ensuring positive performance towards our strategic objectives

Each of the directors of the CCG is responsible for:

- Co-ordinating operational risk in their specific areas in accordance with the Risk Management Strategy
- Ensuring that all areas of risk are assessed appropriately and action taken to implement improvements
- Ensuring that staff under their management are aware of their risk management responsibilities in relation to the Risk Management Strategy
- Incorporating risk management as a management technique within the performance management arrangements for the organisation

The Practices Board has delegated responsibility to the Governing Body for establishing a scheme of governance

The CCG Chief Officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG's process documents comply with all legal, statutory and good practice guidance requirements. This is delegated to the senior managers as follows:

The Executive Director of Nursing and Patient Safety and the Medical Director are together responsible for providing advice and assurance to the Governing Body and Executive Committee on the quality and safety of commissioned services, contributing to the dialogue and challenge at the Governing Body.

The Medical Director has particular responsibility for domains 1, 2 and 3 of the NHS Outcomes Framework. The Medical Director is the Caldicott Guardian for the CCG. The Medical Director brings specific medical expertise to the commissioning of safe and sustainable services.

The Executive Director of Nursing and Patient Safety brings a broader view, from his perspective as a registered nurse, on health and care issues to underpin the work of the CCG especially the contribution of nursing to patient care.

The Chief Finance and Operating Officer has responsibility for:

- Providing professional advice to the CCG Governing Body on the effective, efficient and economic use of the CCG's financial allocation to remain within

the allocation and identify risks to the delivery of required financial targets and duties

- Ensuring robust risk management and audit arrangements are in place to make appropriate use of the CCG's financial resources
- Ensuring appropriate arrangements are in place to identify risks and mitigating actions to the delivery of QIPP and resource releasing initiatives
- Leading on the assessment and overall management of risks pertaining to Information Governance, undertaking the role of Senior Information Risk Officer (SIRO)
- Incorporating risk management as a management technique within the financial performance management arrangements for the organisation

The Head of Corporate Affairs is the CCG's lead for risk management and has responsibility for:

- Ensuring risk management systems are in place throughout the CCG and co-ordinating risk management in accordance with CCG Policy
- Ensuring the Risk Assurance Framework is regularly reviewed and updated
- Ensuring that an external review of the CCG's risk management systems takes place and that the results of this are reported to the Governing Body
- Overseeing the management of risks as identified by the Quality, Safety and Risk Committee, ensuring risks actions plans are in place, regularly monitored and implemented
- Incorporating risk management as a management technique within the performance management arrangements for the organisation
- Ensuring that quality systems are in place for assuring high quality and safe services, and the on-going monitoring of the same
- Ensuring incidents, claims and complaints are managed via the appropriate procedures

The Senior Leads and all staff including agency staff all have a responsibility to incorporate risk management within all aspects of their work.

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

Review of effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the

CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and the Quality, Safety and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The CCG has worked closely with NHS England throughout the year, including participating in the quarterly assurance programme of work and in preparing a joint committee which will be responsible for the co-commissioning of primary care.

In particular, throughout the year, there are some key processes that the CCG uses to be assured that the system of internal control is effective:

- **The Audit Committee:** The Annual Internal Audit Plan, as approved by the Audit Committee, enables the CCG to be reassured that key internal financial controls and other matters relating to risk are regularly reviewed. The Committee has reviewed the internal and external audit reports and has kept the assurance framework under review throughout the year
- **The Quality, Safety and Risk Committee:** This committee provides assurance to the Governing Body that there are adequate controls in place to ensure the CCG is delivering on its statutory and non-statutory clinical duties and responsibilities
- **Review of the CCG Constitution:** The CCG Constitution has undergone review, but has not been amended during 2014-15
- **Assurances of outsourced services:**
    - **Payroll:** The CCG payroll service is provided by Northumbria Healthcare NHS Foundation Trust. No issues of concern have been raised during the year
    - **North of England Commissioning Support Unit (NECS):** Service User Reports in 2014-15 highlighted control weaknesses in relation to transaction authorisation, forecasting, training and records management. In considering these matters, the Audit Committee was assured that alternative controls, coupled with the extent of year end testing by external audit mitigated as far as possible, the risk of any material misstatements in financial reporting and annual accounts preparation

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

Extract from the Head of Internal Audit Opinion

The Head of Internal Audit Opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the CCG's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the CCG in the completion of its Annual Governance Statement.

My opinion is set out as follows:

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

My **overall opinion** is that **significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. Some weakness in the design and/or inconsistent application of controls may put the achievement of particular objectives at risk, but only four issues of note were identified during the year, none of which impacted on the overall assurance levels provided for the audit areas in question, which remained at 'significant assurance' in all cases.

The **basis** for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes
2. An assessment of the range of individual opinions arising from audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses

Lauretta McEvoy
Director of Internal Audit

Data quality

We receive data on quality, performance, finance and contracts which brings together the key strands of provider management responsibility. This ensures that no single aspect of this element of business is seen in isolation and provides an explicit link between finance, quality and performance issues.

Data is also received in relation to human resources, statutory and mandatory training and freedom of information requests which inform the Governing Body of progress and issues in those areas.

The Governing Body considers the data received to be of an acceptable standard.

We ensure that all staff are aware of the data quality policy.

Business critical models

We have a Business Continuity Management Plan, which was formally approved by the Governing Body in August 2015.

We do not have any business critical models.

Data security

We ensure that data security is seen as an important element of the overall functioning of the organisation, and that the Information Security Policy is adhered to by all staff at all times.

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

There were no Serious Untoward Incidents relating to data security breaches, therefore none were reported to the Information Commissioner.

No lapses in data security occurred during 2014-15, therefore nothing was reported to the Information Commissioner.

Discharge of statutory functions

The arrangements put in place by the clinical commissioning group and explained within the Corporate Governance Framework were developed with on-going expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

Directorate structures are periodically reviewed alongside the service agreement with NECS to ensure as far as possible the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Conclusion

2014/15 has been a challenging year for the CCG, as it has developed as an effective commissioning organisation, and prepared to merge with NHS Newcastle North and East CCG and NHS Gateshead CCG on 1 April 2015.

The CCG continues to work closely with NECS to ensure highlighted gaps in its controls environment continue to be addressed.

The Head of Internal Audit Opinion predominantly gives the CCG significant assurance on the work it has done in 2014/15.

2014/15 has also been a challenging year financially. As a result of close working with a number of key partners the CCG has been able to cope with adverse forecasts and post a surplus at the end of our second year of operation.

My review confirms that generally, there is a sound system of internal control in place across NHS Newcastle West CCG.

In accordance with the statutory duties for clinical commissioning groups, as laid down in the Health and Social Care Act 2012, I certify that the continued delivery of those statutory duties will be discharged through NHS Newcastle Gateshead Clinical Commissioning Group during 2015/16.

Mark Adams
Accountable Officer, 27 May 2015

Annual Accounts

Report by the Auditors to the members of the CCG

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS NEWCASTLE GATESHEAD CLINICAL COMMISSIONING GROUP

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

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

- the table of salaries and allowances of senior managers and related narrative notes on pages 42-45;
- the table of pension benefits of senior managers and related narrative notes on pages 46-48; and
- the table of pay multiples and related narrative notes on pages 48-49.

This report is made solely to the members of NHS Newcastle Gateshead Clinical Commissioning Group in accordance with Part II of the Audit Commission Act 1998 and for no other purpose.

Respective responsibilities of the Accountable Officer and auditor

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

Scope of the audit of the financial statements

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

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

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

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

Opinion on regularity

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

Opinion on the financial statements

In our opinion the financial statements:

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

Opinion on other matters

In our opinion:

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

Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

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

Respective responsibilities of the CCG and auditor

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

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

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

CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

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

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

The Audit Commission determined these two criteria as those necessary for us to consider under its Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

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

Conclusion

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

Certificate

We certify that we have completed the audit of the accounts of NHS Newcastle West 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.

Gareth Davies
for and on behalf of Mazars LLP
The Rivergreen Centre
Aykley Heads
Durham
DH1 5TS

28 May 2015

Appendix one: full Annual Accounts

Appendix One - Annual Accounts

Entity name:	NHS Newcastle West CCG
This year	2014-15
This year ended	31 March 2015
This year commencing:	1 April 2014

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The Primary Statements:

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

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	960	867
Operating Expenses	5	186,965	180,734
Other operating revenue	2	(108)	(411)
Net operating expenditure before interest		**187,817**	**181,190**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**187,817**	**181,190**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**187,817**	**181,190**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	900	867
Operating Expenses	5	2,035	2,337
Other operating revenue	2	(30)	(311)
Net administration costs before interest		**2,905**	**2,893**
Programme Income and Expenditure			
Employee benefits	4.1.1	60	0
Operating Expenses	5	184,930	178,397
Other operating revenue	2	(78)	(100)
Net programme expenditure before interest		**184,912**	**178,297**

	2014-15 £000	2013-14 £000
Total comprehensive net expenditure for the year	**187,817**	**181,190**

The notes on pages 5 to 25 form part of this statement

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Total non-current assets		**0**	0
Current assets:			
Trade and other receivables	17	2,118	1,478
Cash and cash equivalents	20	148	132
Total current assets		**2,266**	1,610
Total assets		**2,266**	1,610
Current liabilities			
Trade and other payables	23	(14,504)	(12,637)
Total current liabilities		**(14,504)**	(12,637)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(12,238)**	(11,027)
Non-current liabilities		0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(12,238)**	(11,027)
Financed by Taxpayers' Equity			
General fund	SOCITE	(12,238)	(11,027)
Total taxpayers' equity:		**(12,238)**	(11,027)

The notes on pages 5 to 25 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 21 May 2015 and signed on its behalf by:

Mark Adams
Chief Accountable Officer

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

	Note	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15					
Balance at 1 April 2014		(11,027)	0	0	**(11,027)**
Adjusted CCG balance at 1 April 2014		**(11,027)**	**0**	**0**	**(11,027)**
Changes in CCG taxpayers' equity for 2014-15					
Net operating expenditure for the financial year	SOCNE	(187,817)			(187,817)
Net Recognised CCG Expenditure for the Financial Year		**(187,817)**	**0**	**0**	**(187,817)**
Net funding	SCF	186,606	0	0	186,606
Balance at 31 March 2015		**(12,238)**	**0**	**0**	**(12,238)**

		General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2013-14					
Balance at 1 April 2013		**0**	**0**	**0**	**0**
Adjusted CCG balance at 1 April 2013		**0**	**0**	**0**	**0**
Changes in CCG taxpayers' equity for 2013-14					
Net operating costs for the financial year	SOCNE	(181,190)	0	0	(181,190)
Net Recognised CCG Expenditure for the Financial Year		**(181,190)**	**0**	**0**	**(181,190)**
Net funding	SCF	170,163	0	0	170,163
Balance at 31 March 2014		**(11,027)**	**0**	**0**	**(11,027)**

The primary statements on pages 1 and 4 and notes on pages 5 to 25 form part of this statement

Statement of Cash Flows for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year	SOCNE	(187,817)	(181,190)
(Increase)/decrease in trade & other receivables	17	(640)	(1,478)
Increase/(decrease) in trade & other payables	23	1,867	12,637
Net Cash Inflow (Outflow) from Operating Activities		**(186,590)**	(170,031)
Cash Flows from Investing Activities		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(186,590)**	(170,031)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		186,606	170,163
Net Cash Inflow (Outflow) from Financing Activities		**186,606**	170,163
Net Increase (Decrease) in Cash & Cash Equivalents	20	**16**	132
Cash & Cash Equivalents at the Beginning of the Financial Year	20	**132**	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	20	**148**	132

The notes on pages 5 to 25 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2014-15* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

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

NHS Newcastle West Clinical Commissioning Group was dissolved on 31 March 2015 having joined with NHS Gateshead Clinical Commissioning Group and NHS Newcastle North and East Clinical Commissioing Group to establish NHS Newcastle Gateshead CCG with effect from 1 April 2015. This followed approval at the NHS England Assurance and Development Committee meeting of 7 July 2014.

1.2 **Accounting Convention**

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

1.3 **Acquisitions & Discontinued Operations**

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

1.4 **Movement of Assets within the Department of Health Group**

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

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

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

1.5.1 ***Critical Judgements in Applying Accounting Policies***

There are no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have a significant effect on the amounts recognised in the financial statements:

1.5.2 **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:
The majority of transactions reported are based upon actual transactions, in some cases estimates are required when actual charges have not been received. When this occurs the clinical commissioning group calculates estimates taking account of the latest information available and actual year to date transactions. The main estimate in 2014/15 related to prescribing expenditure.

1.6 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.7 **Employee Benefits**

1.7.1 **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.

Notes to the financial statements

1.7.2 **Retirement Benefit Costs**

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

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

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

1.8 **Other Expenses**

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

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

1.9 **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.

1.9.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.9.2 **The Clinical Commissioning Group as Lessor**

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

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

1.1 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.11 **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 1.50%
- Timing of cash flows (6 to 10 years inclusive): Minus 1.05%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.30%

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

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

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 i 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 CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements."

Notes to the financial statements

1.12 **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.

1.13 **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.

1.14 **Continuing healthcare risk pooling**

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

1.15 **Carbon Reduction Commitment Scheme**

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expectec to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.16 **Contingencies**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the 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.

1.17 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 **Losses & 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 th generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

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

1.19 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

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

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

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

2 Other Operating Revenue

	2014-15 Total	2014-15 Admin	2014-15 Programme	2013-14 Total	2013-14 Admin	2013-14 Programme
	£000	**£000**	**£000**	£000	£000	£000
Education, training and research	16	16	0	33	33	0
Charitable and other contributions to revenue expenditure: non-NHS	14	14	0	20	20	0
Non-patient care services to other bodies	78	0	78	25	0	25
Other revenue	0	0	0	333	258	75
Total other operating revenue	**108**	**30**	**78**	**411**	**311**	**100**

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 NHS Newcastle West Clinical Commissioning Group and credited to the General Fund.

Charitable contributions represents payment for clinical sessions met by charities.

3 Revenue

	2014-15 Total	2014-15 Admin	2014-15 Programme	2013-14 Total	2013-14 Admin	2013-14 Programme
	£000	**£000**	**£000**	£000	£000	£000
From rendering of services	108	30	78	411	311	100
Total	**108**	**30**	**78**	**411**	**311**	**100**

Revenue is totally from the supply of services. NHS Newcastle West Clinical Commissioning Group receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	806	440	366	757	440	317	49	0	49
Social security costs	61	30	31	56	30	26	5	0	5
Employer Contributions to NHS Pension scheme	93	57	36	87	57	30	6	0	6
Gross employee benefits expenditure	**960**	**527**	**433**	**900**	**527**	**373**	**60**	**0**	**60**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**960**	**527**	**433**	**900**	**527**	**373**	**60**	**0**	**60**

2013-14	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	754	752	2	754	752	2	-	-	-
Social security costs	47	47	-	47	47	0	-	-	-
Employer Contributions to NHS Pension scheme	66	66	-	66	66	0	-	-	-
Gross employee benefits expenditure	867	865	2	867	865	2	-	-	-
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-	-	-	-	-	-	-
Total - Net admin employee benefits including capitalised costs	867	865	2	867	865	2	-	-	-

4.1.2 Recoveries in respect of employee benefits

There were no recoveries in respect of employee benefits.

4.2 Average number of people employed

	2014-15			2013-14		
	Total Number	**Permanently employed Number**	**Other Number**	Total Number	Permanently employed Number	Other Number
Total	**8**	**7**	**1**	7	7	0
Of the above:						
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0	**0**	**0**

NHS Newcastle West Clinical Commissioning Group employee benefits include a share of £399k recharged from NHS Gateshead Clinical Commissioning Group for hosted staff that work across Gateshead Clinical Commissioning Group, Newcastle North and East Clinical Commissioning Group and Newcastle West Clinical Commissioning Group. The 23 WTE hosted staff are all reported within Gateshead Clinical Commissioning Group numbers.

4.3 Staff sickness absence and ill health retirements

	2014-15 Number	**2013-14 Number**
Total Days Lost	6	42
Total Staff Years	20	20
Average working Days Lost	**0.3**	**2.1**

Sickness reporting in 2014/15 is based upon 12 months data from January 2014 to December 2014.
Sickness reporting in 2013/14 is based upon 9 months data from April 2013 to December 2013. 2013/14 information has been restated during 2014/15.

There were no ill health retirements in the financial year.

4.4 Exit packages agreed in the financial year

There were no exit packages agreed in the financial year.

4.5 Pension costs

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

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

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to NHS Newcastle West 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 (which until 2004 was every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 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%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of Pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their Pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time

4.5.2 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.

4.5 Pension costs

4.5.3 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 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 NHS Newcastle West 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 AVCs run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2014-15 Total £000	**2014-15 Admin £000**	**2014-15 Programme £000**	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits						
Employee benefits excluding governing body members	687	627	60	601	601	0
Executive governing body members	273	273	0	266	266	0
Total gross employee benefits	**960**	**900**	**60**	**867**	**867**	**0**
Other costs						
Services from other CCGs and NHS England	2,341	1,501	840	1,475	1,229	246
Services from foundation trusts	132,366	53	132,313	130,477	11	130,466
Services from other NHS trusts	202	0	202	294	0	294
Services from other NHS bodies	0	0	0	8	0	8
Purchase of healthcare from non-NHS bodies	27,153	0	27,153	24,385	0	24,385
Chair and Non Executive Members	181	181	0	181	181	0
Supplies and services – general	6	6	0	74	74	0
Consultancy services	5	5	0	0	0	0
Establishment	54	31	23	12	12	0
Transport	0	0	0	1	1	0
Premises	257	0	257	528	528	0
Audit fees	72	72	0	72	72	0
Prescribing costs	23,462	0	23,462	22,720	0	22,720
Pharmaceutical services	56	0	56	0	0	0
GPMS/APMS and PCTMS	179	0	179	126	0	126
Other professional fees excl. audit	215	114	101	190	190	0
Clinical negligence	4	4	0	4	4	0
Research and development (excluding staff costs)	75	0	75	152	0	152
Education and training	68	68	0	35	35	0
CHC Risk Pool contributions	269	0	269	0	0	0
Total other costs	**186,965**	**2,035**	**184,930**	**180,734**	**2,337**	**178,397**
Total operating expenses	**187,925**	**2,935**	**184,990**	**181,601**	**3,204**	**178,397**

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

6.1 Better Payment Practice Code

Measure of compliance	2014-15 Number	2014-15 £000	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	4,271	25,452	3,321	19,693
Total Non-NHS Trade Invoices paid within target	4,168	24,942	3,215	19,351
Percentage of Non-NHS Trade invoices paid within target	**97.59%**	**97.99%**	**96.81%**	**98.26%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,267	136,479	908	133,691
Total NHS Trade Invoices Paid within target	1,237	135,955	892	133,587
Percentage of NHS Trade Invoices paid within target	**97.63%**	**99.62%**	**98.24%**	**99.92%**

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

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no late payment commercial debts paid in the financial year.

7 Income Generation Activities

NHS Newcastle West Clinical Commissioning Group does not undertake any income generation activites.

8. Investment revenue

NHS Newcastle West Commissioning Group had no investment revenue in the year as at 31 March 2015.

9. Other gains and losses

NHS Newcastle West Commissioning Group had no other gains and losses in the year as at 31 March 2015.

10. Finance costs

NHS Newcastle West Commissioning Group had no finance costs in the year as at 31 March 2015.

11. Net gain/(loss) on transfer by absorption

NHS Newcastle West Clinical Commissioning Group had no net gain/(loss) on transfer by absorption as at 31 March 2015.

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payments recognised as an expense					
Minimum lease payments	0	257	0	**257**	526
Total	**0**	**257**	**0**	**257**	**526**

12.1.2 Future minimum lease payments

Whilst our arrangements with Community Health Partnerships Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease payments for the arrangements only

12.2 As lessor

12.2.1 Rental revenue

NHS Newcastle West Clinical Commissioning Group had no rental revenue as at 31 March 2015.

12.2.2 Future minimum rental value

NHS Newcastle West Clinical Commissioning Group had no future rental revenue as at 31 March 2015.

13 Property, plant and equipment

NHS Newcastle West Clinical Commissioning Group had no Property, Plant or Equipment as at 31 March 2015.

14 Intangible non-current assets

NHS Newcastle West Clinical Commissioning Group had no Intangible non current assets as at 31 March 2015.

15 Investment property

NHS Newcastle West Clinical Commissioning Group had no investment property as at 31 March 2015.

16 Inventories

NHS Newcastle West Clinical Commissioning Group had no inventories as at 31 March 2015.

17 Trade and other receivables	**Current 2014-15 £000**	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	364	0	372	0
NHS prepayments and accrued income	1,208	0	532	0
Non-NHS receivables: Revenue	544	0	543	0
Non-NHS prepayments and accrued income	0	0	2	0
VAT	1	0	28	0
Other receivables	1	0	1	0
Total Trade & other receivables	**2,118**	**0**	**1,478**	**0**
Total current and non current	**2,118**		**1,478**	
Included above:				
Prepaid pensions contributions	0		0	

The great majority of trade is with NHS England. 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.

17.1 Receivables past their due date but not impaired	**2014-15 £000**	2013-14 £000
By up to three months	155	369
By three to six months	81	20
By more than six months	530	0
Total	**766**	**389**

£8k of the amount above has subsequently been recovered post the statement of financial position date.

NHS Newcastle West Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2015.

17.2 Provision for impairment of receivables

NHS Newcastle West Clinical Commissioning Group had no provision for impairment of receivables as at 31 March 2015.

18 Other financial assets

NHS Newcastle West Clinical Commissioning Group had no other financial assets as at 31 March 2015.

19 Other current assets

NHS Newcastle West Clinical Commissioning Group had no other current assets as at 31 March 2015.

20 Cash and cash equivalents

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	132	0
Net change in year	16	132
Balance at 31 March 2015	**148**	**132**
Made up of:		
Cash with the Government Banking Service	148	132
Cash and cash equivalents as in statement of financial positior	**148**	**132**
Balance at 31 March 2015	**148**	**132**
Patients' money held by NHS Newcastle West Clinical Commissioning Group, not included above	0	0

21 Non-current assets held for sale

NHS Newcastle West Clinical Commissioning Group had no non-current assets as at 31 March 2015.

22 Analysis of impairments and reversals

NHS Newcastle West Clinical Commissioning Group had impairments or reversals as at 31 March 2015.

23 Trade and other payables	Current 2014-15 £000	Non-current 2014-15 £000	Current 2013-14 £000	Non-current 2013-14 £000
NHS payables: revenue	23	0	4,006	0
NHS accruals and deferred income	4,901	0	86	0
Non-NHS payables: revenue	3,277	0	5,148	0
Non-NHS accruals and deferred income	6,279	0	3,379	0
Social security costs	5	0	5	0
Tax	7	0	5	0
Other payables	11	0	8	0
Total Trade & Other Payables	**14,504**	**0**	**12,637**	**0**
Total current and non-current	**14,504**		**12,637**	

Other payables include £9k outstanding pension contributions at 31 March 2015.

24 Other financial liabilities

NHS Newcastle West Clinical Commissioning Group had no other financial liabilities as at 31 March 2015.

25 Other liabilities

NHS Newcastle West Clinical Commissioning Group had no other liabilities as at 31 March 2015.

26 Borrowings

NHS Newcastle West Clinical Commissioning Group had no borrowings as at 31 March 2015.

27 Private finance initiative, LIFT and other service concession arrangements

NHS Newcastle West Clinical Commissioning Group had no private finance initiative, LIFT or other service concession arrangements as at 31 March 2015.

28 Finance lease obligations

NHS Newcastle West Clinical Commissioning Group had no finance lease obligations as at 31 March 2015.

29 Finance lease receivables

NHS Newcastle West Clinical Commissioning Group had no finance lease receivables as at 31 March 2015.

30 Provisions

NHS Newcastle West Clinical Commissioning Group had no provisions as at 31 March 2015.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of NHS Newcastle West 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 Newcastle West Clinical Commissioning Group at 31 March 2015 is £1,274k.

31 Contingencies

NHS Newcastle West Clinical Commissioning Group is in the process of mediation with a care home provider in respect of a contract dispute with regard to fees payable for continuing healthcare. This mediation process is part of legal proceedings and following legal advice received NHS Newcastle West Clinical Commissioning Group prudently views the claim as only having a possible prospect of succeeding and therefore not requiring provision recognition.

32 Commitments

32.1 Capital commitments

NHS Newcastle West Clinical Commissioning Group had no capital commitments as at 31 March 2015.

32.2 Other financial commitments

NHS Newcastle West Clinical Commissioning Group had no other financial commitments as at 31 March 2015.

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

NHS Newcastle West Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. NHS Newcastle West Clinical Commissioning Group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

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

33.1.4 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2014-15 £000	**Loans and Receivables 2014-15 £000**	**Available for Sale 2014-15 £000**	**Total 2014-15 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	364	0	364
· Non-NHS	0	544	0	544
Cash at bank and in hand	0	148	0	148
Other financial assets	0	1	0	1
Total at 31 March 2015	**0**	**1,057**	**0**	**1,057**

	At 'fair value through profit and loss' 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	372	0	372
· Non-NHS	0	543	0	543
Cash at bank and in hand	0	132	0	132
Other financial assets	0	2	0	2
Total at 31 March 2014	**0**	**1,049**	**0**	**1,049**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £000	**Other 2014-15 £000**	**Total 2014-15 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	4,925	4,925
· Non-NHS	0	9,567	9,567
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**14,492**	**14,492**

	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	4,091	4,091
· Non-NHS	0	8,528	8,528
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2014	**0**	**12,619**	**12,619**

34 Operating segments

NHS Newcastle West Clinical Commissioning Group and consolidated group consider they have only one segment: commissioning of healthcare services.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	187,926	(108)	**187,817**	2,266	(14,504)	**(12,238)**
Total	**187,926**	**(108)**	**187,817**	**2,266**	**(14,504)**	**(12,238)**

35 Pooled budgets

NHS Newcastle West Clinical Commissioning Group and consolidated group were not party to any pooled budget arrangements during 2014-15.

36 NHS Lift investments

NHS Newcastle West Clinical Commissioning Group were not party to any NHS Lift investments during 2014-15.

37 Intra-government and other balances

	Current Receivables 2014-15 £000	**Non-current Receivables 2014-15 £000**	**Current Payables 2014-15 £000**	**Non-current Payables 2014-15 £000**
Balances with:				
· Other Central Government bodies	1	0	64	0
· Local Authorities	498	0	251	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	144	0	1,874	0
· NHS Trusts and Foundation Trusts	1,429	0	3,050	0
Total of balances with NHS bodies:	**1,573**	**0**	**4,924**	**0**
· Bodies external to Government	46	0	9,265	0
Total balances at 31 March 2015	**2,118**	**0**	**14,504**	**0**

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	28	0	37	0
· Local Authorities	433	0	3,065	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	139	0	645	0
· NHS Trusts and Foundation Trusts	765	0	3,446	0
Total of balances with NHS bodies:	**904**	**0**	**4,091**	**0**
· Bodies external to Government	113	0	5,444	0
Total balances at 31 March 2014	**1,478**	**0**	**12,637**	**0**

38 Related party transactions

Details of related party transactions with individuals are as follows:

Comparative information for the prior year is also reported

	2014-15 Payments to Related Party £000	**2014-15 Receipts from Related Party £000**	**2014-15 Amounts owed to Related Party £000**	**2014-15 Amounts due from Related Party £000**	2013-14 Payments to Related Party £000	2013-14 Receipts from Related Party £000	2013-14 Amounts owed to Related Party £000	2013-14 Amounts due from Related Party £000
Newcastle West GP member practices								
Betts Avenue Medical Centre	65	0	0	0	52	0	0	0
Broadway Medical Centre	19	0	0	0	12	0	0	0
Cruddas Park Surgery	186	0	0	0	162	0	0	0
Denton Park Health Centre	58	0	0	0	46	0	0	0
Denton Turret Medical Centre	96	0	0	0	57	0	0	0
Dilston Medical Centre	44	0	0	0	25	0	0	0
Fenham Hall Surgery	64	0	0	0	49	0	0	0
Grainger Medical Group	118	0	0	0	109	0	0	0
Holmside Medical Group	65	0	0	0	87	0	0	0
Newburn Surgery	58	0	0	0	50	0	0	0
Parkway Medical Centre	68	0	0	0	56	0	0	0
Ponteland Road Health Centre	21	0	0	0	11	0	0	0
Prospect Medical Group	79	0	0	0	76	0	0	0
Roseworth Surgery	58	0	0	0	37	0	0	0
Scotswood GP Practice	3	0	0	0	0	0	0	0
Throckley Primary Care Centre	72	0	0	0	97	0	0	0
West Road	75	0	0	0	59	0	0	0
Westerhope Medical Group	75	0	0	0	69	0	0	0
Other Related Parties								
Gateshead Clinical Commissioning Group	671	(129)	90	0	574	(80)	265	(9)
Newcastle North & East Clinical Commissioning Group	2,063	(136)	1,698	0	1,999	0	502	(347)

Newcastle West GP member practices have carried out functions for NHS Newcastle West Clinical Commissioning Group and remuneration has been paid to practices in recognition of their contribution.

NHS Newcastle West Clinical Commissioning Group also commission practices to provide healthcare services to patients.

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

• Newcastle upon Tyne Hospitals NHS Foundation Trust	103,035	0	1,524	0	99,287	0	0	(2,284)
• Northumberland, Tyne and Wear NHS Foundation Trust	23,150	0	3	0	21,985	0	494	0
• North East Ambulance Service NHS Foundation Trust	6,143	0	0	(263)	5,255	0	0	(209)

NHS Newcastle West Clinical Commissioning Group also has other none material transactions with other NHS related parties that include:

• NHS England, NHS Litigation Authority and NHS Business Services Authority.

In addition, NHS Newcastle West Clinical Commissioning Group has had a number of material transactions with other Government departments and other central and local Government bodies. The majority of these transactions to the value of £10,401,000 have been with Newcastle City Council.

39 Events after the end of the reporting period

From 1st April 2015 NHS Newcastle West Clinical Commissioning Group was dissolved with all functions, assets and liabilities transferred to the newly established NHS Newcastle Gateshead Clinical Commissioning Group.

40 Losses and special payments

NHS Newcastle West Clinical Commissioning Group had no losses or special payments during 2014-15.

41 Third party assets

NHS Newcastle West Clinical Commissioning Group did not hold cash and cash equivalents on behalf of other parties.

42 Financial performance targets

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

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

	2014-15 Target	**2014-15 Performance**	2013-14 Target	2013-14 Performance
	£000	**£000**	£000	£000
Expenditure not to exceed income	190,183	187,817	182,807	181,190
Capital resource use does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	190,183	187,817	182,807	181,190
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	3,381	2,905	3,190	2,893

43 Impact of IFRS

NHS Newcastle West's Clinical Commissioing Group's accounts are completed under IFRS at 31st March 2015.

44 Analysis of charitable reserves

NHS Newcastle West Clinical Commissioning Group do not have charitable reserves or funds.