NHS
North Hampshire
Clinical Commissioning Group

# Annual Report
## 2013/14











# 1 Introduction


This our first Annual Report reviews the year from 1st April 2013 to 31st March 2014. The NHS North Hampshire Clinical Commissioning Group (NHCCG) was legally created on 1st April 2013. We are a doctor-led organisation whose role is to ensure that NHS commissioned care for our 216,000 population, who live in North Hampshire, is available where and when it is needed and that it is the best quality and value for money. Local doctors from every General Practice govern our work and influence the decisions we make. This Annual Report has been produced by the CCG Governing Body, on behalf of the GP Membership. The first part of the report comprises a membership report which provides a membership perspective upon how effective the CCG has been during the year.

The CCG role is set out in the NHS Health and Social Care Act 2012, and in the NHS Constitution (the NHS belongs to the people)

## Contents

# 2 Membership Report

## Introduction from Dr Matt Nisbet Chair of Membership Senate

The CCG is a membership organisation which comprises 20 GP practices in the North Hampshire area. The Membership Senate, which I Chair has representatives from each of the practices, and provides a quarterly forum for the members to interact with the CCG on its strategy and its delivery. We are fortunate to have had during 2013/14 two of the most senior posts in the CCG being held by local GPs, Dr Hugh Freeman (Chair) and Dr Sam Hullah (Chief Clinical Officer), both post holders were subject to a membership approval process.

I am pleased to report that the GP practices are closely involved with the work of the CCG in many ways including:

- more than 20 local GPs being involved with the governing body, the clinical cabinet itself or leading on clinical projects
- the practice managers meet on a monthly basis with the CCG to discuss operational matters
- importantly, the patients of local practices have a means to feedback their views on health matters via the North Hampshire CCG Patient Participation Group.

Each GP Practice is represented on the Membership Senate. The Senate has (as set out in the CCG Constitution) delegated decision making to the Governing Body of the CCG. The CCG has made full use of the Senate meetings to capture GP membership priorities and to share strategic and operational plans.

Despite being early in its evolution the CCG is already reaping the benefits of a strong clinical leadership and strong clinical engagement to secure the benefits of clinically led commissioning for the population of North Hampshire.

## Membership Report

The Membership report has been based on soft intelligence gained throughout the year under review and also from two surveys, the first being the Ipsos MORI survey (undertaken nationally) and the second being a local survey of membership practices, this was undertaken independently by the communications function of the Commissioning Support Unit which has no operational involvement in the work of North Hampshire CCG.

## Reflections upon CCG progress and performance

When asked about the how the CCG had performed against the health priorities of the local community and against its strategy and operational plan, members generally gave positive feedback about how CCG/GP involvement has helped to influence decisions about the way healthcare is delivered, resulting in changes to services which have benefitted both patients and finances. The areas where the CCG had prioritised its work were explored with the following areas being rated as good or very good;

- Diabetes 72%
- Dementia 79%
- Chronic Heart Disease and Hypertension 57%
- Mental Health 57%
- Respiratory Disease 57%
- Frail Elderly 64%
- Maternity and Paediatrics 29%
- Cancer 64%

**When asked about the impact** - the CCG had made to the health of the population, the membership was particularly pleased with the roll out of italk, a talking therapies service, for efforts made to improve diabetes care, for effective medicines management and for the redesigned front door of A & E.

## Comments made include:

> **the CCG has made great efforts to come to the practice and listen to our views**

> **a proactive and intelligent partner whose input is always appreciated. They are an excellent sounding board for discussions and have no hidden agenda**

> **integrated care teams are a stunning success; need to be further supported and developed**

## Areas where there is scope for improvement which will be built into CCG work plans for 2014/15

The Musculoskeletal service, was a common theme for improvement over the coming year. GPs were keen to see work in this area progressed in a timely manner to reduce the number of patients progressing to chronic pain.

Dementia was also highlighted. The enthusiasm to make positive changes in this important area could not be faulted, but this didn't seem to have translated into practical improvements at this stage, although it was acknowledged that changing attitudes were also very valuable.

It was suggested that there was a need to support practices in Safeguarding – 43% of practices rated the CCG as average in this area which was less positive than hoped. Practices also requested CCG support in managing and reducing workload pressures.

The importance of stressing the CCG's priorities for the year was key, so that practices are fully aware of where the focus is being placed and could play an active and meaningful role in helping the CCG to achieve its goals.

## Supporting comments:

> **the local tier 2 MSK clinic continues to be a source of disquiet. I would like this to be a high priority**

> **in order to encourage member practices to take more of a leadership role GP's need to be freed up to dedicate more time to the role, we should be encouraging leadership training amongst younger GP's in practices**

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

That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the CCG auditor is aware of that information.

Signed by
Dr Matt Nisbet


# 3 Strategic Report

## Preface by Dr Sam Hullah

The last 12 months have been challenging but also rewarding. As Accountable Officer for the CCG it is ultimately my responsibility to ensure that the CCG carries out all its statutory responsibilities, but in doing that I have been expertly supported by a great team of managers and fellow clinicians, for whose help and support, I am extremely grateful. I would also like to thank our Governing Body, our membership and the public of North Hampshire. All have played their part.

We started our year understanding the tremendous challenges that we faced, but we began with a clear vision of where we wanted to get to and a positive belief in the local NHS workforce. So what is that vision? There are 5 elements.

Firstly we want to improve clinical outcomes for our patients – that means for example fewer medical complications as a result of better treatment of Diabetes, better survival rates for cancer and fewer people suffering strokes through targeted preventative treatments.

Secondly we want to improve patients' experiences of our local NHS. That starts from the first contact with the NHS through 111, accessing your GP practice, or arrival at the Emergency Department, and then continues through all hospital and other NHS services. We want our patients to report that they have received a good service

Thirdly we want to work collaboratively with the health and social care system – hospitals, social services, patient groups and the voluntary sector to name but a few. It is only by working collaboratively that we can deliver the fourth element of the vision which is to redesign services to make them work better (which assists in improving outcomes and experiences). This is an area I have sometimes described as "a system that doctors would be happy to refer their parents into".

When you combine the above you can deliver on the final part of the vision which is to live within our means. It is an uncomfortable reality that health care spending comes from a finite pot, so we need to improve quality and innovation across our local NHS to ensure that we can keep within the resources made available to us.

> **We believe it is the partnership of managers and clinicians that is the key to delivering real positive change, and that over a five year period we can deliver that vision. This report and annual account detail year one.**

The summarised accounts (shown in section 4) have been prepared under a direction issued by NHS England (previously known as NHS Commissioning Board) under the National Health Service Act 2006 (as amended).

## How decisions are made in the CCG

Both the Governing Body and Clinical Cabinet are the "engine room" for decision making in the CCG. Each individual who sits on these committees share responsibility as part of the team to ensure that the CCG acts in accordance with its responsibilities; is responsive to the views of our patients and community and act in the best interest for the health of the population. The individuals each bring a unique perspective, informed by their expertise and experience to support decision making.

## Committees of the CCG

These comprise of:

- The CCG Governing Body – all members of the governing body are voting members except for Gill Duncan, Sallie Bacon, Colin Godfrey, and Anne Phillips
- Audit Committee
- Remuneration Committee
- Clinical Cabinet
- Senior Management Committee
- Integrated Governance Committee
- Link Engagement and Partnership Committee (LEAP)
- Performance and Assurance Working Group
- Clinical Quality Working Group.

Attendance at the three principle committee meetings being the Governing Body, the Clinical Cabinet and the Audit Committee is set out in Addendum B.

The role of the Audit Committee includes a review of the Annual Report and Accounts on behalf of the Governing Body prior to their adoption.

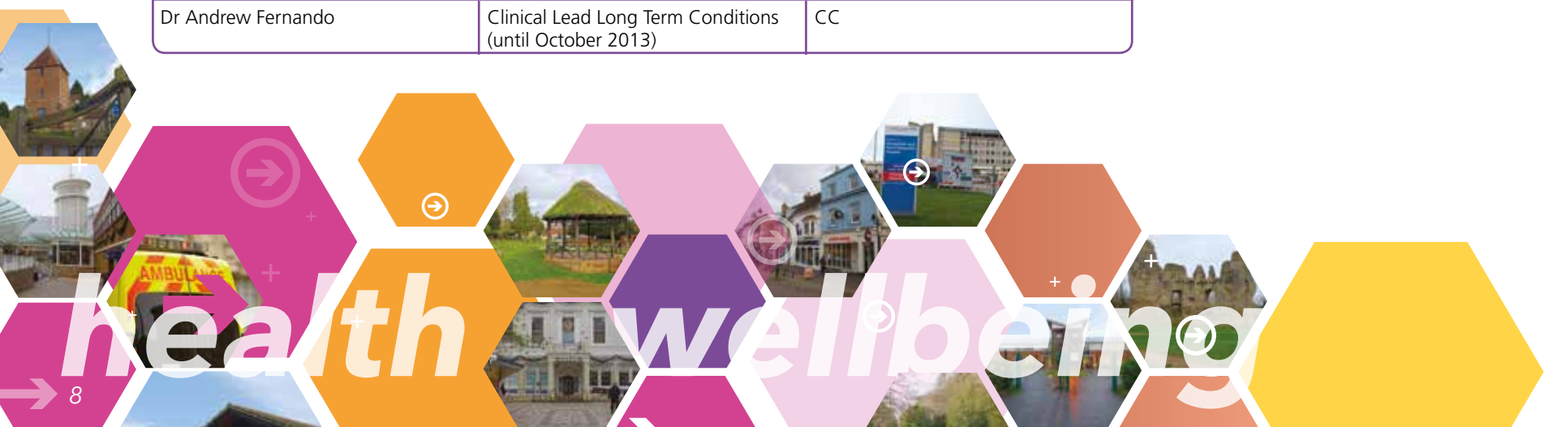
Details of the Remuneration Committee, are provided in the Remuneration section later in this report, further details of committee are set out in the CCG governance statement in paragraph 5.4.

## Audit Committee

| Name and details | Member Attendance | | | |
|---|---|---|---|---|
| | 11 June 13 | 13 Sept 13 | 13 Dec 13 | 1 April 14 |
| **David Rice** (Chair) responsible for audit and remuneration | Yes | Yes | Yes | Yes |
| **Derek Tree** Lay Member | Yes | Yes | Not in attendance | Not in attendance |
| **Dr Angus Carnegy** (Membership elected GP) | Yes | Yes | Yes | Yes |
| **Dr Andrew Cameron** (Membership elected GP) | Yes | Yes | Not in attendance | Yes |


The table below sets out those people who influence decisions made by the CCG and their representation on committees which impact upon the CCG business. These include partnership related committees which are external to the CCG.

| NAME | Role | Committee Membership Details |
|---|---|---|
| Dr Hugh Freeman | Chair | Governing Body (GB), Health and Wellbeing Board (HWB) |
| Dr Sam Hullah | Chief Clinical Officer | GB, Clinical Cabinet (CC), Integrated Governance Committee (IGC), Senior Management Committee (SMC) |
| Lisa Briggs | Chief Operating Officer | GB, CC, SMC, IGC, Performance and Assurance Working Group (PAWG), Link, Engagement and Partnership Committee (LEAP) |
| Pam Hobbs | Chief Finance Officer | GB, SMC, IGC, CC, PAWG |
| Jan Grant | Chief Nurse | GB, CC, IGC, SMC, PAWG, Clinical Quality Working Group (CQWG), Safeguarding Adults Committee (SAC), Vulnerable Persons Committee (VPC) |
| Anne Phillips | Head of Stakeholder Engagement and Communications | GB, CC, SMC, LEAP, |
| Dr Amanda Britton | Vice Chair Clinical Cabinet, Clinical Lead for Children & Maternity Services | GB, CC |
| Dr Angus Carnegy | GP Elected Member | GB, CC, IGC, Audit Committee (AC), Remuneration Committee (RC) |
| Dr Andrew Cameron | GP Elected Member | GB, IGC, AC, RC |
| Dr Nick Sorby | Secondary Care Consultant | GB |
| David Rice | Lay Member | GB, AC, RC |
| Derek Tree | Lay Member | GB, IGC, AC, RC, |
| Colin Godfrey | Patient Representative | IGC, CQWG, LEAP |
| Sallie Bacon | Public Health Consultant | GB, CC, IGC |
| Gill Duncan | Director of Adult Services | GB |
| Dr Andrew Fellows | Clinical Lead for Unscheduled Care | CC |
| Dr Philip Hiorns | Clinical lead for Prescribing | CC |
| Dr Robert Green | Clinical Lead for Mental Health | CC |
| Dr Robert Walker | Clinical Lead for Research, Innovation & Education | CC |
| Dr Sunil Rathod | Clinical Lead for Information Management and Technology | CC |
| Dr Andrew Fernando | Clinical Lead Long Term Conditions (until October 2013) | CC |






## Our population and their health

North Hampshire is a mix of both urban and rural areas covering Basingstoke, Alton, Hook, Tadley, Odiham and many villages. Our local authority partners are Basingstoke & Deane Borough Council, East Hampshire and Hart District Councils and Hampshire County Council who provide countywide services.

Public Health in Hampshire County Council produce a document called the Joint Strategic Needs Assessment (JSNA) which sets out in great detail the health of the population and the factors that influence health. North Hampshire CCG uses the JSNA to identify inequalities in the health of its people and to set its priorities for commissioning.

## Some key facts about the North Hampshire CCG population

- the population is a relatively young one, with a higher proportion of people under the age of 15 years old than Hampshire or England.
- the population is expected to increase by 2.27% by 2018. The greatest increase is for over 75s with an increase of 14.4%
- the life expectancy at birth in the CCG is 80.5 years for males and 83.2 years for females.
- whilst the CCG has a low overall level of deprivation when compared to England, smaller pockets of deprivation exist in communities throughout the CCG area affecting a substantial number of people who are consequently likely to have poorer health.
- obesity levels in children (7.9%[1] of 4-5 years olds) are similar to the national average
- the rate of emergency admissions for unintentional and deliberate injuries in people under 19 is higher than the Hampshire rate.
- North Hampshire population have a higher Coronary Vascular Disease mortality rate than Hampshire rate.
- there are 9,258 people with diabetes and a possible further 1,547 people have not been diagnosed.
- approximately 17,000 people in Basingstoke and Deane will have a common mental health disorder.
- the number of people with dementia is predicted to increase by 32% between 2012 and 2020.
- the 2011 Census showed that 5.6% (11,883) of those aged 16-64 years old had their day-to-day activities limited a lot by their long term health condition or disability. This is less than the Hampshire (6.7%) and England averages (8.3%).
- the proportion of adults estimated[2] to be currently smoking is 20.2% in Basingstoke and Deane.
- it is estimated that 62% of the adult population in Hampshire is overweight (38%) or obese (24%).
- crude estimates show that 27.5% of the Basingstoke and Deane population over the age of 16 years old who are identified as drinkers consume more than government recommendations[3].

1 Pooled data for 2007/8 to 2011/12

2 2011/12 Integrated Household Survey, ONS

3 The UK Government recommends that women drink less than 15 units per week and men 22 units per week. Care must be taken when interpreting these data as they are derived from a statistical model.

## Working with others - Key Partnerships

### Health and Wellbeing Board

The Hampshire Health and Wellbeing Board bring together leaders from the County Council, NHS and District and Borough Councils to develop a shared understanding of local needs, priorities and service developments. It seeks to ensure that there is a coordinated approach to the delivery of health and social care thus avoiding duplications and waste and focusing on improving outcomes.

It is a forum where all decisions about changes to services can be discussed and approved. In particular the Government's Better Care Fund initiative which for the first time directs a large amount of health monies to the local authority is an opportunity for the Health and Wellbeing Board to challenge current thinking and make significant change. Dr Hugh Freeman, chair of the North Hampshire CCG is vice chair of the Hampshire Health and Well Being Board.

The Health and Wellbeing Board has produced a Joint Health and Wellbeing Strategy for 2013-18 that explains how healthcare, health improvement and social care services will be changed to improve everyone's health and wellbeing.

### Working with Other CCGs

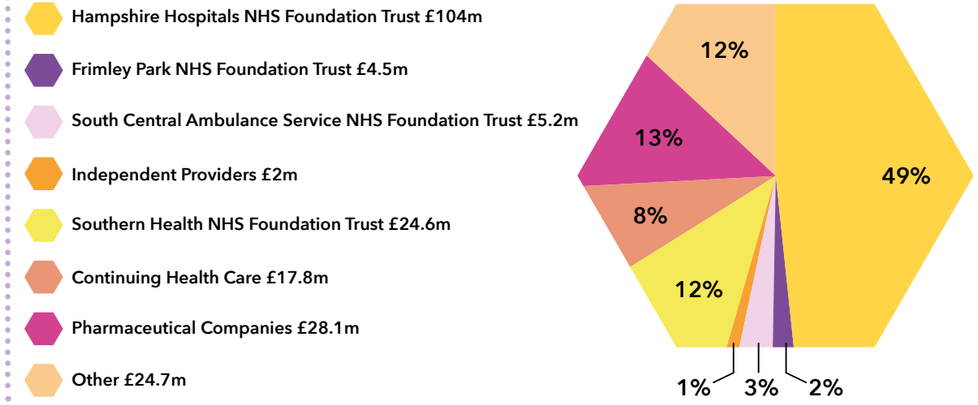
NHS North Hampshire CCG works closely with NHS West Hampshire CCG who also commission services from the providers that our population use, Hampshire Hospitals NHS Trust. The CCG frequently works alongside NHS Fareham and Gosport CCG, NHS South Eastern Hampshire CCG and NHS North East Hampshire and Farnham CCG. Where appropriate the CCG also makes links with NHS Southampton CCG, NHS Portsmouth CCG, NHS Isle of Wight CCG and on occasion NHS Dorset CCG.

### Public Health

The CCG is working in partnership with Public health at Hampshire County Council to improve the health of the population and to tackle health inequalities.We aim to deliver effective services for the population working alongside our public health colleagues, further understand the health needs of our population through analysis of information and production of the Joint Strategic Needs Assessment.

This partnership has enabled us to have a population focus on health care; this helped us plan services for the future changes in the population such as the increasing numbers of older people. In partnership with Public Health we have aimed to ensure that people are supported to lead healthy lives, including a focus on those who find it hard to make positive lifestyle changes.

### Organisations that provide services to the CCG population







## Listening to you

Listening to our local population is extremely important to North Hampshire CCG. If we are to reflect the views of local people in the way we commission healthcare, we need to listen to them and incorporate their opinions and ideas.

There are a variety of ways the CCG listens to and gathers feedback from local people.

- through the review of complaints, compliments and concerns received
- through the feedback form on the CCG website
- from the Patient Participation Group
- from a range of illness or condition specific user groups. For example we asked for members of the public who had suffered with knee problems to help us design a new 'pathway' for musculoskeletal problems
- from our Link Engagement and Partnership Committee. This committee is comprised of a number of local people who represent a range of groups from local councils to voluntary organisations.

### Complaints, Concerns, Compliments and Feedback

We have welcomed feedback from our local population ensuring that all complaints, concerns and enquiries were responded to promptly and in accordance with our Complaints Policy and the "Principles of Remedies". We take seriously all forms of remedy e.g. apology, an explanation, taking action to ensure that mistakes are not repeated. The contacts are also used to inform our commissioning of the best and most appropriate healthcare services for our patients.

The CCG provides advice to patients and their carers on what assistance is available if they are unhappy with the NHS care they have received; this includes signposting to the care provider, independent advocacy services and the Parliamentary Health Service Ombudsman (PHSO) as appropriate.

In the last year the CCG received 52 complaints, 29 concerns, 3 compliments and 4 feedback messages from patients, relatives and their representatives, which covered all areas of healthcare in our locality. Recent organisational changes in the NHS have led to some confusion for the public in identifying the appropriate route to direct their concerns, and the reduction in the number of complaints over the course of the year reflects the better public understanding of the new NHS structures and responsibilities.

No complaints have been referred to the Ombudsman or are related to the CCG in its role as the local commissioner of health services.

A quarter of the complaints received related wholly or in part to local GP practices; whilst these practices are members of the CCG, the CCG itself does not commission their services and is unable to handle complaints about them. In these circumstances the CCG assists both patient and practice to try and resolve the issue locally and simply, before recourse to the formal complaints route to NHS England for investigation.

| Type | Q1 | Q2 | Q3 | Q4 | Total |
|---|---|---|---|---|---|
| Complaints | 21 | 15 | 6 | 10 | 52 |
| Concerns | Not collected | 9 | 8 | 12 | 29 |
| Feedback | 0 | 3 | 0 | 1 | 4 |
| Compliments | 1 | 0 | 1 | 1 | 3 |
| **Total** | **22** | **27** | **15** | **24** | **88** |

# What we achieved in 2013/14

## As a member of the public you can expect to receive care in line with the NHS Constitution

**The NHS Constitution** sets out the rights of a NHS patient. These rights cover how patients access health services, the quality of care which will be received and the treatments and programmes available. It also set out expectations in respect of confidentiality, information and a patient's right to complain if things go wrong.

### Waiting times

The time a patient waits between referral to treatment (RTT) is clearly defined in the NHS Constitution. In the year under review our patients have seen significant improvements; our performance compared to the previous year is as follows:

- Accident and Emergency waiting times at Basingstoke Hospital - 96% of our patients were seen and treated under 4 hours compared to 90% in the previous year
- waiting times for a non-urgent operation or procedure – 92.% of our patients waited 18 weeks or less for at time of treatment in February 2014 compared to 84% in the previous year
- waiting times for a diagnostic test have improved to 99% of our patients receiving their test within 6 weeks, compared to 97% in April 2013
- 96% of our patients with suspected cancer being seen within 14 days after urgent referral being consistent to 2012/13
- 99% of our patients having been diagnosed with cancer receiving treatment within 31 days also consistently good performance compared 2012/13.
- At the end of 2013/14 there were 502 patients waiting over 18 weeks, compared to 853 in April 2013.

### Ambulance Response Times

– South Central Ambulance NHS Foundation Trust (SCAS) improved their response times for emergencies to 78.9% from 77.6% in the previous year.

And for urgent calls to 75.8% from 75.1% in 2012/13

### Local Priorities

The CCG also identified a number of areas where it was seeking to improve patient access to, or quality of services, 2013/14 saw:

- Early diagnosis of patients suffering with dementia – current forecast using the dementia prevalence calculator is 54%. This indicator shows the number of people diagnosed with dementia against the population prevalence (e.g. the percentage of people diagnosed compared to the predicted number)
- Rolling out of Psychological Therapy Services throughout the North Hampshire area, the lack of access having been a concern for a number of years. Services began in December 2013 offering NHS funded psychological intervention and CBT for patients with mild to moderate anxiety and depression. The NHS provider works with the charity Solent Mind, forming a collaboration 'italk'. Take-up has been excellent exceeding an anticipated slow take up in the early months after implementation.
- A greater number of Chronic Obstructive Pulmonary Disease (formally known as Chronic Bronchitis and Emphysema) patients who have a dyspnoea (breathlessness) scale of over 3 being referred to a Pulmonary Rehabilitation Programme
- An increase in the percentage of patients with diabetes who receive from their GP the nine care checks recommended
- Patients being able to book outpatient appointments at a time which is suitable for them, through use of e-referral; usage of this facility has risen to 45% in January 2014 from 26% in April 2013.




# Local achievements

## Over and above those set out in the NHS Constitution

As a CCG we are committed to ensuring that care is provided in a location which best suits the patient. This could be in their own home, in the community (such as GP surgery) or in a hospital.

### Achievements in the last year centred around a patients home or in their community

### Integrated Care teams

Six integrated care teams have been set up across the locality. These teams aim to keep people living at home and maintaining their independence for as long as possible. The teams are made up of health and social care professionals the core team is small but they are beginning to develop so that they can call upon the services of mental health teams, occupational health teams and others according to the need of the patient. Each team has a lead GP and a community matron whose task is identifying and being responsible for those people with one or more long term conditions who need that extra bit of support.

### Integrated Diabetes Service (IDS)

The Integrated Diabetes Service implementation is underway with a focus on a community based service. Each of the five diabetes Consultants has been allocated to a group of GP practices, with a view to establishing phone and email contact (virtual advice) and twice yearly practice visits (joint clinic, case-note reviews, drug updates, education sessions).

### Diabetes UK bid

In 2013/14 the CCG was successful in its bid to be one of 10 England pilot sites for involving Diabetes UK and local patients in having their say in the work of the CCG. They have been involved with:

- a local diabetes website
- patient education and self-management
- setting up a local diabetes support group.

### Dementia Services

The CCG was successful in a £293k bid for funding against the Prime Ministers Challenge Fund for Dementia; working with the voluntary sector a number of innovative training initiatives took place. There have been notable increases in diagnosis rates, and our patients are receiving care in accordance with quality standards for dementia. These standards include referral to a memory assessment clinic, receiving a personalised care plan, carers being offered an assessment of emotional, psychological and social needs, and services in hospital providing a liaison service which specialises in diagnosis and management of dementia.

### Primary Eye care Assessment and Referral Service (PEARS)

The PEARS service was launched on the 22nd August 2013 and is a new service delivered by Optometrists on the High Street who can see and treat common eye conditions in a timely way.

### Oxygen Service

The Home Oxygen contract and its regional manager are hosted by NHCCG on behalf of all CCGs across the south Central region. There are over 5,000 patients across the region on Home Oxygen and the clinical teams deal with some of the most complex patients who are still able to live at home, ranging from a few months old to patients in their 90's. The Home Oxygen supplier is Dolby Vivisol which is the first new supplier of oxygen in the UK for 30 years and as such won a new business award from the Department of Trade and Industry in 2013.

The new contract that started in 2013 has seen improvements for our patients, all of whom received new equipment. There has also been a new transportable concentrator introduced. Costs have been reduced by 8% in 2013/4.

## Achievements in the last year focusing on hospital based services

### Emergency Department at Basingstoke Hospital - new GP contract

North Hampshire CCG and Hampshire Hospitals NHS Foundation Trust have worked together to implement a new system which places them at the forefront of national emergency and urgent care work.

A new service in the emergency department at Basingstoke hospital began in November 2013 with GPs working alongside emergency doctors and nurse practitioners. This has improved patient care and meant that more people have seen the right person for their care when they are unwell or injured.

Emergency nurse practitioners assess every patient on arrival in the department and are able to provide the care needed in the majority of cases. However, patients who could be better managed by a GP or the emergency team are rapidly routed to them. The GPs are from local practices and already know the hospital staff and systems, which helps to keep everything running smoothly.

### Stroke ward and rehabilitation pathway

The Early Supported Discharge (ESD) service was implemented which supports a stroke pathway redesign. Patients are discharged earlier into the ESD service and continued their rehabilitation at home.

### The New Deep Vein Thrombosis (DVT) pathway

Local GPS are using a new DVT pathway which is in line with NICE guidance and brings together primary and secondary care services working together to support patients in the community with suspected DVT's. The pathway uses the ICE system to arrange ultrasounds directly (on-line) for patients who are likely to have a DVT. Patients who then have a positive scan (approximately 25%) are referred directly for anticoagulation.

## Other activities which support patient care

### Medicines (prescriptions)

Responsibility for prescribing medicines to our patients falls to GP's, and Pharmacies. Medicines are increasingly in greater use as a preventative or disease control method so the effective use of medicines is key to the health of those patients who are prescribed the medicine. Our focus in 2013/14 included:

- Every practice putting into place a lead GP who attended regular prescribing fora which included educational sessions and peer support/review.
- Steps were taken through antibiotic prescribing to reduce health-care related infections such as Clostridium Difficile (Cdiff)
- Review of the use of Non-Steroidal Anti Inflammatory Drugs
- Dieticians supporting care homes in nutrition reviews
- New software / IT systems were put into place in practices to support effective prescribing.

### Use of Information Technology and data sharing

Our patients receive care from many providers (GP's, hospital trusts, community nurses and ambulance services to name but a few). We know how important it is to our patients that care is co-ordinated to avoid unnecessary duplication of questions, repeat tests etc., as well as making sure that the people providing care have up to date information about a patient's health and treatment. We also recognise that patients only want their personal information shared with those who need it. During the year the CCG has written to every person in the area to explain about the Summary Care Record and the way data will be shared and protected, with patients being able to opt out where they wish to.

Projects have been started in conjunction with key partners; Adult Social Services, and NHS providers which will enable a clinician to securely look at their own systems when visiting another location. This means a GP will be able to look at their practice system from a ward in a hospital, in a care home or a community hospital. A midwife will be able to access a hospital patient record summary when in a community clinic. A social worker will be able to access their care management system from a GP practice.




## Information on Environmental, Social and Community Issues

### Sustainability Report

The CCG is committed to the sustainability agenda and recognises its role to play both as an employer and as a commissioner of NHS Services. The Chief Finance Officer is the Lead Officer in the CCG.

Although the CCG has yet to develop a comprehensive sustainability development management plan it has taken steps to ensure that its premises provide a sustainable working environment.

### Premises

The CCG occupies 6,570 sq. ft. in a new building which has a BREAM rating of very good.

The building incorporates; LED lighting, an intelligent building management system, motion detecting lighting, exposed concrete soffits to absorb excess heat and reduce cooling energy consumption, has solar control glass to reduce heat gain and rainwater harvesting system and looks to enhance the natural environment e.g. with the use of bat boxes.

NHS Property Services holds the lease for the CCG Headquarters and is responsible in the first instance for the associated rent and charges including utilities. A recharge from NHS Property Services to the CCG is then made together with any space voids relating to property located in the area. These costs together with associated data have not yet been made available.

### Travel Plan

The business park where the CCG headquarters are located has a travel plan which includes a well-used bus service to the town centre and railway station. The CCG employees, lay members and clinical leads have collectively travelled 86,000 miles undertaking duties for the CCG in the year.

### Sustainability Plan

Looking ahead, the CCG is planning to develop a Sustainability Plan which will look to identify the CCG activities which impact upon the environment, and identify areas where we can prioritise sustainability actions. This will include the influence the CCG can make in relation to:-

- Procurement (day to day supplies and healthcare services)
- Contractual clauses with providers with regard to sustainability
- Working with its partners to ensure that property owned and utilised locally by the NHS is maximised and that any decisions made affecting the property take into account the requirement to reduce the carbon footprint
- Introducing travel related initiatives such as a bike purchase scheme and car sharing
- Opportunities for further recycling.

### Emergency Preparedness, Resilience and Response (EPRR)

This is a statutory function under the Civil Contingencies Act (2004), all organisations commissioning or providing NHS services are required to have plans in place to respond effectively in the event of a major incident. The Local Area Team and Public Health England are co-ordinators in the event of any incident with the CCG working at a local basis. The CCG Chief Operating Officer is the CCG EPRR accountable officer. An Incident Response Plan for North Hampshire has been developed, with training using exercises taking place.

During 2013/14, whilst no major incident was declared the guidance set out in the Hampshire Seasonal Plan was helpful in guiding us; in coordinating the management of patient flows between services at times when patients were at a high risk of suffering from the risk of the effects of heat and also during the intense rain and storms during winter which had a significant impact upon the population in Buckskin, Basingstoke.

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

Dr Sam Hullah

## Disclosure of Serious Incidents Requiring Investigation (SIRIs)

Serious Incidents Requiring Investigation (SIRI) in healthcare are rare, but when they do occur, everyone must make sure that there are measures in place to respond to them.

Each SIRI that takes place is subject to an in-depth investigation, the provider is asked to outline a synopsis of the incident and the actions taken to reduce recurrence. Every SIRI investigation report is discussed at a CCG SIRI panel. Once all parties are assured that all relevant actions and organisational learning have taken place in order to minimise the risk of reoccurrence, a decision is taken to close the SIRI.

Key SIRI themes reported in 2013/14 were; -

- pressure ulcers (hospital and community services)
- in patient falls resulting in harm (hospital and community services)
- Suicides (mental health services).

Provider organisations implemented actions such as changes to procedures, policies and the use of different products to minimise the risk of a recurrence.

The CCG monthly Quality report provides the Governing Body with information relating to SIRI's, raising and escalating concerns where applicable.

| Type of SIRI | Number of SIRIs relating to North Hampshire population reported in 2013/14 |
|---|---|
| Clinical | 118 |
| Information Governance | Nil |

## Equality Report

### Equality and Diversity

Equality is not about treating everyone the same; it is about ensuring that access to opportunities are available to all by taking account of people's differing needs and capabilities. Diversity is about recognising and valuing differences through inclusion, regardless of age, disability, gender, race, religion or sexual orientation.

The CCG recognises and values the diverse needs of its population and is committed to reducing health inequalities and improving the equality of health outcomes within Hampshire. It aims to ensure the provision of accessible healthcare and to develop a diverse and well-supported workforce which is representative of the population it serves.

The CCG aims to embed equality and diversity considerations into all aspects of our work, including policy development, commissioning processes and employment practices.

A self-assessment was undertaken against the NHS Equality Delivery System (EDS). This is a framework to review performance on equality and diversity, and to identify future priorities. The self-assessment identified eleven areas that are rated as 'developing'. The CCG developed an action plan that identifies actions which will improve its compliance with the equality duty. Key activities planned in 2014/15 are:

- establishing a robust Equality Impact Assessment process for strategies, policies, projects and decisions, to ensure that the needs of service users in relation to age, disability, gender, race, religion & belief and sexual orientation and transgender are considered in commissioning
- developing a process by which intelligence is gathered and considered in the commissioning of services
- developing and undertaking a staff survey
- setting up a robust training programme.

The CCG evidenced what it has done in the year in respect of its Public Sector Equality Duty through a report to the CCG in January 2014. This set out the organisations equality indicators and objectives alongside an action plan and is published on the CCG website.

### Equal Opportunities

The CCG did not have a specific policy in place in 2013/14 in relation to equal opportunities and disabled employees. However, policies are subject to an equality and diversity impact assessment and some have equality and diversity statement and/or an equality analysis. A number of our Human Resource policies seek to ensure that the CCG gives full and fair consideration to a disabled person in job applications, training and career development.




### Gender Analysis

The two main decision making committees are the Governing Body and Clinical Cabinet which comprise 21 people, (14 are male and 7 female).

The CCG as at end of March 2014 employed 37 members of staff, (of the headcount 9 were male and 28 female).

### Employee Consultation

The CCG has a structure in place in partnership with other CCG's across Southampton, Hampshire, Isle of Wight, and Portsmouth, to consult and negotiate with employee representatives. One pan Wessex CCG meeting took place during 2013/14 in addition to a national consultation in respect of NHS pension contributions and inflation awards. A more proactive approach to employee consultation is planned in 2014/15.

## Our focus upon quality of patient care

The CCG quality team take an active lead in the Hampshire wide clinical quality review process for its main providers. Regular meetings (CQRM) take place ensuring that there is ongoing focus upon the quality of care for patients. The CCG also conduct a rolling programme of CQRM's across the smaller providers that they commission care from. The purpose of the CQRMs' is to review, discuss, challenge and monitor provider compliance with a variety of national and local quality standards.

Monthly quality reports are provided to members of the Governing Body which offer assurance of the quality of services commissioned on behalf of the population of north Hampshire.

In 2014/15 the CCG will continue to coordinate the Hampshire Hospitals Foundation Trust CQRM's and attend other provider quality review meetings. The quality of Community Services provided by Southern Health NHS Foundation Trust and monitored during Hampshire wide meetings will be coordinated locally in North Hampshire from 1 April 2014.

### Infection Prevention and Control and Healthcare Associated Infections

The term Healthcare Associated Infection (HCAI) covers a wide range of infections. The most well-known include those caused by Methicillin-Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. Difficile).

The CCG is strongly committed to reducing Healthcare Associated Infections. The prevention of infection is a crucial part of providing safe care to patients. The CCG work in the year related to HCAI was focussed on two areas, firstly audit and secondly reduction in HCAI. (see table on next page).

| Audit of infection prevention | Reduce numbers of HCAI |
|---|---|
| Implemented an audit programme facilitating General Practice to adhere to the Health and Social Care Act 2008: Code of Practice for Infection Prevention and Control and compliance with CQC essential standards. This programme commenced on the 1st April 2013 and incorporated the following quarterly audits:<br>**Quarter 1:**<br>Standard Precautions<br>**Quarter 2:**<br>Hand Hygiene Environment<br>**Quarter 3:**<br>Infection Prevention Aspects of Wound care<br>**Quarter 4:**<br>Transportation of Specimens / Sharps.<br>The analysis of these audit results was shared with our member practices with subsequent action plans monitored throughout the year. | NHS England published C. Difficile objectives for acute service providers and CCG's for the financial year 2013/14. The objectives were calculated on the basis of requiring continuous improvement from all providers and CCGs. The CCG was allocated a tolerance of no more than 51 C. Difficile cases. The CCG narrowly missed the tolerance level, reporting 56 cases against the objective of 51. |

In 2013/14 all CCG's had the ability to earn a Quality Premium part of which related to HCAI requiring the CCG to have had no reported cases of MRSA and for C. Difficile cases reported being below the tolerance levels set for the CCG population.

Disappointingly, the CCG in the year recorded 3 patients who had acquired MRSA and with 56 cases of C.Difficile also exceeded the tolerance level for the number of C.Difficile cases.

### Pressure Ulcers

A pressure ulcer (also known as a pressure sore or bed sore) is an ulcerated area of skin caused by irritation and continuous pressure on part of the body. A quality objective of 2013/14 was to reduce the incidence and avoidable harm caused by healthcare acquired pressure ulcers grade 2, 3 and 4. The CCG used detailed contract requirements, improvement targets, audit and unannounced visits with its providers to ensure that they worked towards delivering a reduction in pressure ulcers. This focus will also be continued in 2014/15. A local quality indicator was agreed and included in the provider contracts.

### Quality walk rounds

Members of the quality team developed a schedule of quality walk rounds for providers. The objectives being to:

- Gather views and the experiences of patients
- Integrate quality into everything the CCG does
- Through supporting and promoting a safety culture within provider organisations
- Obtain and act on information gathered which identified areas for improvement
- Build relationships and communication with frontline staff
- Increase the awareness of quality issues amongst all clinicians




**The following table highlights the visits to providers and key outcomes from those visits during 2013/14.**

| Provider | Number of Visits | Areas Visited | Findings and actions |
|---|---|---|---|
| Hampshire Hospitals NHS Foundation Trust | Eight | Emergency Department<br>Adult Assessment Unit<br>Care of the Elderly ward<br>Neonatal Unit<br>Oncology<br>Paediatrics<br>Attendance at the Schwartz Round. | The Director of Nursing presented initiatives that HHFT implemented to improve patient safety and experience including:<br>• the relocation of nurses stations to each bay<br>• a programme of work to build ensuite facilities in each bay<br>• additional reception areas for visitors.<br>A number of patients and relatives shared their experiences of HHFT and the comments were positive, highlighting high standards of care. |
| Southern Health NHS Foundation Trust | Three | Alton Community Hospital | Patients were aware of plans of care and discharge arrangements.<br>Positive feedback from patients. |
| | | Parklands Hospital | Patients on the Psychiatric Intensive Care ward were pleased to show the CCG their environment and appeared calm and well supported by staff. |
| The BMI Hampshire Clinic | Two | In Patient Ward | The patients were pleased with the care they received and shared that staff were constantly washing their hands, answered the call bells within two minutes and were very clear on plans of care and discharge processes. |
| Virgin Health Care | One | Out Patient Facilities | It was not appropriate to talk with patients as they were all receiving treatment. |
| Headway | One | Day Centre | Patients were observed enjoying a number of motivational activities and interacted well with the staff. |
| 111 | One | Emergency Operation Centre | Members of staff demonstrated the patient pathway used by staff and the disposition codes. |

## Looking Ahead to 2014/15

The Health system in North Hampshire has been through a period of great change. The CCG has developed its plans for 14/15 and beyond. These look to address the financial gap across the system while continuing to maintain and improve quality of care. Central to this will be increasing the involvement of North Hampshire patients. The CCG will also be working closely with the NHS England local area team to ensure Specialised Commissioning and primary care development plans align with the CCG work wherever possible.

The CCG expects that in 2014/15 its focus will be on the following:

- Ensuring that healthcare services across the CCG are provided in a safe, clinically effective and responsive manner.
- Better Care Fund - The June 2013 spending round announced the creation of a £3.8 billion Better Care Fund – described as a 'pooled' or shared budget for health and social care services to work more closely together in a local area, and based upon a plan agreed between the NHS and local authorities. The CCG has been actively designing and commissioning an integrated delivery model between health and social care over the past few years and will now use this fund to enable services to cut across the usual organisational boundaries thereby helping to deliver a better co-ordinated and integrated system of care that is also person-centred
- Critical Care Treatment Centre - The CCG will be working in collaboration with West Hampshire CCG and Hampshire Hospitals Foundation Trust to centralise services for the most seriously ill patients in one critical treatment centre. Proposals for this new centre will be put to the public for consultation.
- Implementing Quality, Innovation, Productivity and Prevention plans across North Hampshire transforming the health and social care community to enact the sustainable change required
- Supporting effective transition and integration of key services, including both health and social care services – ensuring all service changes reflect the four key national tests. Firstly, clarity about the clinical evidence base underpinning any proposals; secondly, they must have the support of the CCG involved; thirdly, they must promote choice for patients; and finally, the process must have engaged the public and patients.

**"We certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended)**

Dr Sam Hullah




# 4 Finance Report

## (incorporates the remuneration report)

## What money we had and how it was used

### Overview

The year under review has been a challenging one financially, a year where:

- the economic climate began to impact upon the money our population and the NHS had to spend
- NHS organisational changes and associated finances created complexities and anomalies which required in year resolution, e.g. Specialised Services
- There was a need for the CCG to meet the costs of reducing the number of patients waiting over 18 weeks.

The CCG was allocated a Revenue Allocation of £216.092m and was required to ensure that spending did not exceed the resources given. The financial planning at the beginning of the year indicated that it would need to achieve a challenging amount of savings in 2013/14. In order to smooth these savings over a two year period, NHS England agreed that the CCG would be able to spend up to £2m more than its allocation, any overspend would be recovered by reducing the allocation in 2014/15. In practice the CCG did not need this additional spending capacity.

The CCG savings plan known as QIPP totalling £9.1m (4.2% of the CCG allocation) and was designed to reduce expenditure but at the same time to secure improved **quality** of care, by introducing **innovative** new care pathways, drugs and technological advances, by improving **productivity** and by supporting and encouraging the population to maintain good health (through **prevention**).

The significant savings required together with the knowledge that; in future years the level of growth in the NHS would be small and costs are likely to increase due to the health needs of an increasingly aged population, made it important that 2013/14 was successful financially.

### Financial Performance

The CCG had a number of financial duties;

- to ensure that it stayed within the resources allocated to it including the £2m deficit
- to ensure that the CCG running costs (all expenditure which are not related to direct patient care) do not exceed the running cost allocation
- to manage its cash flow to meet cash draw down requirements
- The CCG is delighted to be able to report success in these three areas, with the CCG ending the year with a £20k surplus, being £1k under its running cost allocation and remaining within its cash draw down target

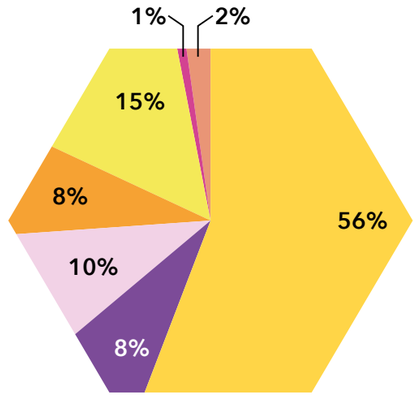
### Better Payment Practice Code

Finally, with regard to the importance of paying our bills promptly, the CCG is able to report that it has paid 99.5% of its non NHS bills within 30 days or 99.1% by value, and 99.7% of its NHS bills within 30 days or 99% by value.

**How the CCG spent its resources** - The CCG analysis of how it has spent its Revenue Resources in respect of the healthcare for its population is as follows:

### Spending by care setting in £m's total £126.1m

- Acute Hospitals £120.5m
- Mental Health £16.9m
- Community Health £21.3m
- Continuing Care £17.8m
- Primary Care £31.9m
- Other £2.5m
- Running Costs £5.2m



## Summarised Financial Statements

The CCG Summarised Financial Statements are shown below. These have been produced under International Financial Reporting Standards (IFRS) as directed and modified by HM Treasury from time to time. The accounts have been prepared on a "going concern basis", the CCG role (as a public sector body) is to be responsible for commissioning of NHS services as such it is anticipated that the commissioning function of the NHS will continue in the future. The CCG External Auditors issued a S19 in respect of a deficit plan for the year, however this position was improved upon with the CCG ending the year with a £20k surplus.

## Statement of Comprehensive Net Expenditure for the Year Ended 31st March 2014

The Statement of Comprehensive Net Expenditure summarises the gross costs and miscellaneous income of the CCG giving a net operating cost for the year. There are no comparative figures with the year 2012/13 as this is the first year of operation for the CCG.

| 2013-14 | £000 |
|---|---|
| **Administration Costs and Programme Expenditure** | |
| Gross employee benefits | 2,048 |
| Other costs | 218,523 |
| Other operating revenue | (4,499) |
| **Net operating costs before interest** | **216,072** |
| Other operating revenue | 0 |
| Other (gains)/losses | 0 |
| Finance costs | 0 |
| **Net operating costs for the financial year** | **216,072** |
| Net (gain)/loss on transfers by absorption | 0 |
| **Net operating costs for the financial year including absorption transfers** | **216,072** |
| Of which: | |
| **Administration Costs** | |
| Gross employee benefits | 1,823 |
| Other costs | 3,854 |
| Other operating revenue | (458) |
| **Net administration costs before interest** | **5,219** |
| **Programme Expenditure** | |
| Gross employee benefits | 225 |
| Other costs | 214,669 |
| Other operating revenue | (4,041) |
| **Net programme expenditure before interest** | **210,853** |
| **Other Comprehensive Net Expenditure 2013-14** | **£000** |
| Impairments and reversals | 0 |
| Net gain/(loss) on revaluation of property, plant & equipment | 0 |
| Net gain/(loss) on revaluation of intangibles | 0 |
| Net gain/(loss) on revaluation of financial assets | 0 |
| Movements in other reserves | 0 |
| Net gain/(loss) on available for sale financial assets | 0 |
| Net gain/(loss) on assets held for sale | 0 |
| Net actuarial gain/(loss) on pension schemes | 0 |
| Share of (profit)/loss of associates and joint ventures | 0 |
| Reclassification Adjustments | 0 |
| On disposal of available for sale financial assets | 0 |
| **Total comprehensive net expenditure for the year** | **216,072** |




## Statement of Financial Position as at 31 March 2014

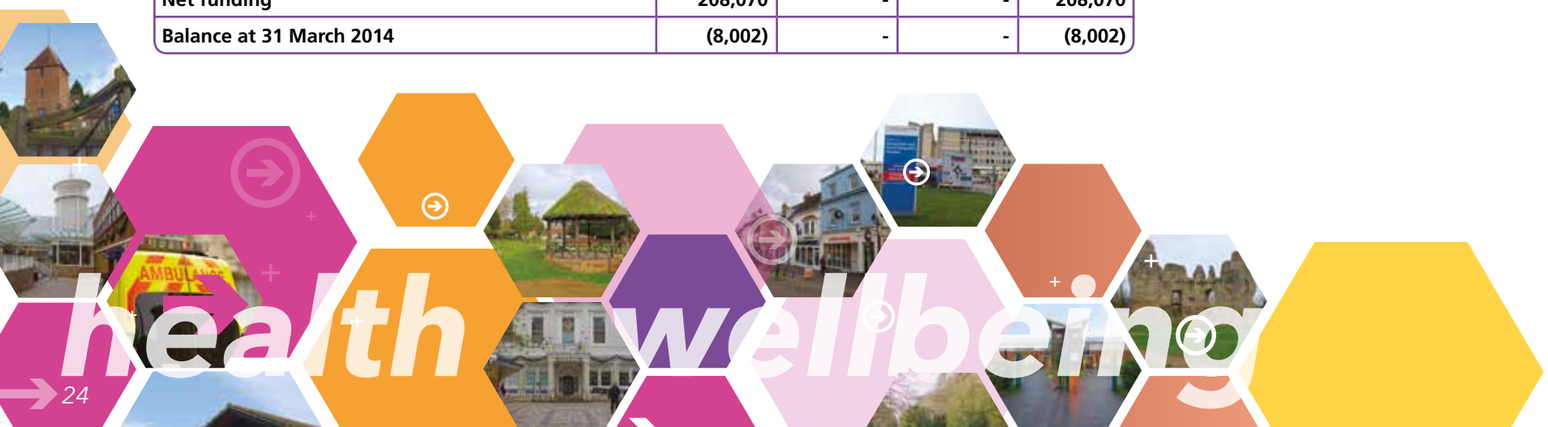
This table shows a snapshot of the CCG position at 31st March 2014, it is worth noting that the CCG does not own any assets. The CCG is a commissioners of services and its functions take place in a building which is leased under an under lease with NHS Property Services. Other material assets used by the CCG related to Information Technology servers which are in the ownership of the CSU.

| | 31 March 2014 £000 |
|---|---|
| **Non-current assets:** | |
| Total non-current assets | - |
| Current assets: | |
| Inventories | - |
| Trade and other receivables | 4,310 |
| Other financial assets | - |
| Other current assets | - |
| Cash and cash equivalents | 168 |
| **Total current assets** | **4,478** |
| **Total assets** | **4,478** |
| **Current liabilities** | |
| Trade and other payables | 11,940 |
| Other financial liabilities | - |
| Other liabilities | - |
| Borrowings | - |
| Provisions | 499 |
| **Total current liabilities** | **12,439** |
| **Total Assets less Current Liabilities** | **(7,962)** |
| **Non-current liabilities** | |
| Trade and other payables | - |
| Other financial liabilities | - |
| Other liabilities | - |
| Borrowings | - |
| Provisions | 40 |
| Total non-current liabilities | 40 |
| **Total Assets Employed** | **(8,002)** |
| **Financed by Taxpayers' Equity** | |
| General fund | (8,002) |
| General fund | - |
| Revaluation reserve | - |
| Other reserves | - |
| Charitable Reserves | - |
| **Total taxpayers' equity:** | **(8,002)** |

## Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2014

Below is the Statement of Changes in Taxpayers Equity for the year summarising the movement on reserves. As a new organisation the opening taxpayers reserve was nil, the net Operating costs for the period was £216,072,000

| | General fund £000 | Revaluation reserves £000 | Other reserves £000 | Other reserves £000 |
|---|---|---|---|---|
| **Changes in taxpayers' equity for 2013-14** | | | | |
| Balance at 1 April 2013 | - | - | - | - |
| Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition | - | - | - | - |
| Transfer between reserves in respect of assets transferred from closed NHS bodies | - | - | - | - |
| Adjusted CCG balance at 1 April 2013 | - | - | - | - |
| **Changes in CCG taxpayers' equity for 2013-14** | | | | |
| **Net operating costs for the financial year** | **(216,072)** | **-** | **-** | **(216,072** |
| Net gain/(loss) on revaluation of property, plant and equipment | - | - | - | - |
| Net gain/(loss) on revaluation of intangible assets | - | - | - | - |
| Net gain/(loss) on revaluation of financial assets | - | - | - | - |
| Total revaluations against revaluation reserve | - | - | - | - |
| Net gain (loss) on available for sale financial assets | - | - | - | - |
| Net gain (loss) on revaluation of assets held for sale | - | - | - | - |
| Impairments and reversals | - | - | - | - |
| Net actuarial gain (loss) on pensions | - | - | - | - |
| Movements in other reserves | **-** | **-** | **-** | **-** |
| Transfers between reserves | - | - | - | - |
| Release of reserves to the Statement of Comprehensive Net Expenditure | - | - | - | - |
| Reclassification adjustment on disposal of available for sale financial assets | - | - | - | - |
| Transfers by absorption to (from) other bodies | - | - | - | - |
| Transfer between reserves in respect of assets transferred under absorption | - | - | - | - |
| Reserves eliminated on dissolution | - | - | - | - |
| **Net Recognised CCG Expenditure for the Financial Year** | **(216,072)** | **-** | **-** | **(216,072)** |
| **Net funding** | **208,070** | **-** | **-** | **208,070** |
| **Balance at 31 March 2014** | **(8,002)** | **-** | **-** | **(8,002)** |






## Statement of Cash Flows for the Year Ended 31 March 2014

The statement of cash flows for the year shows the net cash outflow from the CCG's operating activities, investing activities and financing activities, including parliamentary funding.

| | 2013-14 £000 |
|---|---|
| **Cash Flows from Operating Activities** | |
| **Net operating costs for the financial year** | (216,072) |
| Depreciation and amortisation | - |
| Impairments and reversals | - |
| Donated assets received credited to revenue but non-cash | - |
| Government granted assets received credited to revenue but non-cash | - |
| Interest paid | - |
| (Increase)/decrease in inventories | - |
| (Increase)/decrease in trade & other receivables | (4,310) |
| (Increase)/decrease in other current assets | |
| Increase/(decrease) in trade & other payables | 11,940 |
| Increase/(decrease) in other current liabilities | - |
| Provisions utilised | - |
| Increase/(decrease) in provisions | 539 |
| **Net Cash Inflow (Outflow) from Operating Activities** | **(207,902)** |
| Cash Flows from Investing Activities | - |
| Interest received | - |
| (Payments) for property, plant and equipment | - |
| (Payments) for intangible assets | - |
| (Payments) for investments with the Department of Health | - |
| (Payments) for other financial assets | - |
| Proceeds from disposal of assets held for sale: property, plant and equipment | - |
| Proceeds from disposal of assets held for sale: intangible assets | - |
| Proceeds from disposal of investments with the Department of Health | - |
| Proceeds from disposal of other financial assets | - |
| Rental revenue | - |
| **Net Cash Inflow (Outflow) from Investing Activities** | |
| **Net Cash Inflow (Outflow) before Financing** | **(207,902)** |
| **Cash Flows from Financing Activities** | |
| Net funding received | 208,070 |
| Other loans received | - |
| Other loans repaid | - |
| Capital grants and other capital receipts | - |
| Capital receipts surrendered | - |
| **Net Cash Inflow (Outflow) from Financing Activities** | **208,070** |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | **168** |
| Cash & Cash Equivalents at the Beginning of the Financial Year | - |
| **Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year** | **168** |

## External Auditors

The CCG's External Auditors are Ernst and Young who were appointed as required by the Health and Social Care Act 2012. The act sets out the requirement that the accounts of the CCG are to be subject to audit under the arrangements set out in the Audit Commission Act 1998. The fee for the statutory audit for the year was £85k.

## Full Accounts

The CCG produces detailed Financial Statements these provide further detail. A full set of the accounts can be obtained via the CCG website at www.northhampshireccg.com or in printed format upon request from the Chief Finance Officer, CCG Headquarters, Central 40, Lime Tree Way, Chineham Business Park, Basingstoke, Hampshire RG24 8GU.

The Financial statements on pages 22 to 27 were approved by the Governing Body on 3rd June 2014 and signed on its behalf by:

Dr Sam Hullah
Accountable Officer

# Remuneration Report (subject to External Audit review)

## Remuneration Committee

The CCG has a Remuneration Committee that is chaired by David Rice Lay Member. Membership is limited to the CCG's two Lay members and the two GP elected members.

Attendance at the Remuneration Committee during 2013/14 and in shadow form prior to this period when a number of decisions relating to the year under review were made;

| Name and Details | Members Attendance 20 March 13 | Members Attendance 25 June 13 | 17 Sept 13 |
|---|---|---|---|
| **David Rice** Lay Member | Yes | Yes | Yes |
| **Derek Tree** Lay Member | Not in attendance | Not in attendance | Yes |
| **Dr Angus Carnegy** | Yes | Yes | Not in attendance |
| **Dr Andrew Cameron** | Yes | Not in attendance | Yes |

Both the Chief Clinical Officer and the Chief Finance Officer attend the meeting but are excluded from any discussions or decisions where there is a conflict of interest. Oliver Anderson Associate Director Human Resource Services at the Commissioning Support Unit also attends and advices the committee when required.

It is the Remuneration Committee that determined the remuneration of the three Executive Directors (Chief Clinical Officer, Chief Operating Officer and Chief Finance Officer) who are on contracts outside of Agenda for Change (AfC). The Chief Nurse and all other senior managers are employed under an AfC contract. The Committee also determined the remuneration in respect of GP's who took a lead clinical role in the work of the CCG. All GP's who are on the Governing Body are on the payroll of the CCG. The GP's who are not on the Governing Body who provides clinical leadership to the CCG can opt to either be on the CCG payroll or have a payment made to the GP Practice. This is in accordance with good practice and national guidance. The CCG has not incurred any significant costs (including costs made in respect of a loss of office) to past senior managers.

## Our staff and clinical leaders

North Hampshire CCG has employed an average of 29 whole time equivalent staff over the course of the year; we have also made payment to 11 lay members/GPs through payroll and 11 GP Practices making a remuneration for the work of clinical leads. The CCG full set of accounts provides further details of the employees, including the treatment of pension liabilities, and sickness absence data.

Biographical details of the members of the Governing Body and the Clinical Cabinet are provided in Addendum A, set out at the end of this report.

## Pay Multiples

The CCG is required to disclose the relationship between the Remuneration of the highest paid Director (being the Chief Clinical Officer) and the median remuneration of the CCG workforce.

The Chief Clinical Officer (based on a whole time equivalent) was £166,618; this was 3.7 times the median of the workforce which was £45,455. In 2013/14 no employee received more than the Chief Clinical Officer being the highest paid member of the Governing Body. Remuneration in the CCG ranged between £16,271 to £166,618.

## Off payroll engagements

Where the CCG has had an off payroll engagement for longer than 6 months where the costs exceed £220 per day disclosure is required. During year under review there was 1 person engaged between April and October, assurance was sought from the individual that they are paying the right amount of tax.

## Sickness absence

As recorded on the national Electronic Staff Record using a 9 month period to the end of December an average 28 full time equivalent number of people were employed in the CCG, the sickness absence days lost were 46 (1%).

## Detailed below are the salaries and benefits of Senior Members (defined as those who are members of the Governing Body or Clinical Cabinet)

| | 2013-14 | | | | |
|---|---|---|---|---|---|
| | Salary & Fees* (bands of £5000) | Taxable Benefits (Rounded to the nearest £000) | Performance Related Bonuses (bands of £5,000) | Pension related benefits (bands of £5,000) Employers contribution | Total (bands of £5,000) |
| Name and title | £000 | £000 | £000 | £000 | £000 |
| **Dr Hugh Freeman** Chair | 90-95 | - | - | - | 90-95 |
| **Dr Sam Hullah** Chief Clinical Officer | 95-100 | - | - | 0-5 | 100-105 |
| **Lisa Briggs** Chief Operating Officer | 105-110 | - | - | 0-5 | 105-110 |
| **Pam Hobbs** Chief Finance Officer | 105-110 | - | - | 0-5 | 105-110 |
| **Jan Baptiste-Grant** Chief Nurse * | 80-85 | - | - | - | 80-85 |
| **Anne Phillips** Head of Stakeholder, Engagement & Communications* | 45-50 | - | - | 0-5 | 50-55 |
| **Derek Tree** Lay Member | 10-15 | - | - | - | 10-15 |
| **David Rice** Lay Member | 10-15 | - | - | - | 10-15 |
| **Dr Nicholas Sorby** Secondary Care Consultant Representative | 10-15 | - | - | 0-5 | 15-20 |
| **Dr Amanda Britton** Vice Chair Clinical Cabinet | 25-30 | - | - | 0.5 | 30-30 |
| **Dr Angus Carnegy** GP Elected Member | 15-20 | - | - | 0.5 | 15-20 |
| **Dr Andrew Cameron** GP Elected Member | 10-15 | - | - | 0.5 | 10-15 |
| **Dr Andrew Fellows** | 25-30 | - | - | - | 25-30 |
| **Dr Robert Walker** | 10-15 | - | - | - | 10-15 |
| **Dr Sunil Rathod** | 10-15 | - | - | - | 10-15 |
| **Dr Philip Hiorns** | 10-15 | - | - | - | 10-15 |
| **Dr Robert Green** | 10-15 | - | - | - | 10-15 |
| **Dr Andrew Fernando** (part year) | 20-25 | - | - | - | 20-25 |

* Includes Fees Paid to individuals prior to Permanent Employment pensions information can be found in the table below

## Pensions Benefits

| Name and title | Real increase in pension at age 60 (bands of £2500) | Real increase in pension lump sum at age 60 (bands of £2500) | Total accrued pension at age 60 (bands of £5000) | Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5000) | Cash equivalent transfer value at 31 March 2014 | Cash equivalent transfer value at 31 March 2013 | Real increase in cash equivalent transfer value | Employees contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Dr Sam Hullah** - Chief Clinical Officer | 10-12.5 | 0-2.5 | 30-35 | 100-105 | 784 | 771 | 13 | 14 |
| **Dr Hugh Freeman** - Chair * | - | - | - | - | - | - | - | - |
| **Lisa Briggs** - Chief Operating Officer | 35-37.5 | 0-2.5 | 0-5 | 0-5 | 36 | 0 | 36 | 15 |
| **Pam Hobbs** - Chief Finance Officer | 5-7.5 | 0-2.5 | 45-50 | 140-145 | 1,087 | 1,079 | 8 | 15 |
| **Anne Phillips** - Head of Stakeholder, Engagement & Communications | 10-12.5 | 0-2.5 | 5-10 | 20-25 | 157 | 145 | 12 | 7 |
| **Jan Baptiste-Grant** - Chief Nurse * | - | - | - | - | - | - | - | - |

*Retired from the NHS Pension Scheme

Signed by Dr Sam Hullah

Accountable Officer 2nd June 2014

# 5 Statement of Accountable Officers' Responsibilities

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

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

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

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

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

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

Signed by Dr Sam Hullah

Accountable Officer 2nd June 2014




# 5 Annual Governance Statement

## 5.1 Introduction and Context

NHS England (previously known as The NHS Commissioning Board) authorised (with conditions) and issued a date of establishment for North Hampshire Clinical Commissioning Group (CCG) to become an NHS body with effect from 15th February 2013. The CCG was licenced from 1st April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. There were 5 conditions which applied at the time of authorisation these related to:

- the need for the Governing Body to include both a nurse and a secondary care doctor
- providing evidence that the CCG had secured the expertise of a designated doctor and nurse for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood
- providing evidence that plans were in place to procure Commissioning Support Services through a compliant procurement process between 2013-16
- the requirement for a clear and credible integrated plan that met authorisation requirements
- the requirement for a detailed financial plan that delivered financial balance, setting out how it would manage within its management allowance and how it was integrated with the commissioning plan.

Prior to the start of the financial year the CCG was able to provide assurance and evidence against the first 3 conditions and these were discharged by NHS England in March 2013. The remaining 2 conditions were removed by NHS England following re-assessment on the 8th October 2013.

When designing the Governing Body, the CCG followed the regulations set out in the Health and Social Care Act, with the CCG being built on GP practices that together make up the membership of the CCG. The member practices elected clinical members onto the Governing Body, and were involved in developing the CCG Constitution that sets out how the CCG operates.

## 5.2 Scope of Responsibility

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

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

## 5.3 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 with relevant principles of the Code is considered to be good practice. This Governance Statement is intended to demonstrate how the CCG's had regard to the principles set out in the Code considered for CCG's. For the financial year ended 31 March 2014.

## 5.4 The Clinical Commissioning Group Governance Framework

Our governance framework comprises the systems, processes, culture and values, by which the CCG is directed and controlled. It enables the CCG to monitor achievement of its strategic objectives. The Governing Body Assurance Framework is designed to set out an on-going process to identify and prioritise the management of the concerns which could put at risk the achievement of the CCG objectives and it evaluates the likelihood of those risks being realised and the impact the realisation of those risks would have.

### Governance Structure

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 CCG has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

The CCG is a membership organisation comprising the GP practices that have chosen to be under the umbrella of North Hampshire CCG. The Practices elect GP members to the Governing Body and every practice has a GP representative on the Membership Senate.

Each of the membership practices have signed up to the CCG Constitution which sets out the geographical area for which the CCG is responsible, the Constitution that describes how the CCG will operate, the Mission Statement and Values, the governance structure under which the CCG operates and the standards of business conduct and managing conflicts of interest.

The CCG Governing Body delegates authority on its behalf to the following sub committees and working groups all of which have been in place since the start of the year:

- Audit Committee
- Remuneration Committee
- Integrated Governance Committee
- Clinical Cabinet
- Senior Management Committee
- Link, Engagement and Partnership Committee (LEAP)
- Clinical Quality Working Group
- Performance and Assurance Working Group (PAWG).

The Audit Committee is comprised of the CCG's two lay members and two GPs, one of whom is a membership elected GP. As the Audit Committee does not have executive members, it has the necessary level of independence to fulfil a scrutiny role. It is therefore best placed to consider and advise the Governing Body on the adequacy and effectiveness of internal control systems including Integrated Governance, External and Internal Auditors and the Counter Fraud Specialist. The Committee will also monitor compliance with the CCG Constitution, and review any decisions which affect GP membership and where there is potential for a conflict of interest.

All workforce (defined as those who receive payment from the CCG) issues are overseen by the Remuneration Committee and this includes the development of Human Resource strategies and policies including;

- Business Conduct and Declarations of Interests Policy
- Staff Performance Management Policy
- Disciplinary Policy: Rules and Procedures
- Absence Management Policy
- Grievance Policy and Procedure
- Leave Policy
- Flexible Working Policy
- Local Fraud and Corruption Policy
- Payroll Over and Under Payments Policy.

The Integrated Governance Committee's role is to ensure that our population receive safe and high quality care and that services deliver health benefits, positive clinical outcomes and patient experience. The Integrated Governance Committee receives a report from the Chief Nurse relating to quality issues including reports from regulatory bodies and Serious Incidents Requiring Investigation (SIRIs). The committee also receives a report from the Chief Finance Officer regarding corporate governance. The Committee is supported by the work undertaken by the Clinical Quality Working Group that is tasked with detailed evaluation and reporting of patient safety issues including safeguarding, medicines management exception issues, equality and diversity, the Maternity Liaison Committee and quality related performance breaches. The Performance and Assurance Working Group (PAWG) has responsibility for national and local performance targets, data quality and activity reporting and assuring delivery of the CCG operating plan including Quality, Innovation, Productivity and Prevention plans (QIPP).

The Clinical Cabinet comprises the lead clinicians of major work streams or programmes such as Planned Care, Urgent Care and Long Term Conditions. This committee advises on and approves commissioning strategies, business cases and clinical policies, working with GP portfolio holders to review and transform care pathways.

The Senior Management Committee comprises the executive team and functional heads that direct the operational work of the CCG and ensure that the governing body and its sub committees are supported to fulfil their functions efficiently and that appropriate actions are taken when required.

A Link, Engagement and Partnership (LEAP) Committee is in place to ensure a two way flow of communication and information between the CCG and the public, patient participation groups and partners including the third sector and local authorities.

## 5.5 Working in Partnership

The CCG has a range of formal and informal mechanisms in place to support effective working with partners and stakeholders across the Health and Social Care system. The governance process for each partnership is set out in Terms of Reference and Service Level Agreements, with a CCG nominated representative or lead. These partnerships are set out below:




| Partnership Boards | Responsibility and Governance | CCG Representative |
|---|---|---|
| Health and Wellbeing Board | Shared leadership to reduce health inequalities and improve integrated working between health, social care and public health | Dr Hugh Freeman |
| GP Membership Senate | Engagement and consultation with Practices | Dr Hugh Freeman<br>Dr Sam Hullah |
| Hampshire 5 Committee | Hosting commissioning for Adults (West Hampshire CCG as host)<br>Hosting commissioning for Children (North<br>East and Farnham CCG as host)<br>Issues which are Hampshire wide including Better Care Fund | Dr Hugh Freeman<br>Lisa Briggs<br>Pam Hobbs |
| SHIP 8 Committee<br>(Southampton, Hampshire, IOW, and Portsmouth CCGs) | Working across SHIP<br>Clinical Priorities (through a sub group) | Dr Hugh Freeman as Chair<br>Pam Hobbs (as SHIP wide finance representative) |
| Children's Safeguarding Board | Safeguarding across Hampshire<br>Designated doctor for Child Deaths<br>Designated Doctor for Looked After Children<br>Designated Nurse for Looked After Children | Jan Grant<br>Dr Jean Price<br>Dr Julie Greenslade (from Nov 13) with advice from Dr Jean Price<br>Naomi Black |
| Adults Safeguarding Board<br>Local Safeguarding Board | Safeguarding across Hampshire<br>North Hampshire related | Designated Nurse – Patricia Dennison<br>Dr Sam Hullah<br>Jan Grant |
| Wessex Commissioning Forum | CCGs collaborative across Wessex working with NHS England (Primary Care, Specialised Services) | Dr Hugh Freeman<br>Lisa Briggs |
| North& Mid Hampshire Commissioning Forum | Joint working with West Hampshire CCG in commissioning from HHFT | Dr Hugh Freeman<br>Dr Sam Hullah<br>Lisa Briggs<br>Pam Hobbs |
| Prescribing Forum across North and Mid Hampshire | Drugs and Therapeutic Committee | Dr Phillip Hiorns<br>Alma Kilgariff |

During 2013/14 it was recognised that, although there were some arrangements in place in respect of the Designated Doctor and Nurse, there was a need to secure permanent representation for these key responsibilities. As such new appointments were made as shown in the table above.

A number of Support service functions were provided to the CCG by the Commissioning Support Unit South (CSU) in 2013/14, the CSU are under the umbrella of NHS England. Ideally the CCG would have received prior to year end, a Service Auditor Report (SAR) which would set out the level of assurance that the CSU's Internal Auditors found during their review in respect of the internal control environment in the CSU. Unfortunately the (SAR) is not available at the time of this statement however the CCG has received a letter from the CSU summarising the findings of an in year Internal Audit report, together with a summary of the 18 priority 2 actions. Where the CCG identified potential weaknesses earlier in the year in the control environment in the CSU, controls were instigated in CCG processes to minimise the risks.

## 5.6 Risk Assessment in relation to Governance and Internal Control

The overarching Risk Management Strategy of the CCG identifies the roles and responsibilities of individuals for managing risk and it sets out the CCG's attitude to risk. As a new organisation, it was important for every employee and our clinical leads to understand the Governance Framework, the Risk Management strategy and in particular the benefits of on-going identification and management of risk issues. Awareness and training has taken place throughout the year and in the final quarter the CCG believes that the risk culture is now being embedded into its day to day work. This was an area of the CCG's governance which has taken some time to develop with additional support provided by the CCG's Internal Auditors during the year.

Risks facing the CCG and its objectives are identified through risk assessments, audit, incident reports, complaints, self-assessment and by external regulators such as the Care Quality Commission (CQC) Monitor and the Trust Development Agency. All identified risks are evaluated using the scoring criteria of likelihood of recurrence and consequences (severity and impact) and the risk register records existing controls and gaps in controls. Risks which are red rated are reported to the Governing Body. CCG risks reported were as follows:

- Tendering and mobilisation of new service for children's therapies
- Appointment of designated doctor for Child Deaths
- Patient care quality issues - (incidents, financial viability and CQC registration),
- Consultation process and delivery by North Hampshire Foundation Trust of proposed Critical Care Treatment Centre
- Meeting financial targets – staying within revenue resources allocated delivery of QIPP savings
- Achieving key performance targets e.g. healthcare related infections, and waiting times
- Efficient review and agreement of retrospective continuing care claims
- Securing a Place of Safety for children.

## 5.7 The Clinical Commissioning Group Internal Control Framework

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

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

## 5.8 Assurance reviews undertaken by NHS England

The CCG is subject to a quarterly review by the Local Area team and these checkpoints form a key part of the annual assessment process. The process includes a "balanced scorecard" submission to NHS England and this RAG (red, amber green) rates the CCG's performance against the 5 key NHS performance areas. This assurance process was in the early stage of development at the beginning of this reporting year and therefore there have been some changes between quarters to the assessment criteria. The domains have remained the same throughout the year and are listed below:

**Domain 1**
Are people getting good quality care?

**Domain 2**
Are patients' rights under the NHS Constitution being promoted?

**Domain 3**
Are health outcomes improving for local people?

**Domain 4**
Is the CCG delivering services within their financial plan?

**Domain 5**
Are conditions of CCG authorisation being addressed and removed?

Where the CCG was given a red rating, the CCG produced and implemented an action plan to deliver the required improvement. Notable action plans related to reducing the incidence of Health Care Acquired Infections in HHFT, reducing Referral to Treatment waiting times, implementing the lessons learned from the Francis Report into Mid Staffordshire Trust and the Winterbourne Enquiry into Learning Disability Services, the outcome of the risk summit between Hampshire CCG Commissioners and Southern Health Foundation Trust (looking at Clinical Governance in the Trust) and improving Child and Adolescent Mental Health Services.

## 5.9 Information Governance

The Information Governance Framework sets out the processes and procedures by which the NHS handles information about patients and employees, in particular personally identifiable information. The NHS Information Governance Framework is supported by the Information Governance Toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely efficiently and effectively. The CCG has in place both a Senior Information Risk Owner and Caldicott Guardian. During 2013/14 an Information Governance Working Group was set up to drive forward implementing and embedding the requirements of sound Information Governance. The CCG is required to undertake an annual assessment process using a national toolkit providing evidence to substantiate the level of compliance. The CCG has achieved a level 2 with scoring of 69% in 2013/14.

During the year the Secretary of State for Health approved NHS England's application for Section 251 support which allowed CCG's and CSU's to process patient confidential data (PCD) for invoice validation and this exemption is in place until October 2014. The limitation prior to 1st January 2014 had resulted in an inability to validate invoices and, in the early part of the year, impacted upon the sharing of some data supporting care pathway reviews and practice liaison. However this restriction did not impact upon patient care.

There were no serious untoward incidents relating to data loss or confidentiality breaches reported in the year.

## 5.10 Financial Control – economy, effectiveness and use of resources

The CCG placed a particular emphasis upon its financial planning before the CCG was formally authorised. The process highlighted that the CCG's financial position was to be a considerable challenge and led to NHS England agreeing that the CCG could plan for a deficit of £2m in 2013/14. Financially, the year has been complex with a need to adjust baseline budgets between organisations and this has affected provider contracts with the CCG, most significantly baseline changes relating to Specialised Services.
The Finance and Performance report, presented each month to the Governing Body, outlines the financial performance across each of the expenditure areas of the CCG it also highlighted issues and risks one of which worth noting related to legacy balances in respect of Continuing Care Provisions which were set aside in the accounts of Hampshire PCT the value of the provision will not be transferred to the CCG, however the responsibility for the claims process and payment remains with the CCG and will be recharged to NHS England. NHS England has in turn top sliced the estimated national value of the retrospective settlements to be made in 2014/15 from the CCG 2014/15 allocations.

Continuing care services are hosted on behalf of the five Hampshire CCG's including North Hampshire by West Hampshire CCG. A risk sharing agreement is in place. Priority is given to urgent and new client assessments. The timeliness of processes which took place during 2013/14 was in accordance with the national requirement for a decision to be made within 28 days.

**Breakdown of continuing care retrospective claims**

| Detail | Number of Legacy Claims up to March 31 2013 awaiting decision | North Hampshire related |
|---|---|---|
| Hampshire 5 CCG's | 1,693 | 289 |
| 2013/14 claims awaiting decision | 627 | 106 |

West Hampshire CCG have acknowledged that the level of claims settled to date is lower than would have been expected, and have taken action to secure additional resources to undertake the process. West Hampshire have advised that it may take 2 to 3 years to administer all of the retrospective claims.

Whilst the CCG has in place Prime Financial Policies, it is clear that detailed procedures would provide additional internal controls and assurance. This document is in draft with approval being sought to adopt the document in May 2014.

## 5.11 Pension Obligations

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

## 5.12 Equality, Diversity & Human Rights Obligations

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

## 5.13 Sustainable Development Obligations

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.

We will ensure the CCG complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting Power, and the Public Services (Social Value) Act 2012. We have also set out our commitments as a socially responsible employer.

## 5.14 Looking ahead to 2014/15

As Accountable Officer I am keen to proactively identify areas of change where internal controls need to be implemented or where there is scope in existing systems and processes to make further improvements. In the coming year our actions will include the following areas:

- Developing new policies where a need has been identified including; Equal Opportunity, Disabled Employees Policies and an Operational Policy of the CCG administrative accommodation
- Governance and reporting of Pooled Funds with Hampshire County Council which will in future years be extended to include the Better Care Fund
- Securing more effective internal controls in processes used by the Commissioning Support Unit (Human Resources, creditor payments and authorisation processes)
- Adoption of Detailed Financial Procedures
- Securing an effective Local Security Management Service
- Supporting an effective governance process in the planning and decision making for a Critical Treatment Centre in North and Mid Hampshire ( proposed by HHFT)
- Securing a permanent designated doctor for Children's Safeguarding.

## 5.15 Review of Effectiveness of Governance, Risk Management & Internal Control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the Clinical Commissioning Group. My review is informed in a number of ways:-

- Executive managers within the CCG, in our partner organisations, where commissioning responsibility is hosted, and by the Commissioning Support Unit, who all have responsibility for the development and maintenance of the system of internal control, and also provide me with assurance by identifying and reporting risks.
- The Governing Body Assurance Framework and the discussion at committees where it is presented provide me with evidence that key members of the organisation, clinical leads and the wider GP membership understand and actively engage in managing the risks to the organisation to achieve its principal objectives
- The quarterly assurance checkpoint process triangulates the CCG's self-assessment with national data and the Local Area team views.
- My review is also informed by: feedback from the GP membership, the Audit Committee, External Audit, Financial and Performance reports, Quality reports, operational plans and commissioning updates, the Information Governance Toolkit Assessment, Counter Fraud Reports and Internal Audit.

## 5.16 Internal Audit

The Head of Internal Audit provided me with an opinion on the overall arrangements for gaining assurance through the Governing Body Assurance Framework and on the controls reviewed as part of the Internal Auditors' work. The overall level of the Head of Internal Audit Opinion for 2013/14 is that significant assurance was 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.

I have been advised on the implications of the result of my review of the effectiveness of the CCG's system of internal control by the Governing Body, Audit Committee and Integrated Governance Committee. Plans to address weaknesses and ensure continuous improvements took place throughout the year, and are detailed where weaknesses remain.

## 5.17 Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG and explained within the *'Corporate Governance Framework'* were developed with extensive expert external legal input to ensure compliance with all the relevant legislation. This legal advice also informed the matters and decisions reserved for the Membership Body and Governing Body and the Scheme of Delegation.

In the light of the Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that the CCG is clear about the legislative requirement 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, and Directorates have the structures, capability and capacity to undertake all of the CCG's statutory duties.

## 5.18 Significant Control Issues

With the exception of the Internal Control issues that I have outlined in this statement, my review confirms that North Hampshire CCG has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives and that those control issues identified have been or are being addressed.

Signed by;
Dr Sam Hullah
Accountable Officer
2nd June 2014

# 6 The Head of Internal Audit Opinion formal annual opinion

## Roles and Responsibilities

The whole Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures, together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its AGS.

The matters raised in this report are not necessarily a comprehensive statement of all the weaknesses that exist or all the improvements that might be made. This report has been prepared solely for management's use and must not be recited or referred to in whole or in part to third parties without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared, and is not intended, for any other purpose. TIAA neither owes nor accepts any duty of care to any other party who may receive this report and specifically disclaims any liability for loss, damage or expense of whatsoever nature, which is caused by their reliance on our report.

## The Head of Internal Audit Opinion

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

During the year, South Coast Audit (SCA) merged with TIAA Limited. This opinion from TIAA Limited covers the whole of the year, and we have therefore relied on work carried out by SCA prior to their transfer to us on 1st January 2014. This opinion is not entirely based on work directly carried out by TIAA Limited for the whole period. When forming this opinion TIAA Limited has taken in good faith the audit assurances previously reported by SCA. TIAA does not however accept any liability for errors, omissions or other inaccuracies relating to work completed prior to TIAA taking over responsibility for delivery of audit work on 1st January 2014.

We understand that at the end of the financial year the CCG achieved a surplus of £19k compared to an original planned deficit of £2m. Our opinion on the organisation's system of internal control has taken this factor into account.

My opinion is set out as follows:

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




### 1 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. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

### 2 The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.
- Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances.

### 3 The commentary below provides the context for my opinion and together with the opinion should be read in its entirety.

### 1. Design & operation of assurance framework and associated processes

Our work in this area was undertaken in two parts, the first earlier in the year (September 2013) to confirm processes and reporting were in place and working. Overall, on completion of our first piece of work, we gave the CCG an initial indicative "Limited" assurance that risk management and assurance systems in the CCG were operating effectively at that time. We gave the CCG a list of issues and improvement areas to help support the organisation move from the 'limited' assurance to 'significant'.

The key areas for the CCG were identified as:

- Greater clarity required in the roles of the Integrated Governance Committee (IGC) and the Audit Committee to prevent duplication and overlap;
- The Corporate Risk Register needed to be updated and improved in terms of its readability, content, and description of risk;
- The CCG should take into consideration how it defines its principal risks as it develops an Assurance Framework, making sure the Governing Body understands the difference between concerns and problems and actual risks.
- Improved retention of source documentation to support the Assurance Framework.

The second review is currently in progress to confirm the effectiveness of the processes and risk management generally. Whilst we have not formally reported this tranche of work we are pleased to confirm that improvements were made during the year in establishing risk management arrangements, and an effective BAF was put in operation. Our work has confirmed that the areas identified for attention by the CCG during our first phase audit have been addressed, and that an assurance level of **"Significant"** can now be given.

### 2. Range of individual opinions arising from risk based audits in the year

Other than the Assurance Framework and Risk Management (Phase 1) report referred to above, there were no other reports issued with 'Limited Assurance.

The following audits all provided **"Significant"** assurance:

- Payroll – Processes and Controls
- Key Corporate Governance Controls
- Clinical Governance Framework Overview
- Prescribing and Medicines Management
- Complaints
- Governance over Partnership Working
- Critical Financial Assurance – Financial Accounting and Payroll.

### 3. Reliance placed upon third party assurances

In support of my opinion I have taken into consideration the following third party assurances:

- At the time of preparing this report we had not received the ISAE 3402 report (due April 2014) in respect of SBS for the year ended 31st March 2014, and hence we have been unable to take it into account in preparing my opinion. This is a report by the independent service auditors appointed by SBS, of their annual audit work to review the design and operating effectiveness of certain specified controls related to SBS core Financial and Accounting services to its clients. The report covers Purchase to Pay, Order to Cash, Accounting to Reporting and associated general IT controls. There will also be a separate ISAE3402 report in relation to SBS payroll services.
- The CCG has outsourced the work on many key systems to NHS South CSU. We understand that NHS South CSU have appointed Deloitte as auditors to report on specific key financial systems controls (excluding payroll), and other key systems and controls. At the time of preparing this report we have yet to receive any Service Auditor report covering the year ending 31st March 2014. As part of their internal audit work however, Deloittes, undertook a service auditor reporting readiness assessment in December 2013. The CCGs did not receive the full report but were sent a summary of findings and recommendations, dated January 2014. We note that gaps and weaknesses were found in a number of the CSU's systems and expected key controls, and the report stated:

> **"It is recognised that where there have been control weaknesses during the year, CCG External Auditors may wish to perform additional substantive testing for the periods where reliance cannot be placed on controls testing.**

- I have considered the CCG's LCFS reports throughout the year, and concluded that there are no significant issues to take into account into account in preparing this opinion.

Michael Townsend FCA,
Head of Internal Audit, TIAA Limited
22 April 2014




# 7 Statement of Accountable Officers' Responsibilities

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

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

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

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

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

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

Signed by Dr Sam Hullah
Accountable Officer
2nd June 2014

# 8 Register of Interests

At each meeting of the Governing Body the Chair asks all members whether they have any conflicts of interest to declare. Any declarations are noted within the Register of Interests with individual declarations updated and signed by the Governing Body member.

| Name | Relevant and Material Interests |
|---|---|
| **Dr Sallie Bacon**<br>Associate Director of Public Health | • Employed by Hampshire County Council |
| **Jan Baptiste-Grant**<br>Chief Nurse | • Director/Owner: Baptiste Grant Limited – Consultancy<br>• Trainer for Oxford Deanery & Wessex Deanery<br>• Fitness to Practice Member: Nursing & Midwifery Council<br>• Coaching assessor for the National Skills Academy for Social Care (to 17 Dec 13)<br>• London Deanery: Mentor/Coach ( from May 13)<br>• NHS Leadership Academy: Coach )from August 13)<br>• Trustee: National Sickle Cell Society (From 25 March 14) |
| **Lisa Briggs**<br>Chief Operating Officer | • Partner in Walnut Business Systems<br>• Director of Referral Management Services Limited (RMS) to 27 August 13) |
| **Dr Amanda Britton**<br>Vice Chair of the Clinical Cabinet | • Partner in Hackwood Partnership<br>• Speciality doctor Sexual Health, Solent NHS Trust<br>• Married to John Britton, Orthopaedic Surgeon, HHFT<br>• Trustee of North Hants Hospital Medical Fund<br>• Director of the Ark Conference Centre, Basingstoke<br>• Director of Faculty of Sexual and Reproductive Healthcare of the Royal College of Obstetricians and Gynaecologists<br>• The Hackwood Practice is a shareholder in North Hampshire Alliance |
| **Dr Angus Carnegy**<br>GP Representative | • Sessional doctor – North Hampshire Urgent Care (Hantsdoc)<br>• Director – Advanced Medical Services Ltd (provider of medical services)<br>• Partner at Gillies Health Centre<br>• Wife works for Southern Health as a Smoking Cessation Advisor<br>• Partner of a practice who is a shareholder in North Hampshire Alliance |
| **Dr Andrew Cameron**<br>GP Representative | • Partner at Hackwood Partnership<br>• GP Trainer<br>• Work for North Hampshire Urgent Care (NHUC Out Of Hours Service)<br>• Medical Officer Ashcombe House Nursing Home<br>• The Hackwood Practice is a shareholder in North Hampshire Alliance<br>• Wife works for The Hackwood Partnership as a Financial Administrator. |
| **Gill Duncan**<br>Director of Adult Services | • Director of Adult Services, Hampshire County Council<br>• Member of West Hampshire Clinical Commissioning Group Governing Body |
| **Dr Hugh Freeman**<br>Chair | • Director of Pyotts Medical Limited (provider of medical services)<br>• Locum GP to Cedar Medical, Basingstoke<br>• Sessional GP –North Hampshire Urgent Care<br>• Member of Basingstoke and Deane Borough Council Well-Being Partnership |
| **Colin J Godfrey**<br>Patient Representative | • Sole Proprietor 'Olcote Land' Land Consultancy<br>• Member of "Patients' Voice Forum" Basingstoke & North Hampshire Hospital.<br>• Hon. Chair Basingstoke & Deane Health and Well Being Partnership, Patient Representative.<br>• Honorary President Basingstoke Bluefins Swimming Club.<br>• Volunteer with Basingstoke Cruse Bereavement.<br>• Non-Executive Member Basingstoke Local Sports Council and represent LSC on 'Get Active Group'<br>• Fundraiser for Cystic Fibrosis Trust and 'Charlie's Day Unit Project' at North Hampshire Hospital |
| **Pam Hobbs**<br>Chief Finance Officer | • Member of HFMA South Central Committee |
| **Dr Sam Hullah**<br>Chief Clinical Officer | • Partner Crown Heights Medical Practice<br>• Chair and Director of Cedar Medical Limited<br>• Director (role of parent governor) Robert May's School Odiham (to 25 March 14)<br>• Wife works for Beggarwood Surgery<br>• Practice is a shareholder in North Hampshire Alliance |
| **Anne Phillips**<br>Head of Stakeholder Communications and Engagement | • Company Secretary of Referral Management Services Ltd (to 27 August 13)<br>• Practice Manager Camrose Medical Partnership (to 30 June 13)<br>• Company Secretary Calleva Medical Ltd (to 25 March 2014) |

| | |
|---|---|
| **David Rice**<br>Lay Member<br>(audit and remuneration) | • Director: Rice Associates Limited (Chartered Accountants, Wokingham, Berkshire) |
| **Dr Nicholas Sorby**<br>Secondary Care Consultant | • Locum Consultant Old Age Psychiatrist covering Guildford and Waverley, employed by Surrey and Borders NHS Trust<br>• Medical Member Mental Health Act Review Tribunal<br>• Wife: Dr Sheila Sorby, GP Partner, St Luke's and Botley Healthcare Centre |
| **Derek Tree**<br>Lay Member<br>(Integrated Governance) | • Majority shareholder and CEO of PN Group Limited (PNG) - a psychometric training and certification company. PNG provide on-line psychometric assessment and training services to Health & Social Care in Northern Ireland.<br>• CEO of The Influence Company Global Limited - a PN Group Ltd company providing influence and negotiation workshops.<br>• CEO of the Your Directions Foundation – a not-for-profit social enterprise providing career services including for schools and colleges.<br>• Director of Seminars for Success Limited – a training logistics and on-line survey company.<br>• Works as management consultant and executive coach for global corporations<br>• Spouse is a Director of Seminars for Success Limited and Company Secretary of PN Group Limited |
| **Dr Philip Hiorns**<br>Clinical Cabinet Member | • GP Partner in Chineham Medical Practice<br>• Practice is a shareholder in North Hampshire Alliance |
| **Dr Robert Green**<br>Clinical Cabinet Member | • GP Partner in Chineham Medical Practice<br>• Spouse works as a midwife in Hampshire Hospitals Foundation Trust<br>• Practice is a shareholder in North Hampshire Alliance |
| **Dr Sunil Rathod**<br>Clinical Cabinet Member | • GP Managing Partner at Bramblys Grange Medical Partnership<br>• Doctor at SamedaydoctorHampshire, a private GP clinic<br>• Spouse is Consultant Psychiatrist and Clinical Director in Southern Health<br>• Practice is a shareholder in North Hampshire Alliance |
| **Dr Andrew Fellows**<br>Clinical Cabinet Member | • GP Partner in The Wilson Practice<br>• Part Owner in Anstey Road Pharmacy<br>• Sessional Doctor for North Hampshire Urgent Care<br>• Practice is a shareholder in North Hampshire Alliance |




| | |
|---|---|
| **Dr Robert Walker**<br>Clinical Cabinet Member | • GP Partner at Gillies Health Centre<br>• Practice is a shareholder in North Hampshire Alliance |
| **Dr Andrew Fernando**<br>(31 October 2013) | • Director of North Hampshire Urgent Care<br>• GP Partner in the Hook and Hartley Wintney Practice<br>• Director of Elixia Healthcare Limited<br>• Practice is a shareholder in North Hampshire Alliance |
| **Dr Matt Nesbitt**<br>Chair of Membership Senate | • GP partner in Crown Heights Medical Centre<br>• Spouse is a salaried associate doctor at Crown Heights<br>• Father in law is a Member of Parliament<br>• Father and Mother in law – members of House of Lords with an interest in health policy in particular mental health and drugs policy<br>• Practice is a shareholder in North Hampshire Alliance |

# 9 Independent Auditor's Report to the Governing Body of North Hampshire Clinical Commissioning Group

We have audited the financial statements of NHS North Hampshire Clinical Commissioning Group for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 42. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury 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 on page 32 of the Annual Report;
- the table of pension benefits of senior managers on page 33; and
- the pay multiples and related narrative notes on page 31.

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

## Respective responsibilities of Accountable Officer and auditors

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 30, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

## Scope of the audit of the financial statements

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

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

In addition we read all the financial and non-financial information in the Annual Report 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 who govern them.

## Opinion on regularity

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

## Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS North Hampshire Clinical Commissioning Group as at 31 March 2014 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

## Opinion on other matters

In our opinion:

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

## Matters on which we report by exception

We report to you if:

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

We have nothing to report in these respects.

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

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are also required by the Audit Commission's Code of Audit Practice to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

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

- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent the results of the work have an impact on our responsibilities at the CCG; and
- our locally determined risk-based work.

As a result, we have concluded that there is the following matter to report.

The CCG has a statutory duty to ensure that its revenue resource use in any financial year does not exceed the amount specified by direction of NHS England (under section 223I(3) of the National Health Service Act 2006). The CCG was projecting to spend £2.0m in excess of the amount specified by direction of NHS England for 2013-14. Expenditure in excess of the amount specified is unlawful and, on the basis of these projections, we referred this to the Secretary of State and NHS England under section 19 of the 1998 Audit Commission Act on 14 January 2014.

The CCG has reported in its 2013-14 financial statements (Note 42 Financial Performance Targets) that revenue resource use did not exceed the amount specified in directions, reporting a surplus of £20,000 and therefore complied with its statutory duty.

## Certificate

We certify that we have completed the audit of the accounts of NHS North Hampshire 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.

Mick West, Director
for and on behalf of
Ernst & Young LLP
Southampton
3 June 2014


# 10 Addendums

## Addendum A

### Profiles - Governing Body, Clinical Cabinet and Chair of Membership Senate

#### Chair of Membership Senate

**Matthew Nisbet** trained locally as a GP and for the last five years has been part of the team at Crown Heights Medical Centre - a large busy practice in the centre of Basingstoke. His clinical interests are in the areas of sexual health and young people's medicine.

#### Chair of Governing Body

**Dr Hugh Freeman** has been a General Practitioner in Basingstoke for many years. He retired from full time practice to concentrate on the NHS reforms that have given Primary Care a leading role in shaping the future of our healthcare system.

Until recently Hugh was on the medical team at St Michael's Hospice, he works one day a week in Primary Care. Previously Dr Freeman worked as Medical Advisor to the Automobile Association (AA), Marks and Spencer and Linde.

#### Chief Clinical Officer and Accountable Officer

**Dr Sam Hullah** is a GP Partner at Crown Heights Medical Centre in Basingstoke. He branched out into management (part time) in the mid-1990s to become Medical Manager of Hantsdoc and a GP representative to Hampshire Primary Care Trust. Dr Hullah left both of these posts to concentrate on GP commissioning and is now Chief Clinical Officer of North Hampshire Clinical Commissioning Group. Dr Hullah is also Chair of the Clinical Cabinet.

#### Chief Operating Officer

**Lisa Briggs** has been working with North Hampshire Clinical Commissioning Group since 2007. She joined the NHS in 1999 having worked in a number of corporate organisations. She has worked within social care, primary care and secondary care sectors in Hampshire, Berkshire and Oxfordshire at senior executive level and moved to work more closely with the NHS commissioning agenda under practice based commissioning.

#### Chief Finance Officer

**Pam Hobbs** is Chief Finance Officer for the CCG; She qualified as an Accountant (CIPFA) in 1991 and has been a Director in the NHS for the last 13 years. For most of her career Pam has been working in the public sector, beginning training at East Hampshire District Council and upon qualifying moved into the NHS. During the 23 years in the NHS, she has worked in a Health Authority, Provider Trusts (acute, community and mental health) and for Southampton and Portsmouth PCT's where her roles also included responsibility for Information Technology and a large Estates Department.

#### Chief Nurse

**Jan Baptiste-Grant** is an experienced senior NHS Manager and nurse with over 30 years NHS experience. She has held Board or sub board portfolios in Nursing, Quality and Governance and her experiences in senior leadership positions span both Primary and Secondary Care. Jan has also worked in the Department of Health as the Clinical Advisor and held the Associate Director of Nursing position in Thames Valley Strategic Health Authority.

#### Head of Stakeholder Engagement and Communication

**Anne Phillips** has been working in the locality of North Hampshire since 2005 when she first became involved with the 'Calleva' practice based commissioning organisation as Company Secretary.

Before joining the CCG Anne was practice manager at the Camrose Medical Partnership in Basingstoke. Prior to that she held a variety of senior managerial and director posts, mainly in the field of children's books.

#### Vice Chair Clinical Cabinet

**Dr Amanda Britton** is a part time partner at Hackwood Surgery and is also the Service Lead for the Contraception and Sexual Health Service in North and East Hampshire run by Southern Health. As well as sitting on the Governing Body, Dr Britton is vice chair of the Clinical Cabinet and is the Lead for Child and Family Services & Gynaecology.

#### GP Elected Member

**Dr Angus Carnegy** has been a GP in Basingstoke at Gillies Health Centre for the past 18 years. He is a GP trainer and has a special interest in acupuncture. He also undertakes sessions for NHUC (North Hampshire Urgent Care) Out of Hours Service and is the Planned Care Lead for the CCG.




#### GP Elected Member

**Dr Andrew Cameron** trained in medicine in Dublin having done a first degree in science at Dundee University. After working as a Medical Senior House Officer at Basingstoke Hospital he embarked on GP training in the town. He was fortunate enough to be taken on as a Partner by the Practice at which he trained and has been a full time Principal for the past eighteen years. He is also a GP trainer and teacher and does regular shifts out-of-hours with NHUC.

#### Secondary Care Consultant

**Dr Nick Sorby** was first appointed as a Consultant Old Age Psychiatrist in North Hampshire in 1988 and retired from full time practice in 2012. He knows North Hampshire well and has always had close links with local GPs and the hospital. He continues to work part time in Guildford as an Old Age Psychiatrist and is also a member of the Mental Health tribunal.

#### Lay Member for Audit and Remuneration

**David Rice** is a qualified Chartered Accountant who set up and ran his own practice in Crowthorne, after 12 years in industry, providing accounting, taxation and audit services to a variety of clients. He retired from full time practice in September 2011 and now acts as a consultant.

He was President of the Thames Valley of Chartered Accountants in 1981/82 and also served on their Technical Committee for thirty years to 2010. He has spent fifteen years as a Non-Executive Director on Berkshire Health Authority (and its predecessor bodies) until 2000. he also chaired the Audit Committee of Berkshire Health Authority for some years.

#### Lay Member for Integrated Governance and Patient and Public Involvement

**Derek Tree** is an experienced Executive and Interim Director who currently runs a number of businesses concerned with psychometric assessment, leadership development and executive coaching. He is the CEO of the Your Directions Foundation, a social enterprise providing career services in the public and private sectors.

As well as having the lead role in patient and public engagement, he also chairs the Integrated Governance Committee.

#### Patient Representative

**Colin Godfrey** is now retired after 40 years in the Residential Development Industry; he first became a Patient & Public Involvement Forum member in 2004, working on the local Primary Care Trust and the Hospital Forums. Colin is now a member of 'Patients' Voice Forum' at Hampshire Hospitals Foundation Trust, Hon. Chair of Basingstoke & Deane Health and Wellbeing Partnership, Vice chair of Basingstoke Local Sports Council, Hon President of Basingstoke Bluefins Swimming Club, volunteer with Basingstoke Cruse Bereavement as well as being a fund raiser for the Cystic Fibrosis Trust and the Charlie's Day Unit Project at North Hampshire Hospital.

### Director of Adult Services, Hampshire County Council

**Gill Duncan** has been in post as Director of Hampshire County Council's Adult Services since December 2008. On occasions Sue Pidduck attends meetings representing Gill Duncan

Prior to joining Hampshire County Council in 2004 Gill was a Primary Care Trust Chief Executive bringing with her over 10 years board level leadership and a clinical background in nursing and community services.

As the Director of Adult Services in Hampshire, Gill oversees around 4,000 staff commissioning and providing residential, day care and home care services to older people and people with disabilities and mental health problems.

### Public Health Consultant

**Dr Sallie Bacon** worked as a general practitioner in North West London and then in Chandlers Ford, Hampshire for many years before moving into Public Health medicine. She is currently Associate Director of Public Health, Hampshire County Council.

### Clinical Cabinet members (other than those on the Governing Body as set out above)

**Dr. Sunil Rathod** works as a GP at Bramblys Grange Medical Practice. He has been working in General Practice since 1997 and took over as Managing Partner in 2009. He has been on the Hampshire wide IT steering Group since 2000. Served on the Hampshire Local Medical Council from 2005 to 2010 and now is the North Hampshire CCG IT Lead.

**Andy Fellows** qualified in London in 1989, and had been working in hospitals before undertaking his GP training in Leicestershire. He has been a GP Partner at The Wilson Practice in Alton for 15 years, and a GP trainer for 8 years. Andy has been working with North Hampshire CCG since its inception as Clinical Lead for Unscheduled Care.

**Dr Robert Green** is the CCG Mental Health lead and GP partner at Chineham Medical Practice. He graduated from Southampton in 2006 and started work as a GP in 2012. Following foundation training, Rob spent a further year in ENT, gaining vital experience.

After applying for GP and Psychiatry training in 2009, he chose to pursue a career in General Practice, continuing to hold a keen interest in Mental Health.

**Dr Philip Hiorns** is Senior Partner at Chineham Medical Practice and is prescribing lead for the CCG. Philip also provides some medical cover for St Michael's Hospice in Basingstoke.

**Dr Robert Walker** is a part time partner at Gillies Health Centre in Basingstoke. He has an interest in 'evidence based medicine' and is a firm believer that applying good quality evidence into primary care can improve patient outcomes and satisfaction. He works on the Clinical Cabinet as lead for education, research and innovation.

**Dr Andrew M Fernando** Medically trained at the Royal London Hospital and registered in 1985. After several years in Army General Practice he joined the Hook and Hartley Wintney medical partnership in 1998 as a Full -Time Partner and provides full general medical services. He also has a personal interest in Occupational Health.




# 10 Addendums

## Addendum B

## Schedule of Attendance

### Governing Body 12 meetings

| Name | % Attendance |
|---|---|
| Dr Hugh Freeman (Chair) | 100% |
| Dr Sam Hullah | 75% |
| Lisa Briggs | 92% |
| Pam Hobbs | 100% |
| Jan Baptiste-Grant | 67% |
| Dr Amanda Britton | 33% |
| Dr Angus Carnegy | 92% |
| Dr Andrew Cameron | 83% |
| Dr Nick Sorby | 83% |
| David Rice | 92% |
| Derek Tree | 50% |
| Anne Phillips | 92% |
| Colin Godfrey | 92% |
| Sallie Bacon | 75% |
| Local authority social care representative (Gill Duncan/Sue Pidduck) | 92% |

### Clinical Cabinet 12 meetings

| Name | % Attendance |
|---|---|
| Dr Sam Hullah | 92% |
| Dr Amanda Britton | 83% |
| Dr Andy Fellows | 67% |
| Dr Angus Carnegy | 83% |
| Dr Andrew Fernando (to October 2013) | 100% Part year |
| Dr Philip Hiorns | 75% |
| Dr Rob Green | 92% |
| Dr Rob Walker | 92% |
| Dr Sunil Rathod | 42% |
| Dr Sallie Bacon/Simon Bryant | 42% |
| Lisa Briggs | 92% |
| Anne Phillips | 100% |
| Jan Baptiste-Grant | 58% |

### Audit Committee

| Name and Details | Members Attendance 11 Jun 13 | 13 Sep 13 | 13 Dec 13 | 1 Apr 14 |
|---|---|---|---|---|
| David Rice (Chair) responsible for audit and remuneration | Yes | Yes | Yes | Yes |
| Derek Tree Lay Member | Yes | Yes | Not in attendance | Not in attendance |
| Dr Angus Carnegy (Membership elected GP) | Yes | Yes | Yes | Yes |
| Dr Andrew Cameron (Membership elected GP) | Yes | Yes | Not in attendance | Yes |