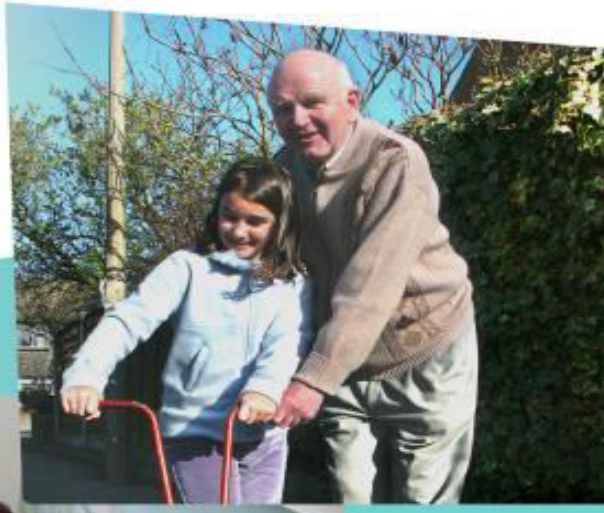
NHS
Gateshead
Clinical Commissioning Group



Annual report and accounts

2014-15

Transforming lives together

Contents

Foreword

Welcome to the 2014-15 annual report for NHS Gateshead Clinical Commissioning Group (CCG).

Established as a statutory organisation in April 2013, NHS Gateshead Clinical Commissioning Group (CCG) is the body responsible for the planning and commissioning of healthcare services to meet the needs of the local community. We are a membership organisation of 31 general practices looking after a population of over 205,000.

As a clinically-led organisation run by a team of doctors, nurses and healthcare professionals and supported by an experienced management team, we believe that we are best placed to understand the needs of the patients in the community we serve.

We are now at the end of our second year and we have worked hard to cement the progress made, successfully transforming many aspects of patient care and laying the foundations for a healthier and happier Gateshead.

Although we have been operating in an environment of uncertainty and financial constraint, we are pleased to have made some notable successes in line with our key priorities.

A major achievement for the CCG has been the completion of the new state-of-the-art Emergency Care Centre at the Queen Elizabeth Hospital. This £32 million transformation of urgent and emergency care services will greatly enhance patient experience and care by fully integrating a wide range of services in one place.

We are proud to have been identified by Diabetes UK as the top performing area in the North of England for carrying out health checks and 12th out of more than 200 CCGs across England whilst our work to improve the health of care home residents has won national recognition as one of 29 ‘vanguard’ areas announced by NHS England. The Gateshead Care Home Initiative has brought a 9% reduction in admissions to hospital from people living in care homes and has been cited as an example of good practice.

Although we have begun to make progress in identifying and responding to the health and social care needs of our local community, we are aware that this is only the first step and there is still much to do.

Gateshead is ranked among those 20% of local authority areas with the highest levels of social and economic deprivation. We are facing an increasing ageing population and a rise in numbers of those with long-term conditions. Health inequalities and an

over reliance on acute services combined with higher public expectations and financial constraints means that in coming years we will face many challenges.

We believe the best way to address these problems is to strengthen links between local health and social care providers. Over the last year, we have made considerable progress with our Better Care Fund work, building on a joint plan developed with Gateshead Council and informed by the views of patients, carers, and service users.

We are committed to involving our patients, carers and communities as much as possible in what we do and the CCG has a range of ways that local people can share their views with us, including patient participation groups, the Gateshead Patient User Carer Public Involvement Group (PUCPI), forums, events, consultations, Healthwatch, MY NHS and social media.

After much consultation with stakeholders, the public, patients and the membership practices involved, it was agreed that from April 2015 Gateshead CCG will merge with its neighbouring NHS Newcastle North and East CCG and NHS Newcastle West CCG to form the new NHS Newcastle Gateshead Clinical Commissioning Group (CCG), a single body to coordinate the planning and buying of NHS health services across Newcastle and Gateshead.

We believe that as a single organisation, we can work more efficiently, sharing knowledge and best practice and pooling resources, ensuring we are well placed to deal with the challenges ahead. As a fully merged organisation, we will continue to build on the strong partnerships and relationships we have in place, so that we can deliver the best possible care and services for people in Gateshead and Newcastle.

The annual report reflects on our progress and performance throughout the year and gives details of the impact our members have had in key areas. The report also includes information about how the Governing Body has evaluated their performance; this information can be found in the governance statement.

Dr Mark Dornan
Chair, Gateshead CCG

Strategic report

This strategic report sets out how the Clinical Commissioning Group's members and Governing Body have performed in delivering against its objectives.

One of 12 CCGs in the region, NHS Gateshead CCG is a membership organisation led by its 31 member practices.

Our key responsibilities are:

- Urgent and emergency hospital care
- Long-term conditions
- Mental health and learning disability services
- End of life care

Our aim is to improve the quality of health services and ensure the people of Gateshead live longer, happier and healthier lives. This aim is supported by six core values which inform everything we do:

- Compassion
- Improving lives
- Working together for patients
- Respect and dignity
- Everyone counts
- Commitment to quality of care

Central to this vision is our commitment to clinically-led commissioning, in partnership with patients and health and social care professionals in the region. As doctors, nurses and healthcare professionals, we are close to our patients, therefore well placed to develop quality health services that are responsive to our local people's needs.

This is reflected in the continued progress we have made in engaging with local partners including Newcastle Hospitals NHS Foundation Trust, Gateshead Health NHS Foundation Trust, South Tyneside Community Services, Northumberland Tyne and Wear NHS Foundation Trust, North East Ambulance Services NHS Foundation Trust, Gateshead Council, the Health and Wellbeing Board and Healthwatch Gateshead. In addition, we buy specialist business services from NHS North of England Commissioning Support Unit (NECS).

Hospital and community services in the area are largely provided by Gateshead Healthcare NHS Foundation Trust and South Tyneside NHS Foundation Trust. Primary care services include GP surgeries, dentist practices, optometric practices, and pharmacies, 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.

The development of our increasingly close joint working with neighbouring CCGs through the Newcastle Gateshead Alliance is set out on the following page.

Our healthcare priorities

In common with neighbouring areas, Gateshead faces some significant health challenges as well as demographic changes which will have important implications for healthcare provision over the coming years. Our population in Gateshead is projected to grow by 5% by 2032, with a substantial increase in the number of people aged 65 and over.

Gateshead is ranked among those 20% of local authority areas with the highest levels of social and economic deprivation. Levels of health and underlying risk factors are among the worst in the country and average life expectancy is two years lower than the national average, with significant differences between different areas of the borough.

Lifestyle factors, such as high levels of smoking, alcohol consumption, and obesity are also higher than the national average. This picture of an ageing population, health inequalities and an over reliance on acute services will in future mean significant changes to the way we work and more joined-up working if we are to make the necessary impact on our key target areas:

- Preventing people from dying prematurely
- Enhancing the quality of life for those with long-term conditions
- Helping people to recover from ill health or injury
- Ensuring that people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

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 the two Newcastle CCGs

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 even greater potential to do more for the 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 organisation 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.

Our performance

Improving performance

We have been committed to the delivery of safe, high quality and cost effective services for local people. These are essential if we are to improve the health outcomes of the local population and meet our 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 areas performing particularly well and some that still require improvement.

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

- A&E four hour waits – March 2015
- Ambulance Response times –February 2015
- Ambulance handovers – February 2015
- Healthcare associated infections – February 2015 (MRSA) and March 2015 (clostridium difficile)
- 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 four hour waits 

There have been national pressures in the latter part of 2014/15 in terms of A&E waiting times, and these have been reflected locally at both Newcastle Hospitals NHS Foundation Trust and Gateshead Health NHS Foundation Trust. However both local hospital trusts have met the annual target for this standard in 2014/15.

Ambulance performance

Ambulance handovers

CCGs and North East Ambulance Service (NEAS) are working collectively to improve ambulance turnaround times at hospitals in the North East. Regionally, Gateshead Health and Newcastle upon Tyne Hospitals NHS Foundation Trusts are good performers, and delays have been kept to a minimum, although there have been 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 that could usually have been avoided through better management in primary or community care. Local performance data shows that Gateshead is not yet achieving the required reduction in emergency admissions in 2014/15, and initiatives have been identified to improve this position going forward.

Cancer waiting times

The NHS Constitution sets out that CCGs are to achieve nine cancer waiting times standards. Gateshead is currently expecting to achieve these standards at the year end.

Mental health - parity of esteem

We recognise mental health as important and the Mental Health Programme Board is well established involving providers, both acute and community, as well as users and carers.

Improving Access to Psychological Therapies (IAPT)

We have made significant progress towards the number of patients accessing psychological therapies (IAPT services) and the access target is currently expecting to meet the required standard in 2014/15.

Recovery rates remain good and the provider continues to exceed the national standard rate of recovery for patients accessing IAPT services.

Dementia

Improvements have been made to the dementia diagnosis target and we have met the required standard in 2014/15.

Healthcare associated infections

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 (C Diff) and MRSA.

There has been 2 cases of MRSA in the Gateshead community to date. 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.

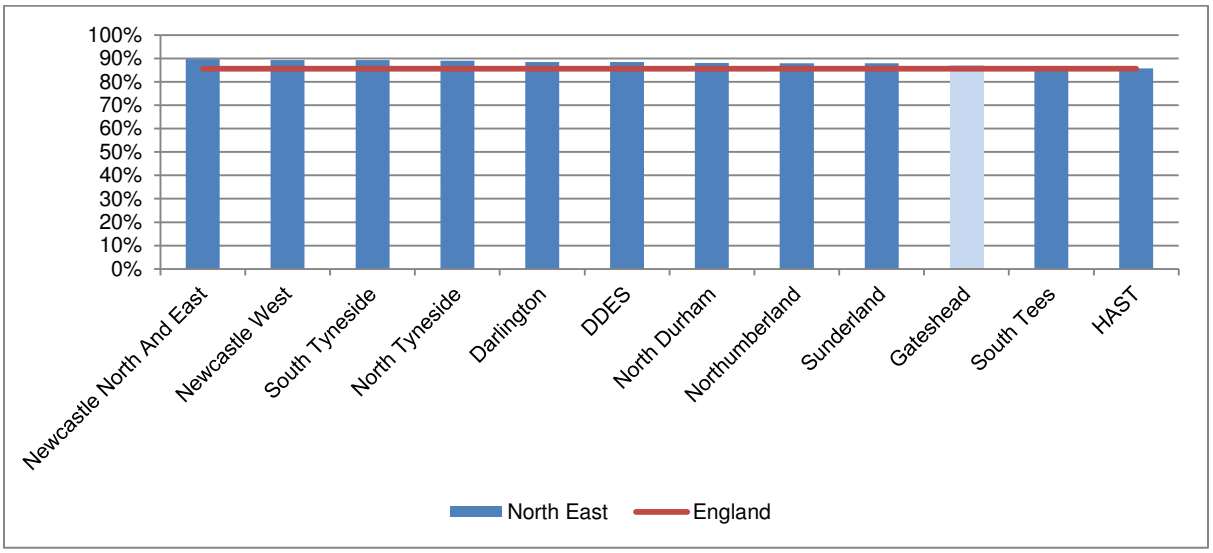
Referral to treatment

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

GP experience

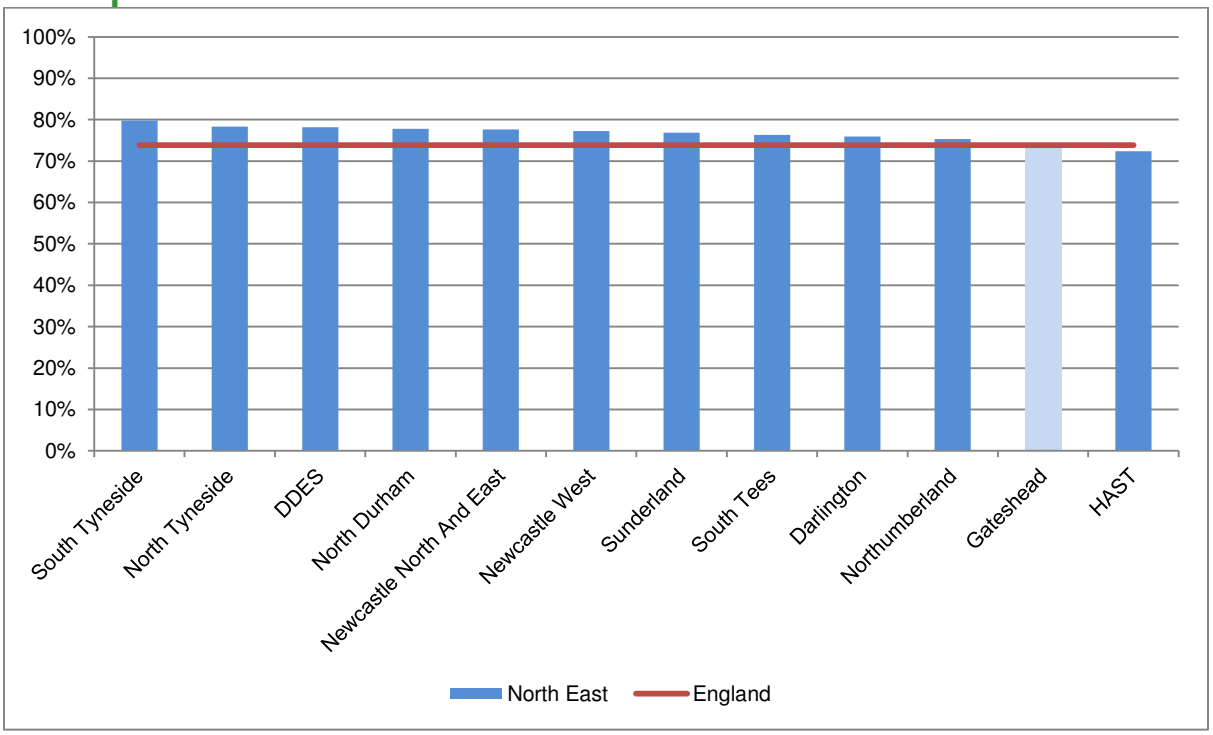
Source: GP Patient Survey – December 2014 Results are published for every CCG in the country and the national results, using aggregated data collected during January-March 2014 and July-September 2014.

GP experience – quality of consultation



We're performing slightly better than average in terms of positive responses to five questions in relation to quality of their consultation with a GP.

GP experience - access



We're performing slightly better than average with 74.4% of positive responses to the question "Overall how would you describe your experience of making an appointment".

As part of our ongoing work, we are reviewing all urgent care services to ensure that they are accessible and provide the right care for patients who need medical help quickly and unexpectedly. These services include A&E, walk in centres and nursing.

Financial performance

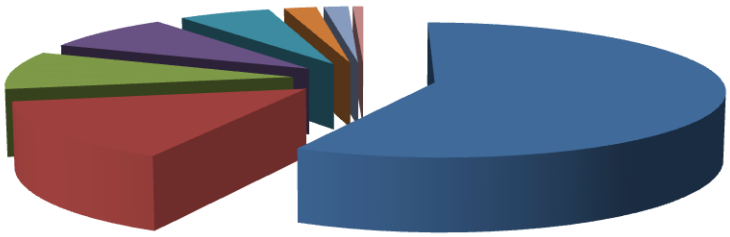
The Governing Body approved a commissioning budget for 2014/15 based upon an initial allocation of £295.6m, excluding the running costs allowance of £4.7m. Within this budget approval was a planned surplus of £3.0m consistent with the financial planning framework for CCGs.

An actual surplus of £5.9m was achieved for the reporting period, £2.9m in excess of plan, The increase was due to reduced contributions to the national risk share arrangements for continuing healthcare restitution cases, together with slippage on in year commissioning developments. 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:

- £2.0m on general and acute hospital episodes of care
- £1.7m on continuing and funded nursing care
- £1.1m on prescribing of drugs
- £0.7m on non-NHS mental health and learning disabilities

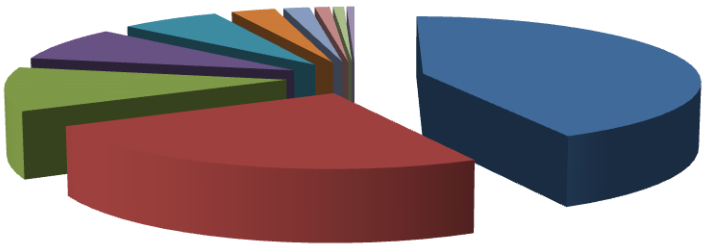
Full resource allocation for the CCG was £302.2m, against which expenditure in 2014/15 totalled £296.4m and was applied in the following way:

How the money was spent



- Acute Services, £170.4m
- Primary Care & Prescribing, £43.3m
- Mental Health & Learning Disabilities Services, £27.3m
- Community Services, £25.2m
- Continuing Healthcare & Funded Nursing Care, £17.5m
- Ambulance Services, £6.1m
- Running Costs, £4.7m
- Other Services, £1.9m

Health care spend by provider



- Gateshead Health NHS Foundation Trust, £124.1m
- Non-NHS Providers, £72.3m
- Newcastle upon Tyne Hospitals NHS Foundation Trust, £31.6m
- South Tyneside NHS Foundation Trust, £24.6m
- Northumberland Tyne & Wear NHS Foundation Trust, £19.2m
- North East Ambulance Service Foundation Trust, £8.4m
- Other NHS Providers, £5.0m
- City Hospitals Sunderland NHS Foundation Trust, £2.9m
- County Durham & Darlington NHS Foundation Trust, £2.1m
- Northumbria Healthcare NHS Foundation Trust, £1.5m

Looking ahead

On 1 April 2015, we joined with Newcastle West CCG and Newcastle North and East CCG to form NHS Newcastle Gateshead CCG, covering the area of the three former separate organisations. For 2015/16 and future years the new CCG will receive one allocation to commission healthcare services/programme spend 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 Better Care Fund 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 AandE 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, our 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 that our plans are clear and credible. This will 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 using 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	296,371
Final revenue resource limit for year	302,226
Underspend against revenue resource limit	5,855

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 98.83% of correctly addressed and undisputed invoices were paid within the required 30 days as a percentage of the total value of invoices paid and 95.98% 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	5,348	37,952
Total bills paid within target	5,132	37,069
Percentage of bills paid within target	95.96%	97.68%
NHS creditors		
Total bills paid in the year	1,738	224,896
Total bills paid within target	1,669	222,711
Percentage of bills paid within target	96.03%	99.03%

Running costs

We are required to maintain running costs within an allowance of £24.73 per head of population, equating to £5.056m. 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)	4,657
Population (number)	204,448
Running cost per head of weighted population (£)	22.78

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 a busy second year for the CCG, we have successfully transformed many aspects of patient care, from planning for the Better Care Fund and public consultation about reforming mental health services to opening the new Emergency Centre at the Queen Elizabeth Hospital and preparing for the merger with the two Newcastle CCGs.

Engagement and participation

We are committed to active community engagement, to ensure that we fully understand the issues that affect our community. Over the past year, we have progressed a wide range of initiatives to ensure that the voice of patients is heard both in making strategic decisions around service reviews and commissioning decisions, and through ongoing engagement with forums, patient participation groups and MY NHS.

Engagement principles

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

- Patients and public are at the centre of informing, influencing and shaping
- CCG commissioning and development and we have on-going conversations
- Agreement to align engagement mechanisms and share best practice where pragmatic and find common solutions to problems
- Trusting each other, sharing resources, ideas and enthusiasm
- Engagement and involvement is systematic and on-going, using both new and innovative methods as well as tried and tested techniques
- We will change the culture about the value of engagement and involvement and how it will influence, ‘we asked, you said and this is how it was changed’
- Ensuring key issues and insights are levered into strategic plans and acted upon, systematic feedback on how patient insights have been used to inform commissioning and influence process
- Honest, open and transparent about patient experience and their stories
- Actively listening, asking communities once, using plain language
- Agreement to work on issues together whenever possible and to be planned and timely – and in partnership with other organisations where we can

Valuing the differences of the communities in each locality and between each locality and ensuring work is locality driven.

On-going participation

Our **Local Engagement Board** meets four times a year, offering a chance for local people to engage with healthcare partners and help to shape local NHS services.

The Gateshead Patient User Carer Public Involvement Group (PUCPI) meets monthly, attracting strong attendance from patients and carers as well as the voluntary and statutory sectors and contributing to the development of strategic plans for local healthcare.

Patient participation groups meet on a regular basis to discuss the services on offer from their practice, and how improvements can be made. Patients can choose their level of involvement, from attending meetings to taking part in a 'virtual group'.

Healthwatch works to give users of health and social care services a stronger voice, and we work closely together to identify problems and opportunities for improvement.

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 about our work and encourage people to have their say and get involved. We have also established our presence on Twitter and Facebook, and will combine these accounts with the other Alliance social media feeds when the three organisations merge.

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.

Children and young people – child and adolescent mental health services (CAMHS)

An in-depth assessment of CAMHS services available to children and young people in Gateshead is currently being conducted supported by North of England Commissioning Support (NECS). The first stage of this process is a desk top exercise to explore what in the last 18 months if any, patient engagement has already taken place around the current CAMHS service. The information will be collated, themes and issues will be identified which will inform the phase two of the process. NECS will provide a report.

Respiratory review

Following a whole system workshop to review respiratory care, service improvement are being made by working with the British Lung Foundation to engage with patients in order to incorporate their perspectives into the respiratory services in Gateshead.

Long term conditions

The Long Term Condition Strategic Implementation Group is developing a robust patient engagement plan. A patient representative sits on the strategy group and a patient advisory is being established.

Community services procurement group

A host of patient engagement including in depth patient and carer interviews have taken place. The qualitative information gathered from patients on the services they receive from community nursing have informed the community services service specification.

Musculoskeletal services (MSK)

Newcastle Gateshead Alliance 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.

Medicine 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.

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.

Towards the end of the year, we were formulating options for change with a view to carrying out a formal public consultation during the coming year.

£32m urgent care transformation complete

The opening of Gateshead's new state-of-the-art Emergency Care Centre at the Queen Elizabeth Hospital in February marked the completion of a transformation in urgent and emergency care services in the borough.

The new centre will significantly enhance patient experience and care by fully integrating a wide range of services including A&E, walk-in centre, GP care, medical and surgical assessment and urgent children's services.

This will make things easier for our patients as all of these services will share the same reception within one building, making sure they can be seen by the right member of staff.

This means less moving around for the patient, less waiting time as specialist staff and testing facilities to diagnostic problems are all in such close proximity.
The centre also includes a 24-bed short stay unit for adult medical patients who are able to be treated and sent home within a short space of time.

National vanguard status for care home project

Our work to improve the health of care home residents in Gateshead has won national recognition as one of 29 'vanguard' areas announced by NHS England in March.

The Gateshead Care Home Initiative, which is backed by Gateshead Council, has been selected for its success in reducing hospital admissions among the borough's care home residents and put forward as an example of good practice.

The initiative sees individual GP practices each allocated to a specific care home, making it possible to offer greater continuity of care and more effective prevention of illness through regular home visits, with the number of admissions dropping as a result.

Over the past two years, this has brought a 9% reduction in admissions to hospital from people living in care homes, and this new status will enable us to build on that and share what we have learned with other areas.

Vanguard status will allow us to go further and faster in improving the health of people living in care homes, with specialist support at national level.

Prime Minister's Challenge Fund success

A successful bid to the Prime Minister's Challenge Fund, which was led by Gateshead Community Based Care (CBC) Ltd with support from NHS Gateshead Clinical Commissioning Group, will make it easier for Gateshead residents to see a GP in future.

The Gateshead Extra Care project aims to provide over 800 additional appointments every week, as well as more home visits for the borough's most vulnerable patients, while improving GPs' shared use of technology and increasing flexibility around appointments.

The more flexible service will offer patients more flexibility in the way they see GPs while also safeguarding the continuity of care that they receive from their practice. This means a service which is more suited to modern lifestyles, as well as meeting the increasing demand for home visits for more frail patients and people with complex conditions.

The £2m scheme will develop three new 'general practice hubs' offering services for patients with minor illnesses seven days a week, as well as two 'home visiting hubs' providing 90 hours of clinical time each week to support patients in their own homes. The use of the same EMIS IT system as practices will ensure that GPs can access and record information on the patient's medical file in real time.

Patients will have a much wider choice of ways to see a GP, with longer opening hours, the option to see a GP near work or in the future to use Skype-style consultations if they prefer.

The home visiting service will be delivered from two centres operating 4pm-8pm Monday to Friday and 8am-8pm at weekends. The service will operate mainly through face-to-face visits, but will also explore using technology with care homes to ensure that patients can use video-style consultations.

The changes are hoped to reduce the growing pressure on A&E services and walk-in centres, and free up GP practices to spend more time on health promotion, prevention of illness and management of patients with long term conditions.

British Heart Foundation – House of Care Project in Gateshead

We are working on a British Heart Foundation (BHF) project to change how long-term conditions, particularly cardiovascular disease (CVD), are managed.

The focus of the project is to improve identification and prevention of CVD and implement a new approach to the management of long-term conditions – the Year of Care Approach. This approach aims to enable patients with CVD and their carers to be engaged, informed and empowered to better care for themselves, and enable health professionals and the voluntary sector to support self-care.

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, we undertook a formal voting process. The process itself was agreed with member practices and Local Medical Committee 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 two involvement, which provides for co-commissioning arrangements with NHS England and the creation of a joint primary care committee.

Research and development

Gateshead CCG has a total of nine practices who are actively engaging in research and development. We believe this is an important part of the work we do. We are very proud that compared to this point last year, the number of patients recruited in Gateshead practices to research studies has increased by 170%.

Two practices have taken part in their first diabetes study as a recruiting site, with support from NECS Research Nurses Rachel Nixon and Nicky Todd. They are Glenpark Medical Practice and Oxford Terrace and Rawling Road Surgery. This has enabled a new group of patients across the practice populations to be given the opportunity to take part in research.

Commissioning intentions

We have conducted many consultations regarding our commissioning intentions and we have involved and been influenced by our stakeholders, patients and local communities as well as our 31 member practices.

We are determined to build on the progress achieved over this last year and also to align our commissioning intentions with the emerging priorities identified in the Gateshead Health and Wellbeing strategy in order to ensure better integrated commissioning.

We are also undertaking a review of our suppliers to make sure that they are aligned with our commissioning intentions strategy.

Better Care Fund

Over the past year, we have continued to progress with our Better Care Fund work, building on a joint plan developed with Gateshead Council. Starting in April 2015, we will pool more than £17 million in resources as a way to improve the integration of health and social care services.

We have worked closely together across health and social care for a number of years, and this new step will reduce duplication of services and focus our efforts on improving our social care and health services, helping people to better manage their own health and wellbeing and reducing hospital admissions.

Focusing initially on services for older people and people with long term conditions, our plan has been informed by the views of patients, carers, service users and the people who work with them.

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); and 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).

Top of the class for health checks

Health professionals in the area were singled out for praise this year by Diabetes UK, who identified NHS Gateshead CCG as the top performing area in the North of England for carrying out health checks.

Health checks have been a priority area for Gateshead, and GP practices have worked hard to increase the number of checks performed locally. The report also highlighted Gateshead as coming 12th out of more than 200 CCGs across England.

Health checks are a key part of our work to reduce and improve diagnosis of conditions like cardiovascular disease and diabetes, with our analysis showing that one case of hypertension is identified for every ten health checks performed.

Review of voluntary and community sector contracts

A major review is underway to map the services we commission from voluntary and community sector organisations and ensure that they are aligned with our strategic plans.

With this in mind, Newcastle Gateshead Alliance has asked NHS North of England Commissioning Support Unit (NECS) to undertake a review of community based services it funds across Gateshead and Newcastle. The three CCGs commission over £4 million in health-related community services from third sector providers every year, but the majority of these services are based on historical funding arrangements with the old primary care trusts and have not been subject to review within the past five years.

The timing of the review fits with the NHS commissioning cycle to ensure that future contracts are strategically aligned with broader commissioning intentions.

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 and was delivered by North of England Commissioning Support (NECS).

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 AandE more appropriately, saving £1.4m in public money.

For every £1 invested in the Keep calm and look after yourself 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.

Practice IT systems

During the past year, we have implemented a series of IT upgrades and improvements to provide better integration of GP practice IT systems. This has resulted in more efficient sharing and management of patient information , which can significantly improve the quality and consistency of care that can be provided.

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 Gateshead CCG	Male	Female
Governing body members	10	2
Very senior managers	0	1
CCG employees	10	36

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 Gateshead. 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:

- 108 Rawling Road
- Beacon View Medical Centre
- Bensham Family Practice
- Bewick Road Surgery
- Birtley Medical Group
- Blaydon GP Practice and Minor Injuries/Illness Unit
- Bridges Medical Centre
- Central Gateshead Medical Group
- Chainbridge Medical Partnership
- Crawcrook Surgery
- Crowhall Medical Centre
- Fell Cottage Surgery
- Fell Tower Medical Centre
- Glenpark Medical Centre
- Grange Road
- Hollyhurst
- Longrigg Medical Centre
- Metro Interchange Surgery
- Millennium Family Practice
- Oldwell Surgery
- Oxford Terrace and Rawling Road Medical Group
- Pelaw Medical Centre
- Primary Health Care Centre

- Ryton Surgery
- Second Street Surgery
- St Albans Medical Group
- Sunniside Surgery
- Teams Medical Practice
- The Medical Centre (Rowlands Gill)
- Whickham Health Centre
- Wrekenton Medical Group

The chair of the Clinical Commissioning Group is Dr Mark Dornan and the accountable officer is Mr Mark Adams.

Membership Body (Practices' Board)

The composition of the Membership Body is:

Members representative	Job title	Practice
Dr Muthu Krishnan	GP	108 Rawling Road
Dr Sangeetha Bommisetty	GP	Beacon View Medical Centre
Dr DA Roberts	GP	Bensham Family Practice
Jane Dammers	GP	Bewick Road Surgery
Dr Joanna Hughes	GP	Birtley Medical Group
Dr Dayalan	GP	Blaydon GP Practice and Minor Injuries/Illness Unit
Dr Turner	GP	Bridges Medical Centre
Dr Linda Nutting	GP	Central Gateshead Medical Group
Dr S Robson	GP	Chainbridge Medical Partnership
Dr Stella Jacobs	GP	Crawcrook Surgery
Dr Helen Groom	GP	Crowhall Medical Centre
Dr Jerry Warwick	GP	Fell Cottage Surgery
Dr N Green	GP	Fell Tower Medical Centre
Dr Chris Jewitt	GP	Glenpark Medical Centre
Dr Geoff Smith	GP	Grange Road
Dr IJ Singh	GP	Hollyhurst
Dr Allan Reekie	GP	Longrigg Medical Centre
Dr SM Imam	GP	Metro Interchange Surgery
Dr Mohammed Ilyas	GP	Millennium Family Practice
Dr Matthew Robinson	GP	Oldwell Surgery
Dr Caroline Snell	GP	Oxford Terrace and Rawling Road Medical Group
Dr Manjit Suchdev	GP	Pelaw Medical Centre
Dr MS Hassan	GP	Primary Health Care Centre
Dr Steve Hilton	GP	Ryton Surgery
Dr Anil Kumar	GP	Second Street Surgery
Dr Tom Stadward	GP	St Albans Medical Group
Dr Alan Hunt	GP	Sunniside Surgery
Dr Paul Cassidy	GP	Teams Medical Practice
Dr Rob Dawson	GP	The Medical Centre (Rowlands Gill)
Dr A Porter	GP	Whickham Health Centre
Dr Varun Kaura	GP	Wrekenton Medical Group

Governing Body

The composition of the Governing Body is:

Chair	Dr Mark Dornan
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	Mr Bill Cunliffe
Lay member: **To lead on audit, remuneration and conflict of interest matters**	Tim Morgan
Lay member: **To lead on patient and public participation matters**	Paul Gertig
Member practice representatives	Dr Steve Kirk Dr Peter Ward Deborah Dews Sheinaz Stansfield
	Director of Public Health: Mrs C Wood, Gateshead Director of Commissioning: Jane Mulholland Head of Corporate Affairs: Jeffrey Pearson Minute taker: Louise McAndrew

Audit Committee

The composition of the Audit Committee is:

- 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 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 are outlined in Note 4.5 to the accounts. In addition the remuneration report outlines the cash equivalent transfer values.

Sickness absence data

A table is included in the employee benefits note to the financial statements and shown 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 £70,000 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.

Cost allocation and setting of charges for information

The Clinical Commissioning Group has 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 Clinical Commissioning Group as part of best practice recommendations within the complaints 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.

We have a range of forums and ways of engaging with staff including:

- 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 incuded:

> "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 real 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 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.

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 the major incident plan and 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 Clinical Commissioning Group

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 clinical commissioning group 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 Governing Body members, two GPs and the practice manager representative are not directly employed by the CCG, with their services provided through separate agreements between the CCG and their 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:

Gateshead CCG senior officers' 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 Mark Dornan	Chair	85-90	0	0	0	2.5-5	85-90
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 Piercy	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
Tim Morgan	Lay member, audit, remuneration and conflict of interest matters	10-15	0	0	0	0	10-15
Paul Gertig	Patient and public participation matters	5-10	0	0	0	0	5-10
Dr Steve Kirk	Member practice representative	55-60	0	0	0	0	55-60
Dr Peter Ward	Member practice representative	0-5	0	0	0	0	0-5
Deborah Dews	Member practice representative	10-15	0	0	0	107.5-110	120-125
Sheinaz Stansfield	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
Jane Mulholland	Locality Director of Commissioning	85-90	0	0	0	2.5-5	85-90

Gateshead CCG senior officers' 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 Mark Dornan	Chair	95-100	0	0	0	167.5-170	265-270
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 Piercy	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
Tim Morgan	Lay member, audit, remuneration and conflict of interest matters	10-15	0	0	0	0	10-15
Paul Gertig	Patient and public participation matters	5-10	0	0	0	0	5-10
Dr Steve Kirk	Member practice representative	65-70	0	0	0	0	65-70
Dr Peter Ward	Member practice representative	0-5	0	0	0	0	0-5
Deborah Dews	Member practice representative	10-15	0	0	0	12.5-15	25-30
Sheinaz Stansfield	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
Jane Mulholland	Locality Director of Commissioning	85-90	0	0	0	440-442.5	525-530

Notes:
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 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 Mark Dornan (for the period April 2013 to November 2013 only. Directly employed from December 2013)
Dr Neil Morris
Dr Peter Ward
Sheinaz Stansfield (for the period April 2013 to March 2014 only. Directly employed from April 2014)
Deborah Dews (for the period April 2013 to November 2013 only. Directly employed from December 2014)
Dr Steve Kirk (for the period April 2013 to February 2014 only. Directly employed from March 2014)

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

Mrs C Wood, Director of Public Health, Gateshead 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 Gateshead CCG. The staff sharing arrangement calculation is apportioned based upon CCG recurrent running cost allocation.

Staff sharing arrangements for Gateshead CCG senior officers' 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	55-60	0	0	0	0-2.5	55-60
Joe Corrigan	Chief Finance Officer and Operating Officer	50-55	0	0	0	0	50-55
Chris Piercy	Chief Nursing Officer	40-45	0	0	0	0	40-45
Dr Neil Morris	Medical Director	35-40	0	0	0	0	35-40
Bill Cunliffe	Secondary Care Specialist Doctor	10-15	0	0	0	0	10-15
Jeffrey Pearson	Head of Corporate Affairs	20-25	8	0	0	5-7.5	25-30

Staff sharing arrangements for Gateshead CCG senior officers' salaries and allowances 2013/14:

Mark Adams	Chief Officer	55-60	0	0	0	42.5-45	95-100
Joe Corrigan	Chief Finance Officer and Operating Officer	50-55	0	0	0	35-37.5	85-90
Chris Piercy	Chief Nursing Officer	35-40	0	0	0	0	35-40
Dr Neil Morris	Medical Director	30-35	0	0	0	0	30-35
Bill Cunliffe	Secondary Care Specialist Doctor	10-15	0	0	0	0	10-15
Jeffrey Pearson	Head of Corporate Affairs	20-25	12	0	0	10-12.5	30-35

Gateshead CCG senior officers' 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 Dornan, Chair	0 -2.5	0-2.5	5-10	25-30	117	133	13	12
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
Jane Mulholland, Locality Director of Commissioning	0-2.5	0-2.5	20-25	65-70	463	505	30	12
Jeffrey Pearson, Head of Corporate Affairs	0-2.5	2.5-5	5-10	20-25	149	0	0	8
Deborah Dews, Member Practice Representative	2.5-5	12.5-15	15-20	45-50	185	284	93	2

Pension numbers disclosed represent contributions in full for officers employed by more than one NHS body and not just those from their relevant CCG employment.

Gateshead 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 Dornan, Chair	5 - 7.5	20-22.5	5-10	25-30	21	117	95	4
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
Jane Mulholland, Locality Director of Commissioning	17.5 - 20	57.5 – 60	20 - 25	65 – 70	39	463	422	12
Jeffrey Pearson, Head of Corporate Affairs	0 - 2.5	2.5 – 5	5 - 10	15 – 20	112	149	34	7
Deborah Dews, Member Practice Representative	0	0- 2.5	10 - 15	30 - 35	166	185	16	1

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 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. Pay multiples reporting includes the staff sharing value of these employees relating only to Gateshead CCG.

The mid-point of the banded remuneration of the highest paid member of the Governing Body in Gateshead CCG in the financial year 2014/15 was £87,500 (2013/14, £97,500). This was 3.9 (2013/14, 3.3) times the median remuneration of the workforce, which was £22,521 (2013/14, £29,432). The increase in ratio is due to a reduction in reported remuneration for the highest paid director and the decrease in median remuneration in 2014/15.

In 2014/15, no employees (2013/14, no employees) received a full time equivalent remuneration in excess of the highest paid member of the Governing Body. Full time equivalent remuneration for employees ranged from £7,378 to £86,390 (2013/14, £7,167 to £99,316)

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 member of Governing Body (£'000)	85 - 90	95 – 100
Median Total Remuneration (£)	22,521	29,432
Ratio	3.9	3.3

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	6
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	6
Of which:		
• assurance has been received	0	6
• 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	6
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)	15	15

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.

Declarations of Interest: Governing Body

Name	Position held on Governing Body	Declarations of interest	Identified conflicts of interest
Dr Mark Dornan	Chair	Member of the Gateshead Practices Federation. Income from LESs, LIS, SLAs some of which are commissioned by the CCG and some by partners, e.g. LA.	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
Tim Morgan	Lay member (governance)	Finance director, Shared Interest Society. Company Secretary Cafedirect Producers' Foundation. Non-executive director Ecology Building Society	None identified

Name	Position held on Governing Body	Declarations of interest	Identified conflicts of interest
Paul Gertig	Lay member (patient and public involvement)	Sessional support worker with the Tyneside Cyrenians in their hostels. Because of work in GCCG Paul does not work in Gateshead or Newcastle. He usually covers Plawsworth in Durham. Daughter will be doing F1 (Doctor's Foundation Year) at the Queen Elizabeth Hospital, Gateshead.	None identified
Dr Steve Kirk	Clinical vice-chair	Member of the Gateshead Practices Federation. Income from LESs, LIS, SLAs some of which are commissioned by the CCG and some by partners eg LA	None identified
Dr Peter Ward	Practice representative	LMC member. Wife a nurse in the Royal Victoria Infirmary, Newcastle Member of Community Based Care. Work for Gatdoc	None identified
Deborah Dews	Practice representative	Practice Nurse at Birtley Medical Centre	None identified
Sheinaz Stansfield	Practice representative	Partner Oxford Terracen Medical Group	None identified
Jane Mulholland	Director of commissioning	None	None identified
Jeffrey Pearson	Head of corporate affairs	Brother works for NHS Business Serrvices 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 31 Member Practices, acting on behalf of the Practice in dealings with the CCG and to representing the Member Practice at meetings of the Practices Board. The Practices Board is chaired by Dr Mark Dornan.

Governing Body

The Governing Body is responsible for reviewing decisions and formally approving CCG plans and spending.

The Governing Body is also responsible for an annual budget of £302 million.

The members of our Governing Body are:

Dr Mark Dornan, Chair
Mark has been working on improving health services in Gateshead for many years. He was elected Chair of NHS Gateshead CCG by the practices in Gateshead in 2013. He is a GP partner working in Teams Medical Practice which serves a

deprived part of Gateshead. The Teams area has some of the highest levels of ill health in the country. Many people have some of the hardest challenges in trying to improve their lives and health. This means Mark has a good daily grasp on residents' issues with using services. He is trainer of junior doctors and leads the Newcastle Gateshead Alliance's work on IT.

Mark Adams, Chief Officer
As chief officer, Mark ensures 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 ensuring 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.

Tim Morgan, Deputy Chair and Lay Member
A non-executive director since 2007, Tim Morgan is also audit committee chair. A chartered accountant and chartered secretary by profession, Tim has spent most of his career working in value-based organisations. He was the financial director of Traidcraft plc for eight years and continues to work with a number of fair trade organisations.

Dr Steve Kirk, Clinical Vice-chair
Steve works at Whickham Cottage Practice and has been a GP in Whickham since 1995. He has been involved in commissioning from 1997 and has been the GP lead for cardiovascular disease in Gateshead for about 12 years. Over that time he has worked with practices and the local hospital to improve care for people suffering from heart disease and stroke.

More recently he has helped practices develop their services for people with heart failure. Steve is currently leading a project to simplify care for people with irregular heartbeats, a condition known as atrial fibrillation.

Paul Gertig, Lay Member
Paul has worked in Gateshead since 1984, first as a social worker in adult mental health and then as a team manager of an older people's mental health team. For four years he led a mixed team of health, social care and the voluntary sector as Gateshead's dementia collaborative coordinator, improving services for people with dementia and their carers. A secondment as health development manager enhanced his experience of working with different health services and communities who were living with many inequalities.

After taking early retirement from Gateshead Council, Paul now works for Tyneside Cyrenians as a sessional support worker in their homeless hostels. Paul's role involves ensuring patients, carers and the public are involved with and consulted by NHS Gateshead CCG.

Chris Piercy, Executive Director of Nursing and Patient safety
Chris' role is to assure the delivery of the highest levels of service quality, patient safety and value for money in all commissioned services whilst ensuring the patients and carers are central to all decision-making and that their voice can be heard across the CCG.

He is also the CCG lead for Safeguarding Children and Adults and the lead for Infection Prevention and Control. His role also fulfils the statutory requirement as Director of Nursing for the CCG.

Bill Cunliffe, Secondary Care Clinician
Bill's role brings a broader view on health and care issues to underpin the work of the CCG with particular focus of patient care in the secondary care setting.

He 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 CCG business.

Bill has also worked with the north east Strategic Health Authority and is currently a member of the invited review panel and an examiner for the Royal College of Surgeons of England.

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 officer means that he is the Governing Body's 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 Peter Ward, Practice Representative
Dr Peter Ward has been a GP partner at Central Gateshead Medical Group for 12 years. He is particularly interested in treating drug and alcohol abuse, and he leads on child protection and medical student teaching in the practice as well as working on a sessional basis for the out of hours GP service provider Gatdoc. In the past Peter has been a member of the General Practice Committee and was vice-chair of the GP Registrars' committee. He currently sits on the Local Medical Committee for South Tyneside and Gateshead.

Sheinaz Stansfield, Practice Representative
Sheinaz Stansfield is a practice manager with over 30 years' experience in the NHS. She initially trained as a nurse and health visitor, and then worked in commissioning at PCT and strategic health authority level, concerned mostly with developing services outside hospital, for example, integrated primary and community services, integrated nursing teams and services in GP practices. She has also worked for a Primary Care Group as a primary care development and commissioning/contracting manager and helped set up clinical commissioning in Gateshead. She is an elected locality manager for Gateshead Clinical Commissioning Group, practice representative on the Gateshead Newcastle Alliance Governing Body and the practice manager representative on the RCGP Northern Faculty Board.

Deborah Dews, Practice Representative
Deborah took up the post of senior nurse at Birtley Medical Group in 2001. She works four days a week in clinical practice and is committed to improving the quality of care for all patients in Gateshead.

Deborah takes an active role in developing and delivering training and education for nurses. For the last two years she has been respiratory clinical lead for the Gateshead practice-based commissioning group (GatNet) and worked as part of a team that has developed a primary care pulmonary rehabilitation program in partnership with Gateshead Council.

As Governing Body member, Deborah feels her role is to raise the profile of practice nurses in the commissioning process making sure that nurses are very much a part of the commissioning process.

Declarations of interest: Member Practice Representatives

Name	Position held on Governing Body	Declarations of interest	Identified conflicts of interest
Dr Muthu Krishnan	108 Rawling Road	General Practitioner	None identified
Dr Sangeetha Bommisetty	Beacon View Medical Centre	General Practitioner	None identified
Dr DA Roberts	Bensham Family Practice	General Practitioner	None identified
Dr Jane Dammers	Bewick Road Surgery	General Practitioner	None identified
Dr Joanna Hughes	Birtley Medical Group	Lead GP for liaising with CCG, GP Trainer, GP Partner	None identified
Dr Dayalan	Blaydon GP Practice and Minor Injuries/Illness Unit	General Practitioner	None identified
Dr Turner	Bridges Medical Centre	General Practitioner	None identified
Dr Linda Nutting	Central Gateshead Medical Group	General Practitioner	None identified
Dr S Robson	Chainbridge Medical Partnership	General Practitioner	None identified
Dr Stella Jacobs	Crawcrook Surgery	General Practitioner	None identified
Dr Helen Groom	Crowhall Medical Centre	General Practitioner	None identified
Dr Jerry Warwick	Fell Cottage Surgery	General Practitioner	None identified
Dr N Green	Fell Tower Medical Centre	General Practitioner	None identified

Name	Position held on Governing Body	Declarations of interest	Identified conflicts of interest
Dr Chris Jewitt	Glenpark Medical Centre	General Practitioner	None identified
Dr Geoff Smith	Grange Road	General Practitioner	None identified
Dr IJ Singh	Hollyhurst	GP Partner	None identified
Dr Allan Reekie	Longrigg Medical Centre	General Practitioner	None identified
Dr SM Imam	Metro Interchange Surgery	General Practitioner	None identified
Dr Mohammed Ilyas	Millennium Family Practice	General Practitioner	None identified
Dr Matthew Robinson	Oldwell Surgery	General Practitioner	None identified
Dr Caroline Snell	Oxford Terrace and Rawling Road Medical Group	General Practitioner	None identified
Dr Manjit Suchdev	Pelaw Medical Centre	General Practitioner	None identified
Dr MS Hassan	Primary Health Care Centre	General Practitioner	None identified
Dr Steve Hilton	Ryton Surgery	General Practitioner	None identified
Dr Anil Kumar	Second Street Surgery	GP Partner	None identified
Dr Tom Stadward	St Albans Medical Group	General Practitioner	None identified
Dr Alan Hunt	Sunniside Surgery	General Practitioner	None identified
Dr Paul Cassidy	Teams Medical Practice	General Practitioner	None identified
Dr Rob Dawson	The Medical Centre (Rowlands Gill)	General Practitioner	None identified
Dr A Porter	Whickham Health Centre	General Practitioner	None identified
Dr Varun Kaura	Wrekenton 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 Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for 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 Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Manual for Accounts issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements
- 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 clinical commissioning group was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the NHS Act 2006. The clinical commissioning group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the clinical commission group taking on its full powers.

During the course of 2014/15 the clinical commissioning group has been engaged in a process which has culminated in a merger with NHS Newcastle North and East CCG and NHS Newcastle West 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 clinical commissioning group'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 clinical commissioning group 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 ended 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 clinical commissioning group 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 the chair 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 NHS Gateshead Commissioning Group 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 NHS Newcastle North and East Clinical Commissioning Group and NHS Newcastle West Clinical Commissioning Group.

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 Gateshead Clinical Commissioning Group 2014/15						
Name	Title	Governing Body	Audit Committee	Remuneration Committee	Quality, Safety and Risk Committee	Executive Committee
Mark Dornan	Chair	5/5				10/10
Tim Morgan	Deputy Chair and Lay Member for Governance/Audit	5/5	7/7	1/1		
Paul Gertig	Lay Member	5/5		1/1	4/5	
Steve Kirk	Clinical Vice Chair	0/5				9/10
Peter Ward	Practice Representative	2/5				
Sheinaz Stansfield	Practice Representative	4/5				
Deborah Dews	Practice Representative	0/5				4/5
Neil Morris	Medical Director	4/5			5/5	7/10
Bill Cunliffe	Secondary Care Doctor	2/5	4/7[1]		1/5	5/10
Chris Piercy	Director of Nursing	3/5	3/7[2]		5/5	3/5
Mark Adams	Chief Officer	5/5			0/5	9/10
Joe Corrigan	Chief Finance and Operational Officer	5/5	7/7			7/10
Jane Mulholland	Commissioning Director	3/5			1/5	10/10

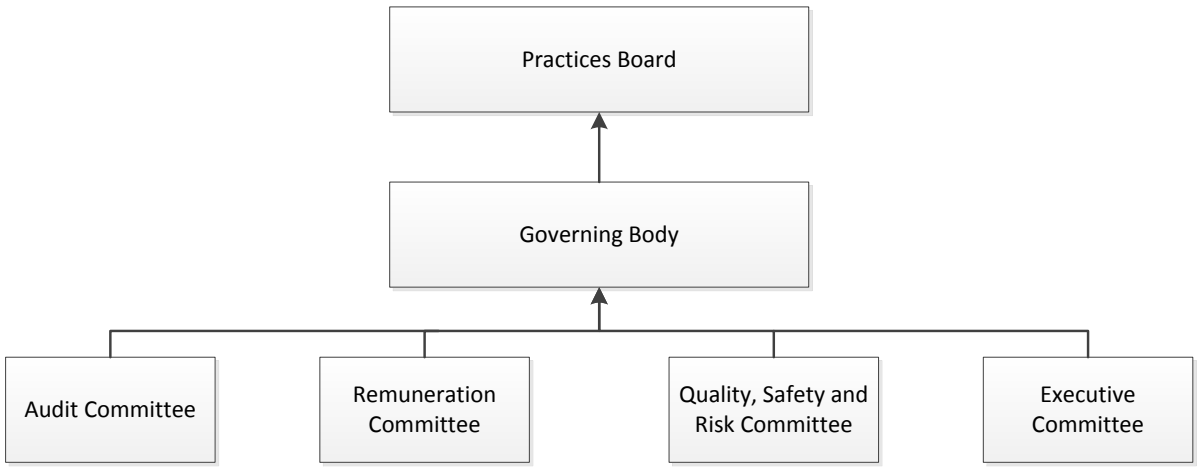
It should be noted that whilst Mark Adams is listed in the terms of reference as a member of the Quality, Safety and Risk committee, a decision was taken that the Executive Director of Nursing, Quality and Patient Safety should take a lead in relation to this group.

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

[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.

effective governance. The organisational structure including key committees is set out below.



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 two 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) (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 240 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 counter 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 Health and Wellbeing Board, and the implementation of the Health and Wellbeing 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 one (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 £11.2m and further local efficiency savings of £1.8m. 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 is 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 clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit is as follows:

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 are 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.

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 clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the 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 Newcastle West 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 Gateshead 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 Gateshead 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 39-42;
- the table of pension benefits of senior managers and related narrative notes on pages 43-45; and
- the table of pay multiples and related narrative notes on pages 45-46.

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 Gateshead 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 Gateshead 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 Gateshead 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 Gateshead CCG
This year	2014-15
This year ended	31 March 2015
This year commencing:	1 April 2014

CONTENTS **Page Number**

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	2,641	2,372
Operating Expenses	5	295,261	286,503
Other operating revenue	2	(1,531)	(945)
Net operating expenditure before interest		**296,371**	**287,930**
Net operating expenditure for the financial year		**296,371**	**287,930**
Total Net Expenditure for the year		**296,371**	**287,930**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	2,402	2,213
Operating Expenses	5	3,483	3,480
Other operating revenue	2	(1,228)	(889)
Net administration costs before interest		**4,657**	**4,804**
Programme Income and Expenditure			
Employee benefits	4.1.1	239	159
Operating Expenses	5	291,778	283,023
Other operating revenue	2	(303)	(56)
Net programme expenditure before interest		**291,714**	**283,126**

	2014-15 £000	2013-14 £000
Total comprehensive net expenditure for the year	**296,371**	**287,930**

The notes on pages 5 to 27 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:			
Property, plant and equipment	13	64	142
Total non-current assets		**64**	142
Current assets:			
Trade and other receivables	17	2,781	3,180
Cash and cash equivalents	20	201	184
Total current assets		**2,982**	3,364
Total assets		**3,046**	3,506
Current liabilities			
Trade and other payables	23	(17,132)	(16,296)
Total current liabilities		**(17,132)**	(16,296)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(14,086)**	(12,790)
Non-current liabilities		0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(14,086)**	(12,790)
Financed by Taxpayers' Equity			
General fund		(14,086)	(12,790)
Total taxpayers' equity:		**(14,086)**	(12,790)

The notes on pages 5 to 27 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		(12,790)	0	0	**(12,790)**
Adjusted CCG balance at 1 April 2014		**(12,790)**	**0**	**0**	**(12,790)**
Changes in CCG taxpayers' equity for 2014-15					
Net operating expenditure for the financial year	SOCNE	(296,371)	0	0	(296,371)
Net Recognised CCG Expenditure for the Financial Year		**(296,371)**	**0**	**0**	**(309,161)**
Net funding	SCF	295,075	0	0	295,075
Balance at 31 March 2015		**(14,086)**	**0**	**0**	**(14,086)**

		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**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition		**244**	**0**	**0**	**244**
Adjusted CCG balance at 1 April 2013		**244**	**0**	**0**	**244**
Changes in CCG taxpayers' equity for 2013-14					
Net operating costs for the financial year	SOCNE	(287,930)	0	0	(287,930)
Net Recognised CCG Expenditure for the Financial Year		**(287,686)**	**0**	**0**	**(287,686)**
Net funding	SCF	274,896	0	0	274,896
Balance at 31 March 2014		**(12,790)**	**0**	**0**	**(12,790)**

The primary statements on pages 1 and 4 and notes on pages 5 to 27 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		(296,371)	(287,930)
Depreciation and amortisation	5	78	102
(Increase)/decrease in trade & other receivables	17	399	(3,180)
Increase/(decrease) in trade & other payables	23	836	16,296
Net Cash Inflow (Outflow) from Operating Activities		**(295,058)**	(274,712)
Cash Flows from Investing Activities		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(295,058)**	(274,712)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		295,075	274,896
Net Cash Inflow (Outflow) from Financing Activities		**295,075**	274,896
Net Increase (Decrease) in Cash & Cash Equivalents	20	**17**	184
Cash & Cash Equivalents at the Beginning of the Financial Year	20	**184**	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	20	**201**	184

The notes on pages 5 to 27 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 Gateshead Clinical Commissioning Group was dissolved on 31 March 2015 having joined with NHS Newcastle North and East Clinical Commissioning Group and NHS Newcastle West Clinical Commissioning Group to establish NHS Newcastle Gateshead Clinical Commissioning Group 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 **Pooled Budgets**

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
If the clinical commissioning group is in a “jointly controlled operation”, the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group’s share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group’s share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group’s share of any liabilities incurred jointly; and,
- The clinical commissioning group’s share of the expenses jointly incurred.

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

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

1.6.1 ***Critical Judgements in Applying Accounting Policies***

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:

1.6.2 **Key Sources of Estimation Uncertainty**

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

1.7 **Revenue**

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

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Notes to the financial statements

1.8.2 **Retirement Benefit Costs**

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

1.9 **Other Expenses**

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

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

1.1 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,

- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 **Valuation**

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11 **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.

1.11.1 **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.

1.11.2 **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.

Notes to the financial statements

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.

Notes to the financial statements

1.12 **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.

1.13 **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 in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements."

1.13 **Clinical Negligence Costs**

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

1.14 **Non-clinical Risk Pooling**

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

1.15 **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.

1.16 **Carbon Reduction Commitment Scheme**

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected 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.

1.17 **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.

1.19 **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.

1.20 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

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

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

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

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

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

2 Other Operating Revenue

	2014-15 Total	**2014-15 Admin**	**2014-15 Programme**	2013-14 Total	2013-14 Admin	2013-14 Programme
	£000	**£000**	**£000**	£000	£000	£000
Recoveries in respect of employee benefits	873	742	131	658	658	0
Education, training and research	53	53	0	56	56	0
Charitable and other contributions to revenue expenditure: non-NHS	19	19	0	0	0	0
Non-patient care services to other bodies	586	414	172	226	175	51
Other revenue	0	0	0	5	0	5
Total other operating revenue	**1,531**	**1,228**	**303**	**945**	**889**	**56**

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 Gateshead 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	1,531	1,228	303	945	889	56
Total	**1,531**	**1,228**	**303**	**945**	**889**	**56**

Revenue is totally from the supply of services. NHS Gateshead 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	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	2,222	2,130	92	2,028	1,936	92	194	194	0
Social security costs	183	183	0	165	165	0	18	18	0
Employer Contributions to NHS Pension scheme	236	236	0	209	209	0	27	27	0
Gross employee benefits expenditure	**2,641**	**2,549**	**92**	**2,402**	**2,310**	**92**	**239**	**239**	**0**
Less recoveries in respect of employee benefits (note 4.1.2)	(873)	(873)	0	(742)	(742)	0	(131)	(131)	0
Total - Net admin employee benefits including capitalised costs	**1,768**	**1,676**	**92**	**1,660**	**1,568**	**92**	**108**	**108**	**0**

2013-14	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	2,049	1,969	80	1,920	1,840	80	129	129	-
Social security costs	141	141	-	129	129	-	12	12	-
Employer Contributions to NHS Pension scheme	182	182	-	164	164	-	18	18	-
Gross employee benefits expenditure	**2,372**	**2,292**	**80**	**2,213**	**2,133**	**80**	**159**	**159**	**-**
Less recoveries in respect of employee benefits (note 4.1.2)	**- 658**	- 658	-	**- 658**	**- 658**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**1,714**	**1,634**	**80**	**1,555**	**1,475**	**80**	**159**	**159**	**-**

4.1.2 Recoveries in respect of employee benefits

2014-15	Total	Permanent Employees	Other
	£000	£000	£000
Employee Benefits - Revenue			
Salaries and wages	(728)	(728)	0
Social security costs	(67)	(67)	0
Employer contributions to the NHS Pension Scheme	(78)	(78)	0
Total recoveries in respect of employee benefits	**(873)**	**(873)**	**0**

2013-14	Total	Permanent Employees	Other
	£000	£000	£000
Employee Benefits - Revenue			
Salaries and wages	- 547	- 547	-
Social security costs	- 53	- 53	-
Employer contributions to the NHS Pension Scheme	- 58	- 58	-
Total recoveries in respect of employee benefits	**- 658**	**- 658**	**-**

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	**37**	**36**	**1**	36	35	1
Of the above:						
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0	0	0

NHS Gateshead Clinical Commissioning Group host staff which are shared with Newcastle North and East Clinical Commissioning Group and Newcastle West Clinical Commissioning Group. The 23 WTE who work across the 3 organisations are all reported in Gateshead Clinical Commissioning Group numbers.

4.3 Staff sickness absence and ill health retirements

	2014-15 Number	**2013-14 Number**
Total Days Lost	50	31
Total Staff Years	30	19
Average working Days Lost	**1.7**	**1.6**

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 Gateshead 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 Gateshead 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	2014-15 Admin £000	2014-15 Programme £000
Gross employee benefits						
Employee benefits excluding governing body members	2,182	1,943	239	1,909	1,750	159
Executive governing body members	459	459	0	463	463	0
Total gross employee benefits	**2,641**	**2,402**	**239**	**2,372**	**2,213**	**159**
Other costs						
Services from other CCGs and NHS England	3,151	2,156	995	2,113	2,099	14
Services from foundation trusts	217,992	53	217,939	213,560	11	213,549
Services from other NHS trusts	413	0	413	281	0	281
Services from other NHS bodies	0	0	0	6	6	0
Purchase of healthcare from non-NHS bodies	33,430	0	33,430	31,931	0	31,931
Chair and Non Executive Members	129	129	0	128	128	0
Supplies and services – clinical	68	0	68	135	0	135
Supplies and services – general	270	70	200	317	75	242
Consultancy services	73	73	0	68	68	0
Establishment	149	94	55	100	96	4
Transport	14	14	0	10	10	0
Premises	577	279	298	296	296	0
Depreciation	78	78	0	102	102	0
Audit fees	84	84	0	84	84	0
Prescribing costs	36,832	0	36,832	36,203	0	36,203
Pharmaceutical services	19	0	19	0	0	0
GPMS/APMS and PCTMS	876	0	876	664	0	664
Other professional fees excl. audit	643	418	225	482	482	0
Clinical negligence	5	5	0	5	5	0
Education and training	37	30	7	18	18	0
CHC Risk Pool contributions	421	0	421	0	0	0
Total other costs	**295,261**	**3,483**	**291,778**	**286,503**	**3,480**	**283,023**
Total operating expenses	**297,902**	**5,885**	**292,017**	**288,875**	**5,693**	**283,182**

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	5,348	37,952	3,495	32,771
Total Non-NHS Trade Invoices paid within target	5,132	37,069	3,323	32,392
Percentage of Non-NHS Trade invoices paid within target	**95.96%**	**97.68%**	**95.08%**	**98.84%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,738	224,896	1,194	213,011
Total NHS Trade Invoices Paid within target	1,669	222,711	1,152	212,475
Percentage of NHS Trade Invoices paid within target	**96.03%**	**99.03%**	**96.48%**	**99.75%**

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 Gateshead Clinical Commissioning Group does not undertake any income generation activites.

8. Investment revenue

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

9. Other gains and losses

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

10. Finance costs

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

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

NHS Gateshead 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	516	0	**516**	273
Total	**0**	**516**	**0**	**516**	**273**

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 these arrangements only.

12.2 As lessor

12.2.1 Rental revenue

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

12.2.2 Future minimum rental value

NHS Gateshead Clinical Commissioning Group has no future rental revenue as at 31 March 2015.

13 Property, plant and equipment

2014-15	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2014	0	0	0	0	244	0	0	0	244
Cost/Valuation At 31 March 2015	**0**	**0**	**0**	**0**	**244**	**0**	**0**	**0**	**244**
Depreciation 1 April 2014	0	0	0	0	102	0	0	0	102
Charged during the year	0	0	0	0	78	0	0	0	78
Depreciation at 31 March 2015	**0**	**0**	**0**	**0**	**180**	**0**	**0**	**0**	**180**
Net Book Value at 31 March 2015	**0**	**0**	**0**	**0**	**64**	**0**	**0**	**0**	**64**
Purchased	0	0	0	0	64	0	0	0	64
Total at 31 March 2015	**0**	**0**	**0**	**0**	**64**	**0**	**0**	**0**	**64**
Asset financing:									
Owned	0	0	0	0	64	0	0	0	64
Total at 31 March 2015	**0**	**0**	**0**	**0**	**64**	**0**	**0**	**0**	**64**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

NHS Gateshead Clinical Commissioning Group had no additions to assets under construction as at 31 March 2015.

13.2 Donated assets

NHS Gateshead Clinical Commissioning Group had no donated assets as at 31 March 2015.

13.3 Government granted assets

NHS Gateshead Clinical Commissioning Group had no government granted assets as at 31 March 2015.

13.4 Property revaluation

NHS Gateshead Clinical Commissioning Group had noproperty revaluation as at 31 March 2015.

13.5 Compensation from third parties

NHS Gateshead Clinical Commissioning Group had no compensation from third parties as at 31 March

13.6 Write downs to recoverable amount

NHS Gateshead Clinical Commissioning Group had no assets written down to recoverable amounts as at

13.7 Temporarily idle assets

NHS Gateshead Clinical Commissioning Group had no temporary idle assets as at 31 March 2015.

13.8 Cost or valuation of fully depreciated assets

NHS Gateshead Clinical Commissioning Group had no fully depreciated assets as at 31 March 2015.

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Plant & machinery	1	1

14 Intangible non-current assets

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

15 Investment property

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

16 Inventories

NHS Gateshead 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	65	0	717	0
NHS prepayments and accrued income	906	0	443	0
Non-NHS receivables: Revenue	1,795	0	2,020	0
Non-NHS prepayments and accrued income	6	0	0	0
VAT	8	0	0	0
Other receivables	1	0	0	0
Total Trade & other receivables	**2,781**	**0**	**3,180**	**0**
Total current and non current	**2,781**		**3,180**	
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	74	368
By three to six months	852	19
By more than six months	1	431
Total	**927**	**818**

£295k of the amount above has subsequently been recovered post the statement of financial position date.

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

17.2 Provision for impairment of receivables

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

18 Other financial assets

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

19 Other current assets

NHS Gateshead 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	184	0
Net change in year	17	184
Balance at 31 March 2015	**201**	**184**
Made up of:		
Cash with the Government Banking Service	201	184
Cash and cash equivalents as in statement of financial position	**201**	**184**
Balance at 31 March 2015	**201**	**184**

There was no patients' money held by NHS Gateshead Clinical Commissioning Group in the financial year.

21 Non-current assets held for sale

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

22 Analysis of impairments and reversals

NHS Gateshead Clinical Commissioning Group had no 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	644	0	5,545	0
NHS accruals and deferred income	3,294	0	294	0
Non-NHS payables: revenue	5,067	0	4,642	0
Non-NHS accruals and deferred income	8,008	0	5,815	0
Social security costs	32	0	0	0
Tax	44	0	0	0
Other payables	43	0	0	0
Total Trade & Other Payables	**17,132**	**0**	**16,296**	**0**
Total current and non-current	**17,132**		**16,296**	

Other payables include £43k outstanding pension contributions at 31 March 2015.

24 Other financial liabilities

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

25 Other liabilities

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

26 Borrowings

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

27 Private finance initiative, LIFT and other service concession arrangements

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

28 Finance lease obligations

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

29 Finance lease receivables

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

30 Provisions

NHS Gateshead 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 Gateshead Clinical Commissioning Group. However, the legal liability remains with NHS Gateshead Clinical Commissioning Group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of NHS Gateshead Clinical Commissioning Group at 31 March 2015 is £2,687k.

31 Contingencies

NHS Gateshead Clinical Commissioning Group is entering a 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 Gateshead 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 Gateshead Clinical Commissioning Group had no capital commitments as at 31 March 2015.

32.2 Other financial commitments

NHS Gateshead 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 Gateshead 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 Gateshead 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 Gateshead Clinical Commissioning Group in undertaking its activities.

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

33.1.1 Currency risk

NHS Gateshead 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 Gateshead Clinical Commissioning Group has no overseas operations. NHS Gateshead Clinical Commissioning Group therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

NHS Gateshead 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 Gateshead Clinical Commissioning Group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the NHS Clinical Commissioning Group revenue comes from parliamentary funding, NHS 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 Gateshead Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. NHS Gateshead Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. NHS Gateshead 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**
Receivables:				
· NHS	0	65	0	65
· Non-NHS	0	1,795	0	1,795
Cash at bank and in hand	0	201	0	201
Other financial assets	0	1	0	1
Total at 31 March 2015	**0**	**2,062**	**0**	**2,062**

	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
Receivables:				
· NHS	0	717	0	717
· Non-NHS	0	2,020	0	2,020
Cash at bank and in hand	0	184	0	184
Other financial assets	0	0	0	0
Total at 31 March 2014	**0**	**2,921**	**0**	**2,921**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £000	**Other 2014-15 £000**	**Total 2014-15 £000**
Payables:			
· NHS	0	3,938	3,938
· Non-NHS	0	13,118	13,118
Total at 31 March 2015	**0**	**17,056**	**17,056**

	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Payables:			
· NHS	0	5,839	5,839
· Non-NHS	0	10,457	10,457
Total at 31 March 2014	**0**	**16,296**	**16,296**

34 Operating segments

NHS Gateshead 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	297,902	(1,531)	**296,371**	3,046	(17,132)	**(14,086)**
Total	**297,902**	**(1,531)**	**296,371**	**3,046**	**(17,132)**	**(14,086)**

35 Pooled budgets

NHS Gateshead Clinical Commissioning Group hosted, throughout the year, a pooled budget arrangement between NHS Gateshead Clinical Commissioning Group and Gateshead Council for the provision of an Integrated Community Equipment Service.

The expenditure during the year contributed to the objectives of creating a single pooled budget to support the integrated service delivery and improving standards of service. NHS Gateshead Clinical Commissioning Group accounts for its share of the income and expenditure of the pool as determined by the pooled budget agreement.

NHS Gateshead Clinical Commissioning Group also has two pooled budget arrangements with Gateshead Council where the Local Authority host the pooled budget. These two arrangements are in relation to the requirements of the Mental Capacity Act, and for provision of a Continuing Healthcare and Funded Nursing Care lead commissioning and procurement service. NHS Gateshead Clinical Commissioning Group accounts for its share of the income and expenditure of the pool as determined by the pooled budget agreements for both of these arrangements.

NHS Gateshead Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2014-15 £000	2013-14 £000
Income	0	0
Expenditure	1,913	2,035

36 NHS Lift investments

NHS Gateshead 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	8	0	395	0
· Local Authorities	1,677	0	3,338	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	235	0	79	0
· NHS Trusts and Foundation Trusts	736	0	3,859	0
Total of balances with NHS bodies:	**971**	**0**	**3,938**	**0**
· Bodies external to Government	125	0	9,461	0
Total balances at 31 March 2015	**2,781**	**0**	**17,132**	**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	0	0	133	0
· Local Authorities	1,977	0	872	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	505	0	86	0
· NHS Trusts and Foundation Trusts	656	0	5,753	0
Total of balances with NHS bodies:	**1,161**	**0**	**5,839**	**0**
· Bodies external to Government	42	0	9,452	0
Total balances at 31 March 2014	**3,180**	**0**	**16,296**	**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
Gateshead GP member practices								
108 Rawling Road	21	0	0	0	7	0	0	0
Beacon View Medical Centre	42	0	0	0	33	0	0	0
Bensham Family Practice	40	0	0	0	32	0	0	0
Bewick Road Surgery	62	0	0	0	35	0	0	0
Birtley Medical Group	202	0	0	0	116	0	0	0
Blaydon GP Practice & Minor Injuries/Illness Unit	0	0	0	0	3	0	0	0
Bridges Medical Centre	58	0	0	0	81	0	0	0
Central Gateshead Medical Group	100	0	0	0	56	0	0	0
Chainbridge Medical Partnership	104	0	0	0	39	0	0	0
Crawcrook Surgery	107	0	0	0	55	0	0	0
Crowhall Medical Centre	75	0	0	0	101	0	0	0
Fell Cottage Surgery	116	0	0	0	64	0	0	0
Fell Tower Medical Centre	93	0	0	0	80	0	0	0
Glenpark Medical Centre	108	0	0	0	106	0	0	0
Grange Road	44	0	0	0	42	0	0	0
High Street Medical Centre	16	0	0	0	0	0	0	0
Hollyhurst	27	0	0	0	15	0	0	0
Longrigg Medical Centre	108	0	0	0	71	0	0	0
Metro Interchange Surgery	29	0	0	0	11	0	0	0
Millennium Family Practice	29	0	0	0	19	0	0	0
Oldwell Surgery	51	0	0	0	11	0	0	0
Oxford Terrace & Rawling Road Medical Group	323	0	0	0	143	0	0	0
Pelaw Medical Centre	348	0	0	0	215	0	0	0
Primary Health Care Centre	63	0	0	0	46	0	0	0
Ryton Surgery	26	0	0	0	0	0	0	0
Second Street Surgery	22	0	0	0	10	0	0	0
St Albans Medical Group	94	0	0	0	0	0	0	0
Sunniside Surgery	38	0	0	0	17	0	0	0
Teams Medical Practice	62	0	0	0	35	0	0	0
The Medical Centre (Rowlands Gill)	180	0	0	0	133	0	0	0
Whickham Health Centre	173	0	0	0	83	0	0	0
Wrekenton Medical Group	122	0	0	0	81	0	0	0
Other Related Parties								
Newcastle North & East Clinical Commissioning Group	180	(1,087)	0	(82)	55	(592)	6	(224)
Newcastle West Clinical Commissioning Group	129	(671)	0	(90)	80	(574)	9	(265)

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

NHS Gateshead Clinical Commissioning Group also commission GP practices to provide healthcare services to patients.

The Department of Health is regarded as a related party. During the year NHS Gateshead 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:

• Gateshead Health NHS Foundation Trust	125,109	(345)	430	0	119,116	0	1,399	0
• Newcastle upon Tyne Hospitals NHS Foundation Trust	33,455	0	705	0	30,425	0	1,368	0
• South Tyneside NHS Foundation Trust	27,418	0	88	0	25,491	0	1,071	0
• Northumberland, Tyne & Wear NHS Trust	20,850	0	0	(60)	18,503	0	609	0
• North East Ambulance Service NHS Foundation Trust	8,629	0	44	0	8,257	0	199	0
• City Hospitals Sunderland NHS Foundation Trust	2,875	0	80	0	2,993	0	0	(211)
• County Durham & Darlington NHS Foundation Trust	2,206	0	0	(140)	2,182	0	32	0

NHS Gateshead 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 Gateshead 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 £10,235,000 have been with Gateshead Council.

39 Events after the end of the reporting period

From 1st April 2015 NHS Gateshead 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 Gateshead Clinical Commissioning Group had no losses or special payments during 2014/15.

41 Third party assets

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

42 Financial performance targets

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

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

	2014-15 Target £000	**2014-15 Performance £000**	2013-14 Target £000	2013-14 Performance £000
Expenditure not to exceed income	302,226	296,371	292,220	287,930
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	302,226	296,371	292,220	287,930
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	5,725	4,657	5,100	4,805

43 Impact of IFRS

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

44 Analysis of charitable reserves

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