NHS Darlington Clinical Commissioning Group (CCG) Annual Report and Accounts 2013-14

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Foreword

NHS Darlington Clinical Commissioning Group (CCG) was established on 1st April 2013 following comprehensive reforms of the health service as part of the Health and Social Care Act 2012. We were one of only 43 CCGs that were authorised without any requirement for additional support. During this time, we have continued our work in partnership locally to improve health services for people in Darlington, against a backdrop of a severely testing economic climate.

We are a small CCG which is not without its financial challenges, but gives us great connectivity with the consulting room. This has meant that we have been able to capitalise on a clinically led approach, with GPs best placed to understand the needs of their patients and to guide commissioning decisions. The value of this is evident in the ground breaking work led by Dr Matthew Sawyer with practices and Care Homes to ensure that vulnerable patients are properly looked after.

Although we are not responsible for commissioning primary care (this is the responsibility of NHS England Area Team) we have had a clear focus on Primary Care Services in Darlington as the local practice is often the first ‘port of call’ when people need to access the NHS. Dr Jenny Steel has led work across all eleven practices and spoken with patients, carers and other interested parties to set out a vision for primary care towards which we can now build.

Locally our practices continue to meet demand from patients and routinely see 11,500 patients each week, which is the equivalent of 11% of the local population. Our plans for primary care will need to reflect this demand and how best urgent care and services can be delivered. This work is being led by Dr Chris Mathieson who is working with practices, hospital clinicians, pharmacists and others to ensure the needs of our patients are being met.

Our Community Council, which is made up of volunteer patients from local practices, helped adopt a five-point Charter that sets out our commitment to meaningful engagement, through which we will listen to and act upon the voice of local people and work to improve health and wellbeing across the Borough of Darlington.

It is important as well that we grow and work through ‘third sector which include organisations such as charities or not for profit organisations or voluntary and community sector organisations’ and smaller community groups to build increasing levels of resilience locally. We were very fortunate to be able
to support five schemes through our Community Innovations Fund, ‘Dragons’ Den’, which we will look to continue.

Dragons’ Den

The community innovations fund looked to the voluntary and community sector to explore new ways of working and imaginative models of support to enhance the quality of life for families in Darlington and ensure people receive the correct advice and support for their own health and wellbeing.

We are also working with other CCGs and local hospital trusts on a project called ‘Securing Quality in Health Services’ to ensure that local hospitals can continue to deliver high quality care and services and ensure that the right number of doctors are available on hospital wards to assess, diagnose and treat acutely ill patients.

Dr Andrea Jones
Chair, NHS Darlington CCG

Martin Phillips
Accountable Officer, NHS Darlington CCG

Member practices’ introduction

Close partnership working amongst GP Practices has a long tradition in Darlington and we have worked hard during our first year to consolidate this with the new commissioning arrangements. Our CCG has a clear focus on improving health and healthcare services for our patients.

With a population of just over 100,000 we are one of the smallest CCGs, yet we face some big challenges. Over the next few years we expect that the growing elderly population, variations in health across our area and increases in the number of people with long-term conditions will add more pressure to our services. To meet these challenges we must work to:

- Improve the health status of the people of Darlington
- Address the needs of the changing age profile
- Secure the right services at the right time in the right place
- Manage our resources well
- Invest in primary care and services
- Secure meaningful engagement with people

Supporting our vision ‘Working together to improve the health and wellbeing of Darlington’ we have been working closely with local hospital and community-based services and neighbouring CCGs. We have also started to build closer ties with
Darlington Borough Council, using our combined resources and expertise to develop efficient healthcare services that are focused on our patients' needs.

If we are to meet our challenges we must also connect with our community. Patient participation groups, public events and campaigns have made it easier for local people to let us know what they think about existing healthcare services and helped set priorities that will meet their needs now and in the future. By establishing our own Patient Charter, we have also set out a strong commitment to listen to local people and patients and take action based on what we hear. This is the start of a process we will be developing further in years to come.

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

**Lay Member championing Public and Patient Involvement**

By Michelle Thompson, Lay Champion for Public and Patient Involvement and Engagement

As a member of the Darlington CCG’s Governing Body I share responsibility as part of the team to ensure that the CCG exercises its functions effectively, efficiently, economically, with good governance and in accordance with the terms of the CCG constitution, as agreed by its members. I seek to bring my unique perspective, informed by my own specific expertise and experience, as well as my knowledge as a member of the local community. My focus is strategic and impartial, providing an independent view of the work of the CCG that is external to the day-to-day running of the organisation.

I endeavour to ensure that the voice of the local population is heard and that opportunities are created and protected for patient and public empowerment in the work of the CCG. In particular that:

- Patients, carers and the public views are not only heard, but listened to and acted upon
- Their expectations are understood and met as appropriate
- The CCG builds and maintains an effective relationship with Healthwatch Darlington and draws on existing patient, carer and public engagement and involvement expertise
- The CCG has appropriate arrangements in place to secure patient, carer and public involvement and responds in an effective and timely way to feedback and recommendations.
Prior to authorisation all CCGs were assessed on their plans for inclusion of patients, carers, the public, communities of interest and geography, health and wellbeing boards and local authorities. This included the ability to gather, analyse and act on the information received. Darlington CCG gained an exemplary standard in meeting this requirement.

Public involvement in decisions about their health services underpins the work of CCG. NHS reforms including the strengthening of the NHS Constitution and the Francis and Keogh reports make involving and engaging patients, carers and public, listening to their views and experiences an imperative. Darlington CCG is in a strong position to continue building on the good relationships already in place across the public and voluntary and community sectors in Darlington to enable effective and timely engagement.

The CCG has shown a real commitment to realising their intentions but, due to limited resources, the delivery of their objectives has proved challenging. As Lay Member for Patient and Public Involvement and Engagement (PPIE), I need to seek assurance that patients, carers and the public are fully involved in each step of decision making.

I feel the CCG are clearly demonstrating meaningful and effective involvement of patients, carers, public, groups and organisations. This is becoming evident as we see the views of individual patients translated into commissioning decisions and the voice of the community including each practice population being sought and acted upon.

However there is much more to do including more active involvement with children and young people and easily overlooked groups. To achieve this, the CCG will need to draw on the expertise of the voluntary and community sector to reach a more diverse audience as well as the public and private sectors to reach the educational and working population.

There also needs to be a greater commitment by North of England Commissioning Support (NECS) commissioning managers and planners, and member practices to understand their PPIE requirements. The CCG Governing Body are committed to supporting my recommendation for the implementation of a Patient and Public Engagement Framework template, which is a checklist for types of engagement, planning and evaluation when looking at service re-design strategies.

I am proud to be a part of the CCG’s continuing commitment to meaningful engagement especially with the creation of a PPIE Charter. Not only is this a pledge to listen to what really matters to local people, it’s a pledge to ensure those voices within the very heart of our communities are heard and acted upon throughout the decision making process.
Strategic report

About us

NHS Darlington Clinical Commissioning Group (CCG) took over responsibility for planning and purchasing the majority of health services from Darlington primary care trust and we are responsible for commissioning health care services including:

- Planned and emergency hospital care
- Rehabilitation
- Most community services
- Mental health and learning disability services.

We also arrange emergency and urgent care services and commission services for unregistered patients who live locally.

Clinical Commissioning Groups bring together a range of healthcare professionals and managers to offer patients more control of their own care; provide a greater focus on healthcare and quality; and to increase the freedom of medical professionals.

NHS Darlington CCG is made up of all 11 GP local practices. We work closely with other CCGs, particularly our neighbours at NHS Durham Dales, Easington and Sedgefield CCG and NHS North Durham CCG as well as with local hospitals, Darlington Borough Council, the Health and Wellbeing Board, Healthwatch Darlington and the voluntary and community sector.

We have also developed strong links with health professionals, managers, patients, carers and the public to make changes which will improve the health and experiences of the Darlington population.

We access many specialist business services via the NHS North of England Commissioning Support Unit (NECS).

NHS Darlington Clinical Commissioning Group can certify that it has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended) and that the accounts have been prepared under a direction issued by the NHS Commissioning Board under the National Health Service Act 2006 (as amended).

Our priorities

During our first year we have established a number of priorities. We know that people living within our region have a lower life expectancy than those in other parts of the country; however there are also significant local variations in health and wellbeing. Men from the least deprived areas of Darlington live nearly 15 years longer than those from the most deprived areas and the difference for women is almost 12 years.
Death rates from heart disease and stroke have improved since 2006 to 2008 but remain higher than the England average. Heart disease, stroke and cancer account for approximately 65% of premature deaths (under 75 years) with lung and liver disease also contributing. Common contributory factors include poverty, smoking, alcohol, poor diet, inactivity and high blood pressure.

The stress of living in poverty is particularly harmful to vulnerable groups and income deprivation is a significant issue for many older people in Darlington.

Alcohol consumption has more than doubled in the last 60 years, as has alcohol related harm. Excessive consumption is recognised as a major cause of ill health and community damage, with alcohol-related problems estimated to cost the Darlington economy £42.08m.

Our ‘clear and credible plan’ 2012 – 2017 sets out the CCG’s plan to meet these challenges, identifying the following key objectives:

- Providing health services which are safe and of the highest quality
- Ensuring the best possible health outcomes
- Joining up services which benefit patients and the public and give best value for money

Our operational plan for 2013/14 and the ‘clear and credible’ plan may be found at www.darlingtonccg.nhs.uk/publications/

Over this first year we have worked hard to provide safe, effective, high quality healthcare services that meet the needs of the population. We have sought to commission the right services in the right place and increase services available outside of hospital. By placing care closer to where people live we believe we can improve the quality of life for patients and their carers and address equity of access to healthcare. We are also committed to delivering local people their entitlements and rights under the NHS Constitution.

**Improving performance**

Our vision ‘**Working together to improve the health and wellbeing of Darlington**’ runs through everything we do. This year, we have worked with our partners to improve the health and wellbeing of patients and to improve our performance against national targets, local targets and the requirements of the NHS Constitution.

**Avoidable admissions**

Reduction in avoidable emergency admissions

Considering performance against all of the avoidable emergency admission targets, Darlington CCG has reported a position in 2013-14 below the target set.
There was a single occurrence of a wait in A&E from decision to admit time to admission of greater than 12 hours. This occurred in February 2014 at County Durham and Darlington NHS Foundation Trust. The local CCGs are working together with the trust on a comprehensive action plan to improve patient experience in their emergency departments.

**Cancer waiting times**

Darlington CCG has met the year-to-date targets for eight out of the nine categories for cancer waiting times. Performance for the 62 day wait urgent GP referral category was 84.1% (2013-14 figure), slightly below the 85.0% target. This category was under target in five months (May, September, October, November and March). Performance improved December through to February and performance in February was well above target at 94.4%. Each case that exceeded the timeframe is being reviewed to identify reasons for the delay and identify solutions.

**Healthcare acquired infections**

Darlington CCG had one incidence of MRSA over the period April – March, this case was in December 2013.

Challenging targets for clostridium difficile (CDiff) were set nationally as part of the 2013/14 Operating Framework requirements. The CCG’s yearly threshold for incidence of C-Diff was 21. By 31 March 2014 the CCG had reported 15 cases.

**Referral to treatment**

Darlington CCGs year-to-date performance for referral to treatment pathways treated within 18 weeks are all above target. The position for 2013-14 was 94.3% for admitted pathways, 98.7% for non-admitted pathways and 95.0% for incomplete pathways. For diagnostic tests the 2013-14 performance is 0.2% of patients waiting over six weeks.

Between April 2013 and March 2014, two patients waited over 52 weeks, both were on incomplete pathways.

**Quality premium**

The quality premium rewards clinical commissioning groups (CCGs) for improving quality of services and for associated improvements in health outcomes and reducing inequalities. It is based on a number of different measures that are set each year. Some measures are set nationally for all CCGs and others can be set locally by the CCG to address local priorities.
In 2013/14 four national indicators were based on the NHS Outcomes Framework, and three local indicators were agreed by the CCG with Darlington Health and Wellbeing Boards and with the NHS England Area teams for Durham, Darlington and Tees.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% of Quality Premium</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Preventing people from dying prematurely</td>
<td>12.5%</td>
<td>Reduction 3.2% between 2012 and 2013</td>
</tr>
<tr>
<td>Domain 2&amp;3: Enhancing quality of life for people with long term conditions and helping people to recover from episodes of ill health or following injury</td>
<td>25.0%</td>
<td>ISR 13/14 ≤ ISR 12/13 OR ISR 13/14 &lt; 1,000 per 100,000 population</td>
</tr>
<tr>
<td>Domain 4: Ensuring that people have a positive experience of care</td>
<td>12.5%</td>
<td>Implement FFT in Q1 13/14 AND increase score between Q1 13/14 and Q1 14/15</td>
</tr>
<tr>
<td>Domain 5: treating and caring for people in a safe environment and protecting from avoidable harm</td>
<td>12.5%</td>
<td>Zero MRSA AND decrease C-Diff on target</td>
</tr>
<tr>
<td>Emergency admissions for children with lower respiratory tract infections</td>
<td>12.5%</td>
<td>Less than 586 admissions per 100,000 population</td>
</tr>
<tr>
<td>Under 75 mortality rate for cancer</td>
<td>12.5%</td>
<td>Less than 142 per 100,000 population</td>
</tr>
<tr>
<td>Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19's</td>
<td>12.5%</td>
<td>Less than 395 admissions per 100,000 population</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100.0%</td>
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</tbody>
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The quality premium is payable to the CCG if it manages within its resources for 2013/14, which Darlington CCG was able to do.

The total payment for a CCG (based on its performance against the four national measures and three local measures) will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to:

- Maximum 18-week waits from referral to treatment
- Maximum 4-hour A&E waits
- Maximum 62-day waits from urgent GP referral to first definitive treatment for cancer
- Maximum 8-minute responses for Category A red 1 ambulance calls

Failure of each of these will result in a reduction of the Quality Premium payment of 25.0%.

Data for some indicators will not be available until Autumn 2014 so it is not yet known how much of the quality premium Darlington CCG will earn. Based on March 2014 year-to-date data the CCG will not achieve the indicator relating to Domain 5. In addition the target for 4-hour A&E waits was not met so this will result in a 25.0% reduction to the quality premium and cancer waiting times were slightly below target which means a further 25.0% reduction.
General practice
Investment in primary care and services are clear priorities for the CCG. General Practice is the foundation upon which excellent health and healthcare services are built. The CCG has invested in the development of a Primary Care Strategy which will be taken forward over the next few years. Critical to the success of primary care is the partnership with patients.

The source for patients’ experience of GPs is the GP Patient Survey – December 2013 results [www.gp-patient.co.uk/results/latest_weighted/ccg/](http://www.gp-patient.co.uk/results/latest_weighted/ccg/)
Results included for every CCG in the country using aggregated data collected during January-March 2013 and July-September 2013.

Overall GP experience
For overall GP experience we compare well to the national average. 50% of our patients reported a ‘very good’ experience in Darlington, 6% higher than the national statistic.

Out of hours GP service
For out of hours experience the percentage of people responding ‘very good’ was 5% higher than national average (34% compared to a national average of 29%).

Listening to local people
Meaningful engagement with local people is central to the work of NHS Darlington CCG. We want to make sure that as many people as possible are given the opportunity to have their say on healthcare priorities and decisions about their health services. Over the year local people have been encouraged to get involved in a number of ways:

Patient and public involvement and engagement charter (PPIE)
The CCG is committed to securing meaningful engagement with patients and the public and to ensure that even the quietest voices are heard. By listening to and acting upon the voice of local people we will be better placed to meet our challenges. This has resulted in the development of a five-point Charter, created with the help of the CCG’s Community Council and focusing on the following themes:

- **Meaningful voices**: Engaging with people and involving patients is central to the development, improvement and reform of services provided to the general population. PPIE will be fully embedded in the design and delivery of the services.
- **Leadership**: There is executive level responsibility for PPIE and clear organisational engagement strategy. All job descriptions, performance measures and staff roles will have defined PPIE activity including consistent training and support.
- **Proactive engagement**: We will ensure PPIE is innovative and meets organisational objectives by proactively engaging with individuals and groups across all areas of our business. The cost and benefit of PPIE will be built
into plans and all activities will identify specific PPIE spend.

- **Collaboration:** We will build on good links with local interest groups and organisations to share the best ways of involving local people and to ensure that they are aware of engagement opportunities. This will be linked into wider community programmes ensuring all service and special interest groups are represented.

- **Celebration:** We will celebrate and recognise the contribution that patients, carers and the public makes, in influencing our decision making, understanding the real impact that meaningful PPIE provides across all areas of our work and being accountable for all our decisions.

### Joint patient and public involvement and engagement group

A joint working group has been established between Darlington Borough Council (DBC), the CCG, North of England Commissioning Support (NECS) and Healthwatch Darlington (HWD) to work together on engagement strategies to reduce duplication of work and to share resources.

The group, which was initially established to support the transition arrangements for the Health and Wellbeing Board (HWBB), has recently grown to include County Durham and Darlington NHS Foundation Trust and Tees, Esk and Wear Valley NHS Foundation Trust. Communications and engagement are stronger due to the joined up approach and there is consistency to key messages.

### Governing body

The public are welcome to observe quarterly governing body meetings and, following the meeting, have the opportunity to ask questions. The governing body meets informally once a quarter with members as part of its development programme and to understand issues in depth. These sessions also provide the forum with recommendations to be taken forward in the CCG’s organisation development plan.

### Website - www.darlingtonccg.nhs.uk

The website is updated regularly and is essential to promote and communicate who the CCG are, what they do and how to get involved in influencing decision making. It includes commissioning intentions, plans, policies, reports, e-bulletins, news and information and signposting.

The CCG is also exploring other websites to complement their own and give patients more opportunities to express opinions at a local level. One such website is ‘Patient Opinion’, an independent not for profit community enterprise organisation which has been running for eight years. It enables the public to give real time information about their experiences with local health services. Comments made online are a powerful tool for patient choice and in forcing providers and commissioners to address any public criticisms made.

Most stories receive a response from providers/commissioners straightaway and there have been many satisfactory outcomes for both parties where the smallest of concerns have led to change and made the biggest difference for patients.
Social Networking - @DarloCCG

Although the @DarloCCG Twitter account is in its infancy, it is an effective and popular way to reach out to a younger audience and the working population with the potential for links to online surveys, questions and answer sessions for example #AskTheCCG. Followers are growing steadily and currently stand at 471. Many individuals and organisations will retweet comments they feel are valuable to their followers.

Healthwatch Darlington

Healthwatch Darlington (HWD) is the consumer champion for health and social care services in Darlington and reviews the needs of the community to ensure the right services are provided and challenges to poor health are tackled. They play an important part in gathering and presenting views from service users and the wider community.

It is recognised that the CCG and HWD, whilst operating independently, have a mutual interest in ensuring that patients, carers and the public have a voice in determining the shape and delivery of health and social care services within Darlington.

Working together the two organisations:

- Involve service users, patients and the public in planning and developing new and existing health and social care services that respond to identified local needs
- Ensure active listening and feedback to service users, patients and the public to prove that their views have made a difference at all levels, from AGM to local reporting via newsletters, Twitter and websites.
- Ensure that all the views of service users, patients and the public are heard, including those groups who are often on the margins of society
- Ensure that health care is based around need and is sensitive to differing values and preferences
- Ensure that service users, patients and the public are fully engaged in the process of information giving/receiving and the design of patient information

Recent joint working includes the Your Health, Your Town, Your Say event, Business and Community Roadshows, Enter and View visits to hospital wards and urgent care, #AskTheCCG college student visit, information sharing and help with engagement plans for the Planned Care and Urgent Care committees for the Clinical Programme Board.

Future activities include business and community #AskTheCCG events, Better Care Fund consultation, enter and view visits, engagement plans for specific work streams and for HWD to be a critical friend depending on the outcomes of their frequent consultations and feedback mechanisms.
Voluntary and Community Organisations

eVOLution are the local voluntary and community sector (VCS) infrastructure organisation for Darlington and are members of the CCG Community Council. They provide a voice for the VCS and aim to promote support and develop groups and organisations to bring about positive change in the lives of people and their communities.

There are many local voluntary and community sector organisations with a real commitment to improving outcomes for their service users. They recognise and value their staff and volunteers and continually look for new ways to benefit the people using their services.

In September the CCG launched an innovative funding project inviting proposals from the voluntary and community sector to better understand the sector and the challenges and opportunities it brings. Crucial to the success of the proposals was the ability to embrace the CCG’s project goal: “to enhance the quality of life for families in Darlington and ensure people receive the correct advice and support for their own health and wellbeing”.

The project attracted many imaginative proposals. The CCG look forward to more involvement from the VCS through the many other involvement and engagement opportunities in the future.

Call to Action

The North of England Commissioning Support Unit (NECS) team supported the CCG in encouraging local people to take part in ‘A Call to Action’, a discussion about the future challenges facing the NHS and how local services might change in order to deal with increasing demand and rising costs. Feedback informed the development of a range of 3-5 year strategies designed to safeguard the NHS into the future.

Your Health, Your Town, Your Say

In July 2013 Healthwatch Darlington (HWD) hosted an engagement event in partnership with the CCG and Darlington Borough Council (DBC). The event brought together residents, voluntary and community sector organisations, service providers and commissioners.

The CCG, HWD and DBC gave updates and feedback from the previous year’s event and information about future commissioning intentions and priorities. Feedback was gathered from workshop sessions and questions taken away to gain a better understanding of the needs of residents and organisations.

The objectives for the day were to:

- Learn more about ways to improve Health and Social Care services in Darlington
- Network and get to know each other better
- Learn from successes, and talk about challenges
• Understand how individuals can use their voices to influence change
• Have our say by working together

Discussion included GP access, the Choose Well campaign, what people value from GP practices, suicide prevention, discharge support, inappropriate systems, How to get involved/how to get your voice heard, Taking Responsibility, Adult Mental Health, Diabetes and the Francis Report.

Newsletters including the CCG’s response to attendees’ comments were distributed in August with an update on actions taken in December.

**Frail and elderly clinical summit**

The County Durham and Darlington Clinical Programme Board (CPB) is made up of senior leaders from local CCGs, hospitals and Primary Care. The board gathered in November 2013 to consider the needs of the frail and vulnerable elderly – one of the highest users of health and social care services. The experience of these users commonly demonstrates how services provided for them do not always reflect their needs, or co-ordinate well with each other.

AGE UK Darlington were invited as one of the guest speakers as was HWD and Healthwatch County Durham (HWCD) who had sought patient and carer views prior to the event.

The valuable input received was fed into the summit and two follow up events were held in January in Darlington and in County Durham specifically to give service users, carers and families the opportunity to take part in improvement workshops. Information from the events and feedback gathered from 160 individuals and organisations was included in a report for the CCGs to consider in their strategic plans and plans are now underway to implement some of the changes needed to better meet the needs of the elderly.

**Dementia work stream collaboration project - gathering evidence**

In January 2014 Clinical Commissioning Groups in Darlington and County Durham asked their local Healthwatch organisations to collaborate on a patient journey consultation. The consultation was carried out directly with dementia patients, their families and carers to enable their views, opinions and experiences to directly influence the Darlington and County Durham Dementia Strategy for 2014-17 and to highlight gaps in current dementia services.

The project highlighted the trials and tribulations that carers face on a daily basis, showing where services excel whilst also bringing areas for improvement to the forefront.

**Community Council**

The CCG Community Council acts as an advisory body, championing patient views, providing quality assurance and ensuring that quality services are provided in an appropriate, safe, effective and timely manner.
Local GP practices run Patient Participation Groups, most of which have elected a representative to attend the Community Council providing a direct link to the CCG governing body. The Council also includes representation from HWD and eVOLution.

The Community Council has met monthly since February 2013 covering topics such as the Francis Report, the primary care strategy, securing quality in hospital services, Call to Action, patient transport services and the Choose Well campaign. Recent discussions have included: the 111 service and the issues people face when using the system, end of life and palliative care especially concerns about the Liverpool Care Pathway, why people use accident and emergency instead of GPs and urgent care, the Better Care Fund and the Innovation Fund.

All of the CCG officers have been involved with conversations with the Community Council including the financial health of the CCG. Members appreciate the frank discussions and are keen to ensure the information is cascaded down to their respective patient participation groups and community groups.

The Community Council actively support the setting up of PPGs in Darlington and have already shared good practice between member representatives on engagement work.

**Challenges**

The CCG must continue to engage so that the local population knows who we are and understands our visions and priorities. We have to provide assurance that we will be listening to them and including them in decision making right from the start. As such we must:

- Maximise the use of joint resources and opportunities across partners e.g. The Joint PPIE Working Group
- Ensure we give enough time to consult and use different methods of consultation such as workshops, presentations, surveys and meetings
- Deliver timely feedback and answer questions in an honest and transparent way
- Ensure our bulletins, website and documents are jargon free and easy to understand
- Gain the trust of the local population to ensure their active participation in consultations and communications to help shape future services
- Be aware of the groups we have not yet engaged with effectively and continue to work with HWD to look at new and innovative ways reach our communities

**Patient and public engagement (PPE) framework template**

The CCG will adopt a standard ‘way of working’ which provides a checklist for commissioners and planners to understand PPE requirements. This includes methods of engagement, planning and evaluation. Objectives should be in place to provide meaningful engagement with hard to reach groups including the following:
Community and business engagement
Darlington has a diverse multicultural community, some of which are overlooked, and more work needs to be done to involve these groups in decision making. The CCG is looking to use councillors ward surgeries, community newsletters and community events to promote and engage via #AskTheCCG (small consultation events) at every opportunity. We are exploring the opportunity of working with local businesses to connect with these groups as many employers have a good intranet system which the CCG could use to post surveys and information. This needs to be fully explored and needs to be consistent to be effective.

Black minority and ethnic network
Presentations given to this network at a monthly meeting will reach representatives from the travelling community, Asian community, European community and many others. More work needs to be done and HWD are currently helping the CCG to look at tailoring engagement to each community. HWD are also exploring the Police and Community Together (PACT) meetings including the Polish PACT.

Children and Young People
HWD recently invited the CCG as part of the #AskTheCCG to speak to journalism students at Darlington College to give the students a better understanding of the health and social care system. Further engagement with new innovative ideas is necessary in this area especially with the Youth Parliament and potential health champions in secondary schools.

The year in focus
During our first year as a statutory body, we have worked hard to establish ourselves, focusing on improving the health of our local population and building on high standards of patient care.

We have strengthened relationships with partners across the health and social care sector, setting common goals, making the best use of shared resources and taking our first steps to develop services that will enable the people of Darlington to live longer, healthier lives.

Darlington Together; from rhetoric to reality
Public services continue to be challenged, both financially and by demographic changes. We require an imaginative response to ensure that local people are not disadvantaged as a result. Central to this is creating an environment where people can positively influence outcomes and clinicians are empowered to lead change. The CCG and Darlington Borough Council (DBC) share an Ambition for Excellence that delivers the right care in the right place at the right time with no waste, focusing on:

- Evidence-based, accessible, safe and effective services
- Care that delivers improvement in health outcomes and reduces inequalities
- Integrated care pathways and services across providers
Together with DBC we are developing an action plan for a single pooled budget for health and social care services as part of the Better Care Fund (BCF) which will come into full effect in 2015/16. We are using the fund to stimulate innovation locally and to wrap care and services around communities that will lessen the burden on acute services. The fund will support the vision and priorities in urgent care, mental health, frail elderly and long term conditions.

We have established an ‘Operating Model’ that ensures we work as a collaboration of commissioners and providers, where the interests of the patient is paramount and organisational interest will not get in the way of patient improvements.

Along with DBC we have examined a hypothesis that a single team operating across the local authority and NHS locally is best placed to serve the people of Darlington. We believe that the savings made can be invested front line services. Consequently, we have agreed to share our commissioning resource and pull together ‘health and social care’ commissioning into a single team as the first step towards a strategic partnership that puts the people and place of Darlington at the focus for planning and development.

As a member of the Darlington Health and Wellbeing Board we helped develop the Health and Wellbeing Strategy, which provides the overall framework for improving health and wellbeing across Darlington.

We have set up a Community Innovation Fund for local voluntary and community sector organisations that come up with innovative ideas for improving health and wellbeing locally. During the year we provided almost £60,000 for projects ranging from a club that helps homeless people access health services to a scheme promoting self-confidence through play for children living in the most deprived areas of the town. This year our Community Innovation Fund is:

- Helping the 700 Club to support homeless people and those at risk of being homeless through health lifestyle coaching
- Supporting AGE UK to establish five cafes for older people in Darlington, focusing on healthy hearts, alcohol reduction, depression, hearing loss and macular degeneration
- Helping the Alzheimer’s Society to introduce a ‘Singing in the Brain’ group, a music-themed activity that will run fortnightly and provide attendees with social and fun activities
- Enabling Skerne Park Community Enterprise Association to support families with young children to help make healthy and affordable choices about food and exercise
- Allowing Groundwork to continue to introduce inclusive play activities for children aged 5-13 years who live in some of the most disadvantaged areas promoting healthy lifestyles and the importance of physical activity and healthy eating

The CCG is also working with Darlington Borough Council, Tees, Esk and Wear Valley NHS Foundation Trust and County Durham and Darlington NHS Foundation Trust on a project that will allow people to manage their own long-term condition and
provide a clear pathway for treatment and services.

Primary care strategy and developing the collaborative ‘Caring for Darlington beyond Tomorrow’

The CCG has begun work on a long term programme to deliver significant changes in local service delivery. Starting with GP provision, we recognise that effective and integrated high quality Primary Care services are the bedrock for effective commissioning of other services and pivotal in achieving integrated pathways across health and social care services.

Early in 2013 Darlington CCG established a primary care strategy group under the leadership of Dr. Jenny Steel to capture views on challenges in General Practice and explore the value primary care contributes to the wider healthcare system. The engagement activities also tested the appetite for a different way of working, one that will preserve the best elements of general practice in Darlington and allow it to flourish.

From the initial findings we summarised that Darlington GPs are delivering quality services which are very much valued. However longer life expectancy together with more complex long-term conditions means that many doctors simply cannot continue to meet patient demand.

Dr. Steel has now progressed discussions with practices to a point to which there is an agreement from all eleven practices in Darlington to working more closely together to deliver primary healthcare services. We are delighted that Jenny and her colleagues have secured funding from NHS England Area Team to support the next steps and maintain the momentum of this project.

Better services

We took a step forward in our plan to improve services by relocating evening and overnight urgent care services from Dr Piper House in the town centre to the emergency department at Darlington Memorial Hospital. The integration of services was designed to provide local people with access to the right care, in the right place, first time. It will reduce the number of people who need to be redirected for treatment and mean that fewer people use the emergency department inappropriately.

We are also working with CCGs across Teesside and Durham to improve the quality of hospital care in our region. The Securing Quality in Health Services (SeQIHS) project looked at establishing clinical quality standards in acute hospitals in the areas of paediatrics and maternity services, acute care and end of life care. The next phase of the project will support organisations to work towards achieving these standards.

Improving care for people with chronic breathing problems across Darlington is a key objective. We are joining forces with colleagues in the local hospital trust and community services on a pilot pulmonary rehabilitation programme to improve care for patients with COPD (Chronic Obstructive Pulmonary Disease).
A two year pilot scheme to **enhance the quality of healthcare provision for care home residents** started in September 2013. The scheme sees Darlington GP practices coordinating patient care within nursing and residential care homes, undertaking weekly ward-round visits and working closely with staff at the home to improve use of medications, better care planning and improve care for residents in their final months of life. We expect that the scheme will dramatically improve the care of residents and help to reduce emergency hospital admissions and attendances at A&E.

The CCG has supported two high profile promotional campaigns over the year. Our 'Keep calm and look after yourself' campaign was designed to signpost local people to the right NHS service for their needs and remind them that many common winter ailments and illnesses are easily treated at home, or with advice from a pharmacist – with no need to see a doctor or nurse. The seven week long campaign was launched in November 2013 to coincide with the busy winter period.

The 'My Medicines, My Health' promotion started in February 2014. Collaboratively funded by the region’s 12 clinical commissioning groups, it was designed to encourage people over 60 years of age with long-term medical conditions to keep on top of their illness by storing all their medicines in one place and take them to any medical appointments. The campaign was advertised on regional TV, radio and in shopping centres.

The CCG actively supports the Darlington South Park Run, a free fun 5k run that takes place every Saturday morning. Open to everyone, irrespective of age or ability, the weekly time trial is an ideal opportunity for people to get fit, stay fit and improve fitness.

In January, the CCG worked with its partners Darlington, Drug and Alcohol Action Team, the local authority Licensing Unit, Pubwatch, Dry Friday and police to stage an alcohol-free pub crawl, 'Driday Night Out'. Darlington pubs offered promotions on soft drinks and non-alcoholic cocktails with the aim of showing people that they could have a good time without alcohol.

**Developments in clinical quality**

Assuring the quality of care and services is central to the work of the CCG and in partnership with other CCGs we have implemented processes and resources to ensure clinical quality is managed across local health services. We invested in ‘Patient Opinion’ to enable direct feedback and led the development of ‘Commissioner Visits’ to service providers. We achieve this by:

- Learning when things go wrong by ensuring our providers carry out analysis of critical incidents to prevent recurrence
- Looking at patient complaints to improve services and ensuring providers do the same
- Drawing from surveys and Friends and Family Tests to understand and improve the patient experience
- Setting challenging service standards for our providers, over and above those laid down by government
Friends and Family Test

The Friends and Family Test (FFT) was introduced in April 2013 and requires NHS Trusts to survey patients within 48 hours of discharge from hospital and find out if they would recommend our hospital to friends and family if they needed similar care or treatment?

From 1 April 2013 the FFT was implemented for inpatients and patients discharged from A&E and it was rolled out to maternity services in October 2013.

The FFT for maternity services asks women questions at three stages during their pregnancy, seeking feedback about antenatal care, birth and care on the postnatal ward and postnatal community care.

The graphs below compare the FFT data for the providers most frequently used by Darlington CCG patients. In May 2014 there was a refresh of FFT data for the months March 2013 through to January 2014 and this is now reflected in the results.

In-patient services, response rates and scores
Accident and Emergency Departments, response rates and scores

Maternity services, scores

Q1 - Antenatal Care

Q2 - Birth

Q3 - Postnatal Ward

Q4 - Postnatal Community Provision
Commissioner visit programme

In conjunction with other local CCGs, Darlington CCG operates a very successful rolling programme of visits to provider sites and services. This programme has been nationally recognised by NHS England as a good practice approach by the CCGs, ensuring quality services are being delivered in relation to the following areas:

- Healthcare associated infections
- Patient experience
- 15 steps challenge (first impressions, safety, involvement, privacy and dignity)
- Workforce and staffing
- Clinical quality
- Safeguarding adults
- Safeguarding children

The 2013-14 programme included visits to most of the main acute and community hospital sites within County Durham and Darlington as well as a number of care homes with which the CCGs directly commission beds. The programme also involved a series of visits to community nursing teams, ambulance stations, emergency departments and urgent care/walk-in centres.

At the end of each visit verbal feedback is provided and a formal report outlining visit findings is shared with the provider organisation within four weeks of the visit. Providers are requested to implement action plans and share these with CCGs in order that service improvements can be monitored.

Sustainability and the environment

Strategy

Our Sustainable Development Strategy sets out our commitment to work in ways which maximise the health, social and economic benefits our activities bring to the community while minimising our impact on the environment.

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

Working in a sustainable way means rethinking a lot of what we do. It affects not only the major strategic decisions we take but also how we go about our daily business.

Getting these decisions right will not only help us save money, eliminate unnecessary waste in the system and reduce our carbon footprint; it demonstrates to partners and the public that the CCG is dedicated to enhancing individuals' wellbeing through our work as commissioners of high quality health services, but also by enhancing the wellbeing of the local and global community through taking seriously our corporate responsibilities.
Greenhouse gas emissions and use of finite resources
Data in relation to greenhouse gases and finite resources for the CCGs properties, that are leased from NHS Property Services, could not be provided to the CCG by NHS Property Services for the current year, but will be disclosed in future years.

Waste
We work hard to minimise the creation of waste. The CCG has a robust approach to recycling. Paper, cardboard, glass, metal, ink cartridges, batteries, waste electrical goods and confidential waste are all recycled.

Equality and diversity
NHS Darlington CCG takes equality and human rights into account in everything we do, whether commissioning services, employing people, developing policies, communicating, consulting or involving people in our work.

Using the Equality Delivery System (EDS) framework, we embed equality into all our core business functions and see it as an opportunity to raise equality in service commissioning and performance for the community, patients, carers and staff.

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

Our staff
Our staff continue to manage through unprecedented levels of change as new NHS architecture and new organisations were established.

Equality and diversity training is a mandatory requirement for our staff. Anyone involved in recruitment is required to undertake recruitment and selection training which includes awareness of equality and diversity legislation as it relates to the recruitment process. All staff receive a copy of the quarterly newsletter which contains up-to-date information on equality, diversity and human rights legislation and developments.

Our annual absence rate is 1.2% with an average of 3.75 days being lost each calendar month. CCG policies are in place and applied to manage sickness absence effectively across the staff group.

Equal opportunities for staff
We demonstrate fair recruitment, workforce engagement and employment terms and conditions for staff at all levels in the organisation.
Our governing body members are made up of the following:

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing body members</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Very senior managers</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>CCG employees</td>
<td>2</td>
<td>9</td>
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</table>

**Working relationships**

Engagement and partnership is an important part of our culture, our partnerships with local NHS Trusts, voluntary and community sector organisations and community groups enable us to identify the needs of our diverse community.

We invite people to be involved as little or as much as they like, enabling them to help shape and influence the way NHS health services are commissioned. In particular in 2013/14 we have consulted widely on the proposed relocation and integration of the Urgent Care Service in Darlington.

**Open approach**

As an open, accessible commissioning group we work hard to ensure our services are inclusive and welcoming to everyone. Our public buildings are accessible for people with a disability and we’ve earned the two tick ‘positive about disabled people’ symbol which demonstrates our commitment to employ, retain and develop disabled staff.

When it comes to providing information, we are committed to using everyday language wherever possible, including interpreting services. Public information is offered in other languages and formats such as large print, Braille or audio.

**Compliments and complaints**

We welcome all feedback, positive or negative, and have invested in ‘Patient Opinion’ as a tool to secure direct feedback from local people. Feedback is routinely invited through the website www.darlingtonccg.nhs.uk and Twitter account @DarloCCG. Feedback on people’s experience of local NHS services will helps us to improve services for patients.

**Financial review**

**Financial performance**

The funding allocated to Darlington CCG for 2013/14 was £135.5m, comprising resource to spend on healthcare of £132.9m and an allowance for administration or running costs of £2.6m.

The CCGs net spend on healthcare was £132.8m and on administration was £2.4m resulting in an under spend of £0.3m.

The CCG's financial plan was developed to deliver a surplus of 1% in 2013/14. However it was apparent during the year that this would be challenging and the CCG failed to achieve this, reporting an overall surplus of £0.3m for the year which was
£1m lower than initially planned. Higher than planned costs relating to acute hospital care and high prescribing costs resulting from increases in nationally agreed drugs tariffs were the key drivers of the CCGs failure to perform in accordance with its financial plan. The factors driving the CCGs financial performance have been addressed in operational and strategic plans including the re-establishment of its requirement to generate a 1% surplus.

The chart below indicates how the CCGs funding was split across the services we commission:

The need to increase the funding available for hospital services and prescribing limited the ability of the CCG to invest in service developments and improvements during the course of the year, however a small number of schemes were funded, including:

- Scheme to improve care to patients in nursing and residential care homes in Darlington
- A pilot scheme to provide a rapid response nursing service to palliative care patients
- Enhancement of mental health liaison services
Key financial performance targets

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Performance for Darlington CCG in 2013/14 was as below:

<table>
<thead>
<tr>
<th>Non NHS</th>
<th>NHS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target</strong></td>
<td>95.0%</td>
</tr>
<tr>
<td><strong>Result by number</strong></td>
<td>97.9%</td>
</tr>
<tr>
<td><strong>Result by value</strong></td>
<td>96.9%</td>
</tr>
</tbody>
</table>

Darlington CCG met its duties under the NHS Act 2006 (as amended) with performance against each duty as follows:

<table>
<thead>
<tr>
<th>Duty</th>
<th>Target £000</th>
<th>Performance £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>135,502</td>
<td>135,177</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>135,502</td>
<td>135,177</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>132,892</td>
<td>132,815</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>2,610</td>
<td>2,362</td>
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</table>

Governance, audit and risk committee

A governance, audit and risk committee was in place for Darlington CCG throughout 2013/14.

The role of chair of the governance, audit and risk committee was undertaken by Michelle Thompson in an interim capacity until November 2013, at which point John Flook was appointed as chair.

Other members of the governance, audit and risk committee during 2013/14 were:

- Dr Patrick Holmes, GP and Deputy Lead Clinician
- Dr Richard Harker, GP and CCG Quality Lead
- Lucy Hansen, Secondary Care Clinician
- Andie Mackay, Lay Member
Looking forward

We recognise that in the coming months, with financial uncertainty, we will face many challenges. Within Darlington, there are increasing demands of an ageing and growing population which will increase pressure on services but we need to ensure that we are still maintaining high quality services and ensuring services that we buy are safe and for the benefit of our patients.

The coming years will present further significant financial pressures to Darlington CCG as the demand for health services is expected to grow faster than our funding. It is clear that the existing models and pattern of service provision are unlikely to sustain service quality and reasonable access in the light of foreseeable financial settlements for the NHS nationally. In developing our plans for the next five years we have set a clear direction of travel that requires us to work closely with healthcare providers and other partners such as the local authority to secure the continuity of high quality health care services for the population of Darlington. In so doing we will continue to put the patient at the centre of the healthcare system. This will involve the redesign of some services with a greater focus on the provision of care outside of acute hospital settings where safe and appropriate.

In 2015/16, the Better Care Fund is being introduced which is a single pooled budget across both the CCG and the local authority with the aim to enable us to transform integrated health and social care. This in itself will require substantial changes in the way that services are delivered, with a focus on services being delivered where possible closer to patients homes within the community.

In taking the CCG plans forward the burden of expectation of GPs and other professionals needs to be recognised as we ask an increasingly small cadre of dedicated professionals to free themselves from their day job to ensure that decisions continue to be clinically informed.

Martin Phillips
Accountable Officer
5 June 2014
Members report

Governing body

The governing body is responsible for reviewing decisions and formally approving all the plans for NHS Darlington Clinical Commissioning Group. Details of Members of the Membership Body and Governing Body are below.

Governing body:

Dr Andrea Jones, Chair
Originally from Leeds Andrea qualified as a doctor from the University of Newcastle, started work as a GP in 1990. As Chair of the Darlington CCG her role includes overall responsibility of the governing body and engagement of clinicians, the public, patients and key stakeholders.

Martin Phillips, Chief Officer
Martin joined the NHS in 1984 as a graduate working in Sunderland. He has accumulated almost 30 years of experience in the North East, working in a range of operational, planning and commissioning roles.

Dr Patrick Holmes, Deputy Lead Clinician
Patrick qualified as a GP in 1998 and joined the Felix House Surgery, Middleton St. George in the same year. In addition to being Deputy Clinical Lead, he has specific roles in developing services for the care of long-term conditions. He chairs the CCG Members’ Assembly.

Dr Richard Harker, Quality Lead
Richard was born and bred in Darlington and has been a GP for 28 years. His main interests are quality in General Practice and performance assessments of doctors giving concern.

Lucy Hansen, Secondary Care Clinician
Lucy is a Consultant Physician at Northumbria Health Care Foundation Trust.

Michelle Thompson, Lay Member for Patient and Public Involvement
A volunteer who lost her sister to cancer then survived the disease herself, Michelle has pledged to ensure a strong voice for patients. She raises funds and awareness for Macmillan Cancer Support, and is also the Chair of Healthwatch Darlington.
John Williams, Governance Lay Member (until 30.04.13)

John Williams was formerly leader of Darlington Borough Council and served on the County Durham and Tees Strategic Health Authority. John passed away in July 2013 following a serious illness.

John Flook, Governance Lay Member, (from October 2013)

John has a wealth of NHS and financial expertise built up during his 20 years’ experience as director of Finance and in non-executive roles across the North East.

Andie Mackay, Lay Member (from October 2013)

Andie is a serving firefighter with over 27 years’ experience with the County Durham and Darlington Fire and Rescue Service.

Lisa Tempest, Chief Finance Officer

Lisa joined from South Tees Hospitals NHS Foundation Trust, where she was Chief Operating Officer for the Community Services Division. Prior to joining the NHS in 2008, Lisa worked for BASF plc, National Power plc and Nike.

Elizabeth Graham, Chief Nurse and Quality Lead

Liz trained as a registered nurse and midwife in the 1970s. Her previous roles included senior midwife for quality assurance and staff development at North Tees and Hartlepool Hospitals NHS Foundation Trust. She was previously Director of Nursing and Clinical Quality at NHS County Durham and Darlington Primary Care Trust.

Member practices

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
<th>Postcode</th>
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<tbody>
<tr>
<td>Blacketts Medical Practice</td>
<td>63-65 Bondgate, Darlington</td>
<td>DL3 7JR</td>
</tr>
<tr>
<td>Felix House Surgery</td>
<td>Middleton Lane, Middleton St George, County Durham</td>
<td>DL2 1AA</td>
</tr>
<tr>
<td>Orchard Court Surgery</td>
<td>Orchard Road, Darlington</td>
<td>DL3 6HZ</td>
</tr>
<tr>
<td>Carmel Medical Practice</td>
<td>Nunnery Lane, Darlington</td>
<td>DL3 8SQ</td>
</tr>
<tr>
<td>Parkgate Surgery</td>
<td>Park Place, Darlington</td>
<td>DL1 5LW</td>
</tr>
<tr>
<td>Rockliffe Court</td>
<td>Hurworth Place, Darlington</td>
<td>DL2 2DS</td>
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<tr>
<td>Clifton Court Medical Centre</td>
<td>Victoria Road, Darlington</td>
<td>DL1 5JN</td>
</tr>
<tr>
<td>Moorlands Surgery</td>
<td>139a Willow Road, Darlington</td>
<td>DL3 9JP</td>
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<tr>
<td>Whinfield Surgery</td>
<td>Whinbush Way, Darlington</td>
<td>DL1 3RT</td>
</tr>
<tr>
<td>The Surgery</td>
<td>Denmark Street, Darlington</td>
<td>DL3 0PD</td>
</tr>
<tr>
<td>Neasham Road Surgery</td>
<td>186 Neasham Road, Darlington</td>
<td>DL1 4YL</td>
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# Governing body and committees members 2013/14 CCG

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Governing Body (Public 7 closed)</th>
<th>Executive (1)</th>
<th>Members Assembly (7)</th>
<th>Clinical Leadership Group (4)</th>
<th>Governance Audit and Risk (6)</th>
<th>Quality and Innovation (12)</th>
<th>Finance and Performance</th>
<th>Community Council (10)</th>
<th>Remuneration and Terms of Service (2)</th>
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<tr>
<td>Robert (Steve) Charlton</td>
<td>GP and Practice Representative for Orchard Court Surgery</td>
<td>M (1)</td>
<td></td>
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<tr>
<td>Karen Crook</td>
<td>Practice Manager for Carmel Medical Practice</td>
<td>M (3)</td>
<td></td>
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<tr>
<td>John Flook</td>
<td>Governance Lay Member for Carmel Medical Practice</td>
<td>M (1)</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Ahmet Fuat</td>
<td>GP and Practice Representative for Carmel Medical Practice</td>
<td>M (2)</td>
<td></td>
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<tr>
<td>Angela Gill</td>
<td>Practice Nurse Representative for Whinfield Medical Practice</td>
<td>M (1)</td>
<td></td>
<td>M (0) – until Sept 13</td>
<td>M (2)</td>
<td>M (3)</td>
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<tr>
<td>Elizabeth Graham</td>
<td>Chief Nurse and Quality Lead</td>
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<td>M (9)</td>
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<td>M (11)</td>
<td>M (9)</td>
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<tr>
<td>Richard Harker</td>
<td>Quality Lead, GP Partner and Practice Representative for Whinfield Medical Practice</td>
<td>M (2)</td>
<td>M (6)</td>
<td>M (7)</td>
<td></td>
<td>M (0) – until Sept 13</td>
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<td>C (9)</td>
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<tr>
<td>Lucy Hansen</td>
<td>Secondary Care Clinician</td>
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<tr>
<td>Patrick Holmes</td>
<td>Deputy Lead Clinician and Practice Representative for Felix House Surgery</td>
<td>M (3)</td>
<td>M (5)</td>
<td>C (7)</td>
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<td>M (2)</td>
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<tr>
<td>Sally Hutchinson</td>
<td>Practice Manager for Denmark Street Surgery</td>
<td>M (3)</td>
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<td></td>
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<tr>
<td>Paul Irving</td>
<td>Practice Manager for Moorlands Surgery</td>
<td>C (4)</td>
<td>M (8)</td>
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<tr>
<td>Andrea Jones</td>
<td>Chair</td>
<td>M (5)</td>
<td></td>
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<tr>
<td>Jackie Kay</td>
<td>Assistant Chief Officer</td>
<td>IA</td>
<td>M (5)</td>
<td>IA</td>
<td></td>
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<tr>
<td>Gail Linstead</td>
<td>Commissioning Manager</td>
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<tr>
<td>Andie Mackay</td>
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## Non-CCG

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<th>Quality and Innovation</th>
<th>Finance and Performance</th>
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<td>Darren Archer</td>
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<td>Jean Thurkettle (Apr – May)</td>
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The internal and external auditors attend the Governance, Audit and Risk Committee.
### Register of interests (2013/2014)

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Gifts &amp; Hospitality</th>
<th>Remuneration</th>
<th>Related Undertakings</th>
<th>Contracts</th>
<th>Houses, Land &amp; Buildings</th>
<th>Shares &amp; Securities</th>
<th>Non-Financial Interests</th>
<th>Election Expenses</th>
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<tr>
<td>Andrea Jones</td>
<td>CCG Chair</td>
<td>No interest declared</td>
<td>From 01/05/13 – 30/03/14 Salaried GP working one day a week at Felix House Surgery</td>
<td>No interest declared</td>
<td>No interest declared</td>
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<td>Chair of Parish Meeting at Great Stainton village in the Borough of Darlington</td>
<td>No interest declared</td>
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<tr>
<td>Richard Harker</td>
<td>DCCG Quality Lead GP Partner and Practice Representative for Whinfield Medical Practice</td>
<td>No interest declared</td>
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<td>Vice Chair of Board of Trustees St Theresa’s Hospice</td>
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<tr>
<td>Patrick Holmes</td>
<td>Deputy Lead Clinician and Practice Representative for Felix House Surgery</td>
<td>Occasionally receives funding to cover travel and accommodation to attend the National &amp; International Congresses by Pharmaceutical Companies</td>
<td>Occasionally works for a number of pharmaceutical companies. Research grants State/Education + Industry</td>
<td>Director of Middleton Pharmacy Ltd, DL2 1BN Partner at Felix House Surgery DL2 1AA</td>
<td>No interest declared</td>
<td>Part-own some land in Middleton St. George, close to High Scrogg Farm (potential land for developing a future surgery)</td>
<td>Owns shares in a managed fund – it is possible that this may be healthcare related. Fund is not managed by Dr Holmes</td>
<td>No interest declared</td>
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<td>Wife is employed as a Paediatric Physiotherapist at CDDFT, Member of UNITE</td>
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<tr>
<td>Name</td>
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<td>Full time employment at Northumbria Healthcare NHS Foundation Trust &amp; Medical Major Incident Commander for North East Ambulance Service</td>
<td>Principal Investigator undertaking a non-interventional study of the use of rivaroxaban vs warfarin for deep vein thrombosis, Funded by Bayer into Northumbria trust research fund</td>
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<td>Lucy Hansen</td>
<td>Secondary Care Clinician</td>
<td>No interest declared</td>
<td>Full time employment at Northumbria Healthcare NHS Foundation Trust &amp; Medical Major Incident Commander for North East Ambulance Service</td>
<td>Principal Investigator undertaking a non-interventional study of the use of rivaroxaban vs warfarin for deep vein thrombosis, Funded by Bayer into Northumbria trust research fund</td>
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<td>Sister is employed as Podiatrist by North Tees and Hartlepool FT</td>
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<td>Matthew Sawyer</td>
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<td>Chris Mathieson</td>
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<td>James Nevison</td>
<td>GP Partner and Practice Representative, Denmark St Surgery</td>
<td>Partner at Denmark St Surgery</td>
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<td>Jenny Steel</td>
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<td>Director of Blacketts Skin &amp; Laser Clinic</td>
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<td>Charles McGarry</td>
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<td>Member of the Sedgefield locality executive committee of DDES CCG</td>
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<td>Anthony Shaw</td>
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<td>Prof Ahmet Fuat</td>
<td>GP and Practice Representative for Carmel Medical Practice</td>
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<td>Alison MacNaughton-Jones</td>
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<td>Richard Stevens (Oct – Mar)</td>
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<td>Partner at Orchard Court</td>
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<td>Robert (Steve) Charlton (Apr – Sept)</td>
<td>GP and Practice Representative for Orchard Court Surgery</td>
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Pension liabilities
Treatment of pension liabilities in the accounts is outlined in note 1.9.2 and 3 of the accounts.

Sickness absence data
A table is included in the employee benefits note to the financial statements and shown in note 3.3 of the accounts.

External auditors
Following a procurement process undertaken by the Audit Commission, PricewaterhouseCoopers LLP were appointed as auditors to the CCG for 2013/14. The cost of audit services can be found in note 4 of the CCG’s annual accounts.

The auditors took an annual work plan to the governance, audit and risk committee for approval.

This confirmed that the audit team are independent of the CCG and also would include any details of non-audit work if applicable. When considering whether the level of non-audit work is appropriate the CCG would consider if the auditors continue to be independent.

Disclosure of serious untoward incidents
Information on the disclosure of serious untoward incidents is referenced in the governance statement which can be found on page 47.

Cost allocation and setting of charges for information
We certify that the clinical commissioning group has complied with HM Treasury’s guidance on cost allocation and the setting of charges for information.

Principles for remedy
*Principles for Remedy* published by the Parliamentary and Health Service Ombudsmen in May 2010 have been adopted by the CCG as part of best practice recommendations within the complaints procedure.

Employee consultation
We have regular communication with our employees at Darlington CCG. Some of the mechanisms that we include are:

- Our chair and chief officer report and an overview of our governing body is sent to all employees
• Monthly stakeholder bulletin that is circulated to employees
• Regular news and updates are cascaded throughout the team
• Weekly staff meeting and monthly members’ assembly meetings
• The use of our website and intranet, Communications Wall and GP Teamnet

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

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

Statement as disclosure to auditors
Each individual who is a member of the Governing Body at the time the Members Report is approved confirms:

• So far as the member is aware the is no relevant audit information of which the CCG external auditor is unaware
• That the member has taken all 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’s auditor is aware of that information

Martin Phillips
Accountable Officer
5 June 2014
Statement by the Accountable Officer

Statement of Accountable Officer’s responsibilities

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

Martin Phillips
Accountable Officer
5 June 2014

Governance statement by the Accountable Officer

1. Scope of responsibility

The Clinical Commissioning Group (CCG) was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the NHS Act 2006. Prior to this date the CCG operated in ‘shadow’ form as a Committee of its predecessor Darlington Primary Care Trust. The period of ‘shadow’ operation allowed the CCG to complete its authorisation without any conditions being placed upon it by NHS England.

The Governing Body of the CCG is accountable for internal control. As Accountable Officer, and Chief Officer to the Governing Body of the CCG, a new statutory organisation, I have responsibility for establishing and maintaining a sound system of internal control for policies, aims and objectives. I also have responsibility for the safeguarding of public funds and departmental assets as set out in the Accountable Officer Memorandum and assigned to me in Managing Public Money. As Accountable Officer, I am personally responsible for ensuring that public funds are safeguarded and that the endeavours of the CCG are administered prudently and economically and that resources are deployed efficiently and effectively and with due regard for financial propriety and regularity.

2. The purpose of the system of internal control

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

- Identify and prioritise the risks to the achievement of the policies, aims and objectives
- 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 has been in place in the CCG for the year ended 31 March 2014 and up to the date of approval of the Annual Report and Accounts.
3. Capacity to handle risk
As Chief Officer, I have overall accountability for the management of risk, risk management systems and internal controls in place across the CCG together with the development of corporate governance and assurance framework so that all the statutory requirements are met to ensure positive performance towards our strategic objectives. All officers of the CCG and its agents recognise that the effective management of risk is part of everyday management of business and Directors are responsible for:

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

There are a number of systems and processes in place to ensure the Governing Body receives robust assurances on the overall effectiveness of arrangements. These are set out in the Governance Framework. Arrangements for controlling risks, including support for staff are set out in the risk and control arrangements.

4. Governance framework
The Constitution sets out the duties, responsibilities and overall framework for the good governance of the CCG. The Constitution approved by NHS England in October 2013 sets out the structures systems and process for the discharging of duties, delivery of responsibilities and arrangements for decision-making.

The Governing Body comprises a Clinical Leader who is the Chair, two GP members, a Chief Nurse, Chief Finance Officer, a secondary care clinician, three lay members including one with specific responsibilities for Governance, Audit and Risk as well as one with specific responsibilities for Patient and Public Involvement and Engagement. As Accountable Officer I am also a member of the Governing Body. The lay members, together with the secondary care clinician have important roles within the governance framework of the CCG.

The Governing Body has an ongoing role in reviewing the CCG’s governance arrangements to ensure that these continue to reflect the principles of good governance. The Governance Risk and Audit Committee plays a key role in supporting this by providing assurance to the Governing Body around the risk and governance processes within the CCG.

During the year 2013/14 the CCG’s Governing Body met on four occasions. All meetings were held in public and agendas were structured to deal with strategic, performance, quality assurance, risk and governance issues.

The Governing Body has established five principle Committees for the conduct of its business as well as a Remuneration and Terms of
Service Committee and Clinical Leadership Group. Each Committee is chaired by a member of the Governing Body and all have important roles in the governance framework. The two service Committees are comprised of member practices and chaired by a GP. The Quality and Innovation Committee is chaired by the GP lead for Quality and the Finance and Performance Committee is chaired by the deputy lead clinician. Both Committees have delegated responsibility for and effective scrutiny of the quality and innovation and finance and performance.

The Governance Audit and Risk Committee is chaired by the lay member with the lead role in overseeing key elements of Governance and the Community Council of Patients, Public and Cares by the lay member championing Patient and Public Involvement. The Governing Body is also supported by an Executive which I chair.

As a member organisation, the CCG’s member practices are best placed to direct informed arrangements so that the interests of patients and their care are central to the commissioning decisions of the CCG. I have therefore created an Assembly for members that holds the Governing Body clinically to account. The Members Assembly is chaired by a representative of a member practice.

The roles of each of the Governing Body Committees are set out broadly below. The Governing Body Committees have authority under the Scheme of Delegation to establish sub-committees or sub-groups to enable them to fulfill their role. Each committee has detailed Terms of Reference which are...
referenced within the CCG’s Constitution and are available on the CCG’s website. Each Committee is authorised by the Governing Body to pursue any activity within their Terms of Reference and within the Scheme of Reservation and Delegation.

**Remuneration and Terms of Service Committee**

The Committee is established to make recommendations to the Governing Body on pay and remuneration for senior employees of the CCG and people who provide services to the CCG. This includes remuneration for executive officers as well as the Chair and independent lay members and other Governing Body members. The Committee also consider any business cases for early retirement and redundancy.

**Governance Audit and Risk Committee**

The governance, audit and risk committee supports the governing body in its main function of ensuring the CCG has made appropriate arrangements in place to assure that the CCG exercises its functions effectively, efficiently and economically and adheres to relevant principles of good governance, specifically that the CCG has good systems and processes across all of its functions and statutory responsibilities.

The committee has oversight to review any decision where a GP or other individual has declared an interest, but has agreed to continue to be engaged in the consequent discussion and potentially the decision. Its work will dovetail with that of the quality and innovation committee to seek assurance that robust clinical quality is in place to assure the CCG of its responsibilities for safeguarding and mandatory training.

The Committee’s cycle of business includes review of the CCGs risk management processes, including the Assurance Framework and corporate risk register. The Committee considers the work of both internal and external audit, together with other assurance functions including in particular those relating to North of England Commissioning Support (NECS), upon which the CCG is dependent for the majority of commissioning support, to fulfil its role of providing assurance to the Governing Body.

The Governance Audit and Risk Committee, as part of its terms of reference, provides an Annual Report of its work to the Governing Body and interim updates as required. The report covering the financial year 2013/14 will be available alongside the final Annual Report and Accounts in June 2014 to support the final Annual Governance Statement. The principal purpose of the report is to provide assurance to the Governing Body and to support the Accountable Officer’s review of the internal control arrangements. The Governance Risk and Audit Committee has a business cycle which enables the Committee to carry out the objectives necessary to support its assurances regarding the effectiveness of the organisation’s internal controls.

**Finance and Performance Committee**

The Finance and Performance Committee supports the CCG to achieve financial balance, including delivery of QIPP financial targets, and organisational performance objectives, through reviewing performance in-year and implementing relevant any actions as required.
Quality and Innovation Committee

The quality and innovation committee are driven by an ambition of excellence in clinical quality, clinical effectiveness and patient experience, and the priorities for the Group to improve health outcomes and all associated risks or areas of quality improvement. It will lead innovation and embed best practice principles in commissioned services, always acting with a view to securing continuous improvements in the quality of care and services. The Committee will innovate and oversee research to deliver health gain, improved patient safety and a better experience for patients.

Executive Team

The Governing Body has delegated the day to day operational management of the CCG to the Executive Team. This includes the implementation and delivery of plans agreed by the Governing Body.

The CCG has not entered into any formal joint committees with other CCGs or any other organisations. Collaborative working arrangements have been developed with a number of other CCGs, including joint arrangements with the CCGs in the North of England to determine commissioning for health gain policies and to review and approve individual funding requests, including conducting an appeals process. These joint working arrangements do not represent formal joint committees and the CCG retains responsibility for making any relevant decisions in line with the Scheme of Reservation and Delegation.

In reviewing and assessing the effectiveness of the Governing Body, the guidance contained within The UK Corporate Code of Governance (2012) has been further developed into a Governing Body ‘self-assessment’ questionnaire. The guidance contained within the Code has enabled a detailed review of Governing Body effectiveness against the following criteria – leadership, effectiveness, accountability, remuneration and relations with stakeholders on a ‘comply or explain’ basis. This has been supported by a dedicated session for the Governing Body to review compliance with the Code and further Governing Body development will continue throughout the year. In particular, having reviewed the effectiveness of the CCG’s governance framework and arrangements in relation to The UK Corporate Code of Governance, I consider that the organisation complies with the principles and standards of best practice contained within the guidance as described.

5. The risk and control arrangements


The Risk Management Policy sets out the CCG’s approach to the assessment and management of clinical and non-clinical risk in fulfilment of our overall objective to support the delivery of the CCGs vision of improving the health of local people by commissioning high quality and safe services. This includes the processes and
procedures adopted by the CCG to identify, assess and appropriately manage risks and the detailed roles and responsibilities for risk management. It provides guidance for the systematic and effective management of risk. Key elements of the Risk Management Policy include:

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

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

Counter Fraud activity plays a key part in deterring risks to the organisation’s financial viability and probity. An annual Counter Fraud Plan is agreed by the Governance Audit and Risk Committee which focuses on the deterrence, prevention, detection and investigation of fraud.

Counter Fraud requirements and regulations have been specifically discussed with both the Governing Body and wider CCG employees during the year to cement their knowledge and understanding of Counter Fraud arrangements, with all employees also required to complete e-learning training. Risk management is embedded in the all systems and processes of the clinical commissioning group. For example, any proposal for a decision by the CCG requires a compliance with its Patients Charter and equality impact assessments.

The Governance Audit and Risk Committee manage the Assurance Framework and Risk Register on behalf of the Governing Body.

6. Risk assessment

Operational and financial risk is inherent in any organisation no less so in the CCGs commissioning responsibilities. Risk management assessment is an integral part of prudent management flowing through from strategy development through to delivery of operational plans. All risks are identified and evaluated in accordance with the Risk Management Policy, through the process set out below, collated into a single register and assigned to a Committee and senior officer. Action plans are then developed with clear timescales in relation to the identified risk.
All risks are reviewed monthly by the appropriate Committee to ensure they are appropriately assessed and that action is being taken, with the Executive Team and Governing Body performing an overall review of all risks. Risks identified as having the potential to significantly impact on CCG corporate objective are escalated and specifically reviewed by Governing Body.

The Governance Audit and Risk Committee ensure that the CCG adheres to a robust risk management assessment process. Active steps are taken to ensure that it is regularly updated. In addition, all CCG policies and reports are assessed for equality impact. The CCG also takes measures to secure and take account of the views of its stakeholders, including:

- **Patient and the Public**: The Governing Body meets in public, receiving a report from its lay member that champions Patient and Public Involvement, through its Community Council, Commissioner Visits, regular involvement with the work of the Health and Partnerships Scrutiny Committee, Health and Wellbeing Board, consultations with local people on service change and improvements and commitment to its Patient Charter.

- **Members and Staff**: Personal Objectives/Personal Development Plans linked to CCGs operational and strategic priorities, Members Assembly, regular surveys, supporting Protected Learning Time.
• Other Stakeholders: Working with other partners through Health and Wellbeing Board, Clinical Quality Review Groups and the quarterly Assurance and Performance meetings with NHS England

7. Information governance

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

The CCG’s Information Governance Framework comprises of an approved strategy, a suite of approved policies and procedures, a programme of mandatory training, information risk management, incident management and has also adopted and implemented the Health and Social Care Information Centre’s (HSCIC), ‘Checklist for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation’.

The CCG has in place a standard operating procedure for the reporting of level 2 Information Governance (IG) incidents to the Information Commissioner. This procedure outlines the scope of responsibilities and details the reporting procedures to be used in the event of a data security breach.

There have been no Information Governance breaches in year requiring disclosure to the Information Commissioner or within the annual report. Information Governance processes and arrangements are reviewed by the Governance, Audit and Risk Committee, with the Executive Team overseeing the day to day management of systems and processes. The CCG has also appointed a Caldicott Guardian and Senior Information Risk Owner.

The CCG has published the HSCIC Information Governance Toolkit and has self-assessed as being overall compliant, which confirms the organisation’s rating as overall ‘satisfactory’ in this regard. In accordance with the agreed internal audit plan for 2013/14 an audit of the IG Toolkit self-assessment was undertaken and the outcome of this Audit was that ‘significant assurance’ was warranted.

The CCG complies with its statutory duty to respond to requests for information. During the year the CCG received 205 requests under the Freedom of Information Act 2000 and no requests under the Data Protection Act 1998. All the requests were responded to within the statutory timescales. There have been no Serious Untoward Incidents relating to data security breaches involving the CCG during 2013/14 or up to the date of this statement.

The quality of the data used throughout the CCG, including by Governing Body and all other committees, is considered to be of an appropriate standard and is sufficient to enable all committees to make informed decisions. Much of the information is derived from established national systems and processes, with appropriate review
and reconciliation mechanisms in place before the data is presented to Governing Body or any other committees.

The key corporate risk in year has been the financial health of the CCG following the changes to the organisation of the NHS with effect from April 2013. This has been challenging but the work throughout the year has put in place firm foundations for the sustaining health and healthcare services for people in Darlington. The CCG along with its partners will need to continue to work together to address challenge into the future and the work of ‘Securing Quality in Health Services’ in the cold economic climate. The principle clinical challenges have been around the effective management of emergency and urgent care.

The financial climate for public sector services continues to be bleak which, alongside the increasing demands of an ageing and growing population, will increase pressure on services and potential risks around delivery of performance targets whilst maintaining quality and ensuring services are safe, within available financial resources.

The introduction of the Better Care Fund in 2015/16, a single pooled budget across the CCG and local authority, designed to enable transformation in integrated health and social care, will require substantial change in the way services are delivered with an unprecedented shift in activity required away from hospital and into community settings.

The CCG has agreed a two year operational plan, incorporating the Better Care Fund, with a five year strategic plan in development, all supported by a financial plan. These plans demonstrate how pressures will be managed to enable continued achievement of a balanced financial position whilst also delivering on the strategic aims of the CCG. This remains a substantial risk however, with the impact of the Better Care Fund in particular representing a significant challenge. The implementation of these plans and the schemes designed to take activity out of the acute sector.

8. Review of the effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control.

The CCG has developed systems and processes in place for managing its resources. Robust financial governance arrangements have been maintained throughout the year, including the Standing Orders, Scheme of Delegation and Prime Financial Policies incorporated within the CCG Constitution, supplemented by the CCG’s Standing Financial Instructions and detailed financial limits, all of which provide the framework through which the CCG discharges its business.
Annual budgets were set by the CCG prior to the start of the financial year, based on the medium term financial plan, which set the basis on which resources will be utilised. The financial planning and budget setting process incorporates a review and prioritisation of commissioning intentions and investment decisions to enable the most appropriate use of available resource. Annual budgets and longer term financial plans are reviewed and approved by the Governing Body. This includes plans to deliver against the Quality, Innovation, Productivity and Prevention (QIPP) agenda.

This is supported by comprehensive and established systems of internal control which help to govern the effective use of resources. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework (AF) and on the controls reviewed as part of the Internal Audit Programme. Executive officers, clinical and member leads within the CCG have responsibilities for the development and maintenance of effective arrangements for risk management and internal controls. The AF provides me with assurance that the effectiveness of controls that manage risk to the organisation achieving its aims and objectives has been reviewed.

Both the Executive Team and Finance and Performance committees play a key role in managing performance and delivery against financial plans, ensuring appropriate action is taken to address any issues as required and providing assurance to the Governing Body that resources are being utilised in line with plans. In addition, monthly finance reports are also reviewed by the Governing Body, showing performance against budgets and financial targets, including the QIPP plan.

A service auditor reporting process has been implemented to provide assurance over the effectiveness of controls and processes within NECS. For 2013/14 this report will only cover the six months from 1 October 2013 to allow a period of relative stability to be reviewed. The final Service Auditor Report, dated 12 May 2014, and the results of internal audit work commissioned by NHS England, as the host organisation of NECS, have been shared with the CCG and demonstrate no major deficiencies that would have a significant impact on the operations of the CCG.

The CCG also has additional systems of control and review mechanisms internally over the work performed by NECS which provide additional assurance that there have been no significant internal control issues which have impacted on the CCG.

My review of the effectiveness of the system of internal control is informed by a number of reports from and work of the Committees of the Governing Body between 1 April 2013 and 31 March 2014 has included:

- CCG Assurance Framework in place to ensure effective control systems to manage and mitigate risk
- GARC overview on behalf of the Governing Body including minutes and engagement with the planning and monitoring of the Independent Audit Process
- The results of Internal Audit work, which has provided the CCG with ‘significant assurance’
• External Audit work, including their management letter and other reports
• Evidence in compliance with the information governance
• Reports to the Governing Body on risk

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

The leadership provided by the Governance, Audit and Rick Committee, working directly to the Governing Body, chaired by the lay member with the lead role in overseeing key elements of Governance, including the Independent Audit Process provides a robust and independent lens that provides assurance to the Governing Body:

• The Governing Body’s performance including its assessment of its own effectiveness
• Themed Development sessions for Governing Body
• Each member of staff has agreed individual objectives linked to the CCGs operational and strategic objectives
• I have regular one-to-one sessions with each of the three lay members, as does the Chair\Clinical Lead
• The Chair has an agreed programme for engagement with each member practice
• At the end of our first year of operation all staff have met the requirements for mandatory training which is predetermined as mandatory to them, depending upon their role. This includes but is not limited to Infection, Prevention and Control; Equality and Diversity; Health & Safety; Counter Fraud; information governance, safeguarding and I am assured that principal agents at NECS have significant assurance for mandatory training

I am satisfied that the CCG has built upon the high level of compliance it demonstrated through its authorisation process to become a CCG against NHS England’s ‘CCG Assurance Framework’ and am therefore satisfied that the CCGs structures systems and processes are effective and that there are sufficient resources to allow for the effective management of risk.

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

Roles and responsibilities
The Accountable Officer is responsible 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 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 Annual Governance Statement 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 Governance, Audit and Risk 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 Accountable Officer takes into account in making the Annual Governance Statement.

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

Our opinion is set out as follows:
1. Overall opinion
2. Basis for the opinion
3. Commentary
Our overall opinion is that Significant Assurance can be given that there is a
generally sound system of internal control, designed to meet the organisation’s
objectives, and that controls are generally being applied consistently. However, some
weakness in the design and inconsistent application of controls put the achievement
of particular objectives at risk.

The basis for forming our opinion is as follows:

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

Any reliance that is being placed upon third party assurances
The commentary below provides the context for our opinion and, together with the
opinion, should be read in its entirety.

The design and operation of the Assurance Framework and associated processes:
The Assurance Framework was inherited from the predecessor PCT and has been
further developed in year. Therefore it has existed throughout the year and although
it may require some development it is generally ‘fit for purpose’. Risk management
processes have been in place throughout the year, however, our review highlighted
areas for improvement.

CCG management assurances indicate no significant issues have occurred
throughout the year along with NECS management assertions they are not aware of
any significant issues during the year.

The range of individual opinions arising from risk-based audit assignments,
contained within risk-based plans that have been reported during the year:
During the year 2013/14 we have undertaken our work in accordance with the
Internal Audit annual plan. In October 2013 we reviewed and refreshed the CCG
internal audit plan to ensure the continued provision of effective assurance, which
was approved by the Governance, Audit & Risk Committee. Throughout the year we
have reported our findings to the Chief Finance Officer and Chief Officer (and
Executive colleagues where applicable). Our internal audit progress reports to the
Governance Audit & Risk Committee have set out the areas covered by internal audit
work during the year, our results and matters arising.

The majority of this work would indicate that significant assurance opinions have, or
will be assigned to the majority of the CCG’s systems and processes. There is one
audit that we have not have concluded at the time of writing this annual report;

Francis II Review
We do not anticipate that there will be significant issues arising from this review,
however, it has not contributed to the overall assurance level provided within this
report and will be reported to the Governance, Audit & Risk Committee in due course.

By way of commentary it should also be noted that there have been no ‘no assurance’ final reports issued for 2013/14, nor any ‘limited assurance’ areas.

In undertaking our duties we have identified some weaknesses in the design or effectiveness of controls in certain systems. We have reported these issues during the year, and post the year end, and would specifically bring the following to the Accountable Officer’s attention for potential disclosure within the Annual Governance Statement:

**Governance and risk management arrangements**

A Lay Member of the GARC has acted as the Chair of the committee until the appointment of a permanent Chair in January 2014. This has affected the effectiveness of the committee to provide robust challenge and the reporting requirements between the GARC and Governing Body required clarification. Business plans were not in place for all Committees of the Governing Body, to assist in demonstrating the discharge of respective duties.

The register of interests was not complete for Members and employees of the CCG for the whole year.

When conflicts of interest arise in Committee meetings, minutes have not always clearly recorded the action taken.

The Standard of Business Conduct and Declarations of Interest Policy was brought forward from the PCT but was not amended to reflect CCG procedures. The Risk Management Policy has not been up to date throughout the year and required refreshing, and additional detail.

Updates to the risk register have not been comprehensive or robustly carried out either by responsible directors/risk owners or committees.

Risk management responsibilities for the Finance and Performance Committee are not explicit in the terms of reference.

**Third party assurances**

The CCG has received assurance from NECS management in respect of the controls operating in the first 7 months of 2013/14. In respect of the last 5 months it has received a service user report from NECS listing operating controls and comments on their effectiveness. In addition, NECS contracted with NIAS regarding quality aspects of continuing healthcare.

The CCG has also received service auditor reports from Shared Business Services for finance and accounting and procurement controls. At the time of writing the annual report the service auditor report for payroll had not been received. The CCG has received some support from NECS governance team. Although we have no significant issues, we have discussed some
concerns that exist (from our perspective) regarding those arrangements which require some review and clarification in 2014/15.

Audit North
May 2014

10. 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.

Control measures are in place to ensure that the CCGs public sector equality duty as set out in the Equality Act 2010.

12. Climate change adaptation reporting
The CCG is required to report its progress in delivering against sustainable development indicators.

We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

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

13. Business critical models
The CCG is aware of the quality assurance requirements in respect of business critical models contained within the recommendations in the Macpherson report and I consider that appropriate arrangements are in place to provide sufficient quality assurance.

Any business critical models identified, together with information relating to the quality assurance processes for those models, will be provided to the Analytical Oversight Committee chaired by the Chief Analyst in the Department of Health, as appropriate.

14. 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 the all
relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the Scheme of Delegation.

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

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

15. Conclusion

No significant internal control issues have been identified.

Statement as disclosure to auditors

The Governing Body is not aware of any relevant audit information that has been withheld from the clinical commissioning group’s external auditors, and members of the Governing Body take all necessary steps to make themselves aware of relevant information and to ensure that this is passed to the external auditors where appropriate.

Martin Phillips
Accountable Officer
5 June 2014
Remuneration report

Remuneration and Terms of Service Committee (not subject to audit)
The remuneration and terms of service committee was established to advise the Governing Body about pay and other benefits and terms of employment for the Chief Officer and other senior staff.
The committee comprised:

- Andrea Jones, CCG Chair and Chair of Remuneration and Terms of Service Committee
- Michelle Thompson, Lay Member
- John Flook, Lay Member (from November 2013)

Further detail of membership of the committee and attendance at meetings is included in the Governing Body and Committee Members section of this report.

The policy of the remuneration and terms of service committee on the remuneration of senior managers is to adopt DH guidance on all aspects of senior managers pay. There were no variations to this policy in 2013/14 and the remuneration for senior managers during the financial year was determined in accordance with national policy.

Senior Management Service Contracts (not subject to audit)
All CCG senior managers hold permanent contracts which have no end date or unexpired term. In the event of termination, in line with employment legislation, the only liabilities would be for notice pay and, if applicable, redundancy pay. For the CCG senior managers listed below redundancy pay would be one months’ salary for each complete year of NHS service up to a maximum of 24.

- Andrea Jones, CCG Chair
- Martin Phillips, Chief Officer
- Lisa Tempest, Chief Finance Officer
- Elizabeth Graham, Lead CCG Nurse
- Jackie Kay, Assistant Chief Officer

With the exception of Elizabeth Graham who commenced employment with the CCG on 1 May 2013, all senior managers transferred to the CCG from a Primary Care Trust on 1 April 2014.

Notice periods for the CCG senior managers are as below:

- Andrea Jones, CCG Chair – 6 months
- Martin Phillips, Chief Officer – 6 months
- Lisa Tempest, Chief Finance Officer – 6 months
- Elizabeth Graham, Lead CCG Nurse – 13 weeks
- Jackie Kay, Assistant Chief Officer – 12 weeks
## Darlington CCG Senior Officers Salaries and Allowances 2013/14: (subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Salary &amp; fees (Bands of £5,000)</th>
<th>Taxable benefits (Rounded to the nearest £00)</th>
<th>2013/14 Annual performance related bonuses (Bands of £5,000)</th>
<th>Long-term performance related bonuses (Bands of £5,000)</th>
<th>All pension related (Bands of £2,500)</th>
<th>Total (Bands of £5,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Andrea Jones</td>
<td>Chair</td>
<td>65-70</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0-2.5</td>
<td>65-70</td>
</tr>
<tr>
<td>Dr Andrea Jones</td>
<td>Salaried GP</td>
<td>15-20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>15-20</td>
</tr>
<tr>
<td>Martin Phillips</td>
<td>Chief Officer</td>
<td>100-105</td>
<td>1.9</td>
<td>0</td>
<td>0</td>
<td>127.5-130</td>
<td>235-240</td>
</tr>
<tr>
<td>Lisa Tempest</td>
<td>Chief Finance Officer</td>
<td>80-85</td>
<td>0</td>
<td>0</td>
<td>12.5-15</td>
<td>95-100</td>
<td>95-100</td>
</tr>
<tr>
<td>Jackie Kay</td>
<td>Assistant Chief Officer</td>
<td>80-85</td>
<td>1.3</td>
<td>0</td>
<td>0</td>
<td>12.5-15</td>
<td>95-100</td>
</tr>
<tr>
<td>Richard Harker</td>
<td>Quality Lead</td>
<td>25-30</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>25-30</td>
</tr>
<tr>
<td>Patrick Holmes</td>
<td>Deputy Lead Clinician</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5-10</td>
</tr>
<tr>
<td>Lucy Hansen</td>
<td>Secondary Care Clinician</td>
<td>10-15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10-15</td>
</tr>
<tr>
<td>Michelle Thompson</td>
<td>Lay member</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5-10</td>
</tr>
<tr>
<td>Andie Mackay</td>
<td>Lay member</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>John Flook</td>
<td>Lay member</td>
<td>5-10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5-10</td>
</tr>
<tr>
<td>Elizabeth Graham</td>
<td>Lead CCG Nurse</td>
<td>25-30</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>25-30</td>
</tr>
</tbody>
</table>

**Payments for Loss of Office (subject to audit)**
No individual who was a senior manager in the current or in a previous financial year has received a payment for loss of office during the financial year.

**Pay Multiples (subject to audit)**
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the workforce of the organisation.

The banded remuneration of the highest paid director in Darlington CCG in the financial year 2013/14 was £105 - 110k. This was 1.8 times higher than the median remuneration of the workforce which was £59,001.
In 2013/14, no employees received remuneration in excess of the highest paid member of the governing body. Remuneration ranged from £9,196 to £106,898. Total remuneration includes salary, non-consolidated performance related pay, benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.
### Darlington CCG Senior Officers Pension Benefits 2013/14 (subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Real Increase/(reduction) in pension at age 60 (bands of £2500) £000’s</th>
<th>Real Increase/(reduction) in lump sum at aged 60 (bands of £2500) £000’s</th>
<th>Total accrued pension at age 60 at 31 March 2014 (bands of £5000) £000’s</th>
<th>2013/14 Lump sum at aged 60 related to accrued pension at 31 March 2014 (Bands of £5000) £000’s</th>
<th>Cash equivalent transfer at 31 March 2013 £000’s</th>
<th>Cash Equivalent value at 31 March 2014 £000’s</th>
<th>Real increase in cash equivalent £000’s</th>
<th>Employer’s contribution to partnership pension £00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Andrea Jones</td>
<td>Chair and Lead Clinician</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>0-5</td>
<td>10-15</td>
<td>75</td>
<td>86</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Martin Phillips</td>
<td>Chief Officer</td>
<td>5-7.5</td>
<td>17.5-20</td>
<td>40-45</td>
<td>120-125</td>
<td>622</td>
<td>756</td>
<td>134</td>
<td>0</td>
</tr>
<tr>
<td>Lisa Tempest</td>
<td>Chief Finance Officer</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>5-10</td>
<td>0-5</td>
<td>70</td>
<td>84</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Jackie Kay</td>
<td>Assistant Chief Officer</td>
<td>0-2.5</td>
<td>0-2.5</td>
<td>5-10</td>
<td>0-5</td>
<td>70</td>
<td>84</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>Patrick Holmes</td>
<td>Deputy lead Clinician</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Richard Harker</td>
<td>Quality Lead</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Lucy Hansen</td>
<td>Secondary Care Clinician</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Michelle Thompson</td>
<td>Lay Member</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Andie Mackay</td>
<td>Lay Member</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>John Flook</td>
<td>Lay Member</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Elizabeth Graham</td>
<td>Lead CCG Nurse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Please note: Dr Andrea Jones was employed in two different posts during 2013/14. The above pension disclosure relates to both posts.
Cash Equivalent Transfer Values (subject to audit)
A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Off-payroll Engagements (not subject to audit)
Details of off-payroll engagements as of March 2014 for more than £220 per day and that last longer than six months are as below:

<table>
<thead>
<tr>
<th>The number that have existed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>For less than one year at the time of reporting</td>
<td>1</td>
</tr>
<tr>
<td>For between one and two years at the time of reporting</td>
<td>1</td>
</tr>
<tr>
<td>For between two and three years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>For between three and four years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>For four or more years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>Total number of existing engagements as of 31 March 2014</td>
<td>2</td>
</tr>
</tbody>
</table>

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax, and, where necessary, that assurance has been sought.
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014 | 1
---|---
Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations | 1
Number for whom assurance has been requested | 
Of which, the number: | 
For whom assurance has been received | 1
For whom assurance has not been received | 0
That have been terminated as a result of assurance not being received | 0

The proportion of Governing Body members with off-payroll engagement arrangements is as below:

| Number of off-payroll engagement of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year | 2
| Number of individuals that have been deemed “Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility”, during the financial year (this figure includes both off-payroll and on-payroll engagements) | 10

Performance (not subject to audit)
Continuation of employment, under the senior managers’ contracts of employment is subject to satisfactory performance. Performance in post and progress in achieving set objectives is reviewed annually. There were no individual performance review payments made to senior managers during the year and there are no plans to make such payments in future years outside of the Very Senior Management Pay Framework. This is in accordance with standard NHS terms and conditions of service and guidance issued by the DH.

Contracts of employment in relation to the Chief Officer and senior managers are permanent in nature and subject to six months’ notice of termination by either party. Termination payments are limited to those laid down in statute and those provided for within NHS terms and conditions of service and under the NHS Pension Scheme Regulations for those who are members of the scheme.

Martin Phillips
Accountable Officer
NHS Darlington CCG
5 June 2014
Annual accounts

Report on the financial statements

Our opinion

In our opinion the financial statements, defined below:

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

This opinion is to be read in the context of what we say in the remainder of this report.

What we have audited

The financial statements, which are prepared by NHS Darlington Clinical Commissioning Group (“CCG”), comprise:

- the Statement of Financial Position as at 31 March 2014;
- the Statement of Comprehensive Net Expenditure for the year then ended;
- the Statement of Changes in Taxpayers’ Equity for the year then ended;
- the Statement of Cash Flows for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in their preparation is the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

In applying the financial reporting framework, the Accountable Officer has made a number of subjective judgements, for example in respect of significant accounting estimates. In making such estimates, they have made assumptions and considered future events.

What an audit of financial statements involves

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) (“ISAs (UK & Ireland)”). An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

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

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

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

Opinions on other matters prescribed by the Code of Audit Practice

In our opinion:
• the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements;
• the part of the Remuneration Report to be audited has been properly prepared in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State; and
• 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.

Other matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice issued by the Audit Commission requires us to report to you if:
• in our opinion, the Governance Statement does not comply with the Annual Accounts guidance 2013/14, issued on 27 March 2014 by the NHS Commissioning Board or is misleading or inconsistent with information of which we are aware from our audit;
• we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because 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.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the Accountable Officer

As explained more fully in the Statement of Accountable Officer’s Responsibilities set out on page 39 the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.
Our responsibility is to audit and express an opinion on the financial statements in accordance with Part II of the Audit Commission Act 1998, the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Governing Body of NHS Darlington in accordance with Part II of the Audit Commission Act 1998 as set out in paragraph 44 of the Statement of Responsibilities of Auditors and of Audited Bodies (Local NHS bodies) published by the Audit Commission in April 2014, and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

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

Conclusion

On the basis of our work, having regard to the guidance issued by the Audit Commission in October 2013, we have no matters to report with respect to whether, NHS Darlington CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014.

What a review of the arrangements for securing economy, efficiency and effectiveness in the use of resources involves

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

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

Our responsibilities and those of the CCG

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

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

We certify that we have completed the audit of the financial statements of NHS Darlington CCG in accordance with the requirements of Part II of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Greg Wilson (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Newcastle upon Tyne
9 June 2014

(a) The maintenance and integrity of the Darlington CCG website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.
Financial statements

The full annual accounts are included on the next pages.
The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014 1
Statement of Financial Position as at 31 March 2014 2
Statement of Changes in Taxpayers' Equity for the year ended 31 March 2014 3
Statement of Cash Flows for the year ended 31 March 2014 4

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

<table>
<thead>
<tr>
<th>Note</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross employee benefits</td>
<td>3.1</td>
</tr>
<tr>
<td>Other costs</td>
<td>4</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
</tr>
<tr>
<td><strong>Net operating costs before financing</strong></td>
<td></td>
</tr>
<tr>
<td>Financing</td>
<td></td>
</tr>
<tr>
<td>Investment revenue</td>
<td>7</td>
</tr>
<tr>
<td>Other (gains) / losses</td>
<td>8</td>
</tr>
<tr>
<td>Finance costs</td>
<td>9</td>
</tr>
<tr>
<td><strong>Net operating costs for the financial year</strong></td>
<td></td>
</tr>
<tr>
<td>Of which: Administration costs</td>
<td></td>
</tr>
<tr>
<td>Gross employee benefits</td>
<td>3.1</td>
</tr>
<tr>
<td>Other costs</td>
<td>4</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
</tr>
<tr>
<td><strong>Net administration costs before interest</strong></td>
<td></td>
</tr>
<tr>
<td>Programme expenditure</td>
<td></td>
</tr>
<tr>
<td>Gross employee benefits</td>
<td>3.1</td>
</tr>
<tr>
<td>Other costs</td>
<td>4</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
</tr>
<tr>
<td><strong>Net programme expenditure before interest</strong></td>
<td></td>
</tr>
<tr>
<td>Total comprehensive net expenditure for the financial year</td>
<td></td>
</tr>
</tbody>
</table>
NHS Darlington CCG - Annual Accounts 2013/14

Statement of Financial Position as at 31 March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Current assets:</td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>11</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
</tr>
<tr>
<td>Total assets</td>
<td></td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td></td>
</tr>
<tr>
<td>Financed by taxpayers' equity</td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity:</strong></td>
<td></td>
</tr>
</tbody>
</table>

The notes on pages 5 to 29 form part of this statement

The financial statements on pages 1 to 29 were approved by the Governing Body on 3 June 2014 and signed on its behalf by:

Martin Phillips
Accountable Officer
5 June 2014
NHS Darlington CCG - Annual Accounts 2013/14

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Changes in CCG taxpayers' equity for 2013/14:</th>
<th>General fund £000</th>
<th>Total reserves £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating costs for the financial year</td>
<td>(135,177)</td>
<td>(135,177)</td>
</tr>
<tr>
<td>Net recognised CCG expenditure for the financial year</td>
<td>(135,177)</td>
<td>(135,177)</td>
</tr>
<tr>
<td>Net Parliamentary funding</td>
<td>129,162</td>
<td>129,162</td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>(6,015)</td>
<td>(6,015)</td>
</tr>
</tbody>
</table>
NHS Darlington CCG - Annual Accounts 2013/14

Statement of Cash Flows for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Description</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash flows from operating activities</td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(135,177)</td>
</tr>
<tr>
<td>Increase in trade and other receivables</td>
<td>(1,327)</td>
</tr>
<tr>
<td>Increase in trade and other payables</td>
<td>7,473</td>
</tr>
<tr>
<td>Net cash outflow from operating activities</td>
<td>(129,031)</td>
</tr>
<tr>
<td>Net cash outflow before financing</td>
<td>(129,031)</td>
</tr>
<tr>
<td>Cash flows from financing activities</td>
<td></td>
</tr>
<tr>
<td>Net parliamentary funding received</td>
<td>129,162</td>
</tr>
<tr>
<td>Net cash inflow from financing activities</td>
<td>129,162</td>
</tr>
<tr>
<td>Net increase in cash and cash equivalents</td>
<td>131</td>
</tr>
<tr>
<td>Cash and cash equivalents at the beginning of the financial year</td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents (including bank overdrafts) at the end of the financial year</td>
<td>131</td>
</tr>
</tbody>
</table>
1. Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups (CCGs) shall meet the accounting requirements of the Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2013/14 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

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

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.
NHS Darlington CCG - Annual Accounts 2013/14

1.4.1 Legacy Balances

The accounting arrangements for balances transferred from predecessor Primary Care Trusts ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. No legacy balances were required to be accounted for by the CCG in these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 14 to these financial statements.

1.5 Charitable Funds

From 2013/14, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.6 Pooled Budgets

Where the CCG has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the CCG is in a "jointly controlled operation", the CCG recognises:
- The assets the CCG controls;
- The liabilities the CCG incurs;
- The expenses the CCG incurs; and,
- The CCG's share of the income from the pooled budget activities.

If the CCG is involved in a "jointly controlled assets" arrangement, in addition to the above, the CCG recognises:
- The CCG's share of the jointly controlled assets (classified according to the nature of the assets);
- The CCG's share of any liabilities incurred jointly; and,
- The CCG's share of the expenses jointly incurred.

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:
- determining whether income and expenditure should be disclosed as either administrative or programme expenditure;
- determining whether a substantial transfer of risks and rewards has occurred in relation to leased assets;
- determining whether a provision or contingent liability should be recognised in respect of certain potential future obligations, particularly in respect of continuing healthcare.

1.7.2 Key Sources of Estimation Uncertainty

The key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are considered to relate to:
- the assumptions applied in the estimation of activity not yet invoiced, including partially completed treatment spells as at the Statement of Financial Position date; and
- the estimate of potential future liabilities in respect of continuing healthcare services.
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 Employee Benefits

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

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

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

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

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

1.11 Property, Plant & Equipment

1.11.1 Recognition
Property, plant and equipment is capitalised if:
- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the CCG;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.
1.11.2 Valuation
All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the CCG’s services or for administrative purposes are stated in the Statement of Financial Position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

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

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

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

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

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

1.12.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the CCG’s business or which arise from contractual or other legal rights. They are recognised only:

- When it is probable that future economic benefits will flow to, or service potential be provided to, the CCG;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- The technical feasibility of completing the intangible asset so that it will be available for use;
- The intention to complete the intangible asset and use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,
- The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.12.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the CCG checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.
1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government Grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current Assets Held For Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:
- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.17.1 The CCG as Lessee

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

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

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

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

1.17.2 The CCG as Lessor

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

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

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The CCG therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract ‘lifecycle replacement’.

1.18.1 Services Received
The fair value of services received in the year is recorded under the relevant expenditure headings within ‘operating expenses’.

1.18.2 PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the CCG’s approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 PFI Liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to ‘finance costs’ within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.18.4 Lifecycle Replacement
Components of the asset replaced by the operator during the contract (‘lifecycle replacement’) are capitalised where they meet the CCG’s criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator’s planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a ‘free’ asset and a deferred income balance is recognised.

The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.
1.18.5 Assets Contributed by the CCG to the Operator For Use in the Scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the CCG's Statement of Financial Position.

1.18.6 Other Assets Contributed by the CCG to the Operator
Assets contributed (e.g. cash payments, surplus property) by the CCG to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the CCG, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.19 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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

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

1.21 Provisions
Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.85%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.55%

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

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

1.22 Clinical Negligence Costs
The NHS Litigation Authority operates a risk pooling scheme under which the CCG pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the CCG.
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1.23 Non-clinical Risk Pooling

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

1.24 Carbon Reduction Commitment Scheme

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

1.25 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.26 Financial Assets

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

Financial assets are classified into the following categories:
- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

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

1.26.1 Financial Assets at Fair Value Through Profit and Loss

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

1.26.2 Held to Maturity Assets

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
1.26.3 Available For Sale Financial Assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.26.4 Loans & Receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques using discounted cash flow analysis.

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

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

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

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

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

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

1.27.1 Financial Guarantee Contract Liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:
- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.27.2 Financial Liabilities at Fair Value Through Profit and Loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the CCG’s surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

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

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

1.29 Foreign Currencies

The CCG’s functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the CCG’s surplus/deficit in the period in which they arise.

1.30 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the financial statements since the CCG has no beneficial interest in them.

1.31 Losses & Special Payments

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

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

1.32 Subsidiaries

Material entities over which the CCG has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary’s accounting policies are not aligned with the CCG or where the subsidiary’s accounting date is not co-terminus.

Subsidiaries that are classified as ‘held for sale’ are measured at the lower of their carrying amount or ‘fair value less costs to sell’.

1.33 Associates

Material entities over which the CCG has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the CCG’s accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the CCG’s share of the entity’s profit/loss and other gains/losses. It is also reduced when any distribution is received by the CCG from the entity.

Joint ventures that are classified as ‘held for sale’ are measured at the lower of their carrying amount or ‘fair value less costs to sell’.

1.34 Joint Ventures

Material entities over which the CCG has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as ‘held for sale’ are measured at the lower of their carrying amount or ‘fair value less costs to sell’.
1.35 Joint Operations

Joint operations are activities undertaken by the CCG in conjunction with one or more other parties but which are not performed through a separate entity. The CCG records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.36 Research & Development

Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

1.37 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013-14, all of which are subject to consultation:
- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

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

2. Other Operating Revenue

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Admin £000</th>
<th>2013/14 Programme £000</th>
<th>2013/14 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-patient care services to other bodies</td>
<td>-</td>
<td>327</td>
<td>327</td>
</tr>
<tr>
<td>Total other operating revenue</td>
<td>-</td>
<td>327</td>
<td>327</td>
</tr>
</tbody>
</table>

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

Revenue is totally from the supply of services. The CCG receives no revenue from the sale of goods.
3. Employee benefits and staff numbers

3.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Total</th>
<th>Permanent Employees</th>
<th>Other</th>
<th>2013/14 Admin Total</th>
<th>Permanent Employees</th>
<th>Other</th>
<th>2013/14 Programme Total</th>
<th>Permanent Employees</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>556</td>
<td>540</td>
<td>26</td>
<td>454</td>
<td>439</td>
<td>25</td>
<td>102</td>
<td>101</td>
<td>1</td>
</tr>
<tr>
<td>Social security costs</td>
<td>55</td>
<td>55</td>
<td>-</td>
<td>44</td>
<td>44</td>
<td>-</td>
<td>11</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>Employer Contributions to the NHS Pension scheme</td>
<td>66</td>
<td>66</td>
<td>-</td>
<td>51</td>
<td>51</td>
<td>-</td>
<td>15</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td>Total employee benefits expenditure</td>
<td>687</td>
<td>661</td>
<td>26</td>
<td>559</td>
<td>534</td>
<td>25</td>
<td>128</td>
<td>127</td>
<td>1</td>
</tr>
</tbody>
</table>

No amounts were recovered in respect of employee benefits and no employee benefits were capitalised during the year.

3.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanently employed Number</td>
</tr>
<tr>
<td>Total</td>
<td>11</td>
</tr>
</tbody>
</table>

None of the above people were engaged on capital projects.

3.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total days lost</td>
<td>26</td>
</tr>
<tr>
<td>Total staff years</td>
<td>10</td>
</tr>
<tr>
<td>Average working days lost</td>
<td>3</td>
</tr>
</tbody>
</table>

The staff sickness absence data is based on the 9 months from April to December 2013.

No staff retired early on ill health grounds during the financial year.

3.4 Exit packages agreed in the financial year

No exit packages have been agreed in the financial year.
NHS Darlington CCG - Annual Accounts 2013/14

3.5 Pension costs

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

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

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

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

3.5.1 Full actuarial (funding) valuation

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

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

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of Pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 6.5% of their Pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme’s liabilities.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

3.5.2 Accounting valuation

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

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

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

3.5.3 Scheme Provisions

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

- The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1955 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

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

- Annual Increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Admin £000</th>
<th>2013/14 Programme £000</th>
<th>2013/14 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>182</td>
<td>128</td>
<td>310</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>377</td>
<td>-</td>
<td>377</td>
</tr>
<tr>
<td>Total gross employee benefits</td>
<td>559</td>
<td>128</td>
<td>687</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>1,381</td>
<td>16</td>
<td>1,397</td>
</tr>
<tr>
<td>Services from Foundation Trusts</td>
<td>-</td>
<td>98,527</td>
<td>98,527</td>
</tr>
<tr>
<td>Services from other NHS Trusts</td>
<td>-</td>
<td>283</td>
<td>283</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>-</td>
<td>17,168</td>
<td>17,168</td>
</tr>
<tr>
<td>Chair and lay membership body and governing body members</td>
<td>105</td>
<td>-</td>
<td>105</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>44</td>
<td>231</td>
<td>275</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>4</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Establishment</td>
<td>51</td>
<td>2</td>
<td>53</td>
</tr>
<tr>
<td>Premises</td>
<td>68</td>
<td>1</td>
<td>69</td>
</tr>
<tr>
<td>Audit fees</td>
<td>73</td>
<td>-</td>
<td>73</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>-</td>
<td>16,786</td>
<td>16,786</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>68</td>
<td>-</td>
<td>68</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Education and training</td>
<td>6</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>1,803</td>
<td>133,014</td>
<td>134,817</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>2,362</td>
<td>133,142</td>
<td>135,504</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2013/14 Number</th>
<th>2013/14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-NHS payables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total non-NHS trade invoices paid in the year</td>
<td>3,495</td>
<td>16,664</td>
</tr>
<tr>
<td>Total non-NHS trade invoices paid within target</td>
<td>3,423</td>
<td>16,152</td>
</tr>
<tr>
<td>Percentage of non-NHS trade invoices paid within target</td>
<td>97.94%</td>
<td>96.93%</td>
</tr>
<tr>
<td>NHS payables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>880</td>
<td>92,229</td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>850</td>
<td>92,131</td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>98.84%</td>
<td>99.89%</td>
</tr>
</tbody>
</table>

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

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

There were no payments made in respect of late payments of commercial debts in 2013/14.

6. Income Generation Activities

The CCG does not undertake any income generation activities.

7. Investment revenue

There was no investment revenue in 2013/14.

8. Other gains and losses

There were no other gains and losses in 2013/14.

9. Finance costs

There were no finance costs in 2013/14.
10. Operating Leases

10.1 As lessee

The CCG has entered into a small number of formal operating lease arrangements, relating to leased cars and the lease of photocopying equipment, none of which are individually significant. Specific lease terms vary by individual arrangement but are based upon standard practice for the type of arrangement involved.

10.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Buildings £000</th>
<th>2013/14 Other £000</th>
<th>2013/14 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments recognised as an expense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minimum lease payments</td>
<td>47</td>
<td>1</td>
<td>48</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>1</td>
<td>48</td>
</tr>
</tbody>
</table>

10.1.2 Future minimum lease payments

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Buildings £000</th>
<th>2013/14 Other £000</th>
<th>2013/14 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payable:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

The CCG occupies property owned and managed by NHS Property Services Ltd. For 2013-14, a transitional occupancy rent based on annual property cost allocations was agreed. This is reflected in Note 10.1.1.

While our arrangements with NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note includes only the known future minimum lease payments from other rental arrangements.
NHS Darlington CCG - Annual Accounts 2013/14

11. Trade and other receivables

<table>
<thead>
<tr>
<th>Description</th>
<th>Current 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>400</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
<td>740</td>
</tr>
<tr>
<td>Non-NHS receivables: Revenue</td>
<td>86</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
<td>78</td>
</tr>
<tr>
<td>VAT</td>
<td>21</td>
</tr>
<tr>
<td>Operating lease receivables</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>1,327</td>
</tr>
</tbody>
</table>

The great majority of trade is with other NHS bodies, including other CCGs as commissioners for NHS patient care services. As CCGs are funded by Government to commission NHS patient care services, no credit scoring of them is considered necessary.

11.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th>Period</th>
<th>Current 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>86</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
</tr>
</tbody>
</table>

The CCG did not hold any collateral against receivables outstanding at 31 March 2014.
12. Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net change in year</td>
<td>131</td>
<td></td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>131</td>
<td></td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service: 131
- Cash and cash equivalents as in Statement of Financial Position: 131

Balance at 31 March 2014: 131

The CCG held £nil cash and cash equivalents at 31 March 2014 on behalf of patients.

13. Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 31 March 2014</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>707</td>
<td></td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td>1,170</td>
<td></td>
</tr>
<tr>
<td>Non-NHS payables: revenue</td>
<td>1,044</td>
<td></td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td>4,517</td>
<td></td>
</tr>
<tr>
<td>Other payables</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>7,473</td>
<td></td>
</tr>
</tbody>
</table>

At 31 March 2014, the CCG had no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £nil in respect of outstanding pension contributions at 31 March 2014.


There were no provisions to recognise in the financial statements at 31 March 2014.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the CCG. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £2,516k.

15. Contingencies

There were no contingent assets or liabilities at 31 March 2014.
16. Commitments

There were no contracted or non-cancellable contracts entered into by the CCG at 31 March 2014 which are not otherwise included in these financial statements.

17. Financial instruments

17.1 Financial risk management

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

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

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

17.1.1 Currency risk

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

17.1.2 Interest rate risk

The CCG has no borrowings and has only limited powers to borrow funds from government for capital expenditure, subject to affordability as confirmed by NHS England. The CCG therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

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

17.1.3 Liquidity risk

The CCG is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, from NHS England, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.
NHS Darlington CCG - Annual Accounts 2013/14

17. Financial instruments (continued)

17.2 Financial assets

<table>
<thead>
<tr>
<th>Receivables</th>
<th>Loans and Receivables 31 March 2014 £000</th>
<th>Total 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>1,140</td>
<td>1,140</td>
</tr>
<tr>
<td>Non-NHS</td>
<td>155</td>
<td>155</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>131</td>
<td>131</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td><strong>1,428</strong></td>
<td><strong>1,426</strong></td>
</tr>
</tbody>
</table>

17.3 Financial liabilities

<table>
<thead>
<tr>
<th>Payables</th>
<th>Other 31 March 2014 £000</th>
<th>Total 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>1,876</td>
<td>1,876</td>
</tr>
<tr>
<td>Non-NHS</td>
<td>5,597</td>
<td>5,597</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td><strong>7,473</strong></td>
<td><strong>7,473</strong></td>
</tr>
</tbody>
</table>

18. Operating segments

The CCG has considered the definition of an operating segment contained within IFRS 8 in determining its operating segments, in particular considering the internal reporting to the CCG's Governing Body, considered to be the 'chief operating decision maker' of the CCG, which was used for the purpose of resource allocation and assessment of performance.

All activity performed by the CCG relates to its role as a commissioner of healthcare for its relevant population. As a result, the CCG considers that it has only one operating segment, being the commissioning of healthcare services.

An analysis of both the income and expenditure and net assets relating to the segment can be found in the statement of comprehensive net expenditure and statement of financial position respectively.

19. Pooled budgets

The CCG was not party to any pooled budget arrangements during 2013/14.
20. Intra-government and other balances

<table>
<thead>
<tr>
<th></th>
<th>Current Receivables 31 March 2014 £000</th>
<th>Current Payables 31 March 2014 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balances with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Other Central Government bodies</td>
<td>21</td>
<td>-</td>
</tr>
<tr>
<td>- Local Authorities</td>
<td>121</td>
<td>689</td>
</tr>
<tr>
<td>Balances with NHS bodies:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- NHS bodies outside the Departmental Group</td>
<td>1,027</td>
<td>542</td>
</tr>
<tr>
<td>- NHS Trusts and Foundation Trusts</td>
<td>113</td>
<td>1,334</td>
</tr>
<tr>
<td>Total of balances with NHS bodies:</td>
<td></td>
<td>1,140</td>
</tr>
<tr>
<td>- Public corporations and trading funds</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>- Bodies external to Government</td>
<td>45</td>
<td>4,908</td>
</tr>
<tr>
<td>Total balances at 31 March 2014</td>
<td>1,327</td>
<td>7,473</td>
</tr>
</tbody>
</table>

21. Events after the end of the reporting period

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

22. Losses and special payments

There were no losses or special payments identified in 2013/14.
### 23. Related party transactions

During the year the CCG has undertaken transactions with the following CCG Governing Body members or members of the key management staff, or parties related to any of them:

<table>
<thead>
<tr>
<th>CCG Governing Body Member</th>
<th>Possible Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>M Phillips, Chief Officer</td>
<td>County Durham &amp; Darlington NHS FT</td>
<td>71,572</td>
<td>(594)</td>
<td>399</td>
<td>(41)</td>
</tr>
<tr>
<td>L Tempest, Chief Finance Officer</td>
<td>North Tees &amp; Hartlepool NHS FT</td>
<td>986</td>
<td>-</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Dr P Holmes, Deputy Lead Clinician</td>
<td>Middleton Pharmacy Ltd</td>
<td>6</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Felix House Surgery</td>
<td>174</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dr R Harker, Quality Lead</td>
<td>Whinfield Medical Practice</td>
<td>88</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>St Theresa’s Hospice</td>
<td>245</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>L Hansen, Secondary Care Clinician</td>
<td>Northumbria Healthcare NHS FT</td>
<td>9</td>
<td>-</td>
<td>22</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>North East Ambulance Service NHS FT</td>
<td>3,683</td>
<td>-</td>
<td>123</td>
<td>-</td>
</tr>
<tr>
<td>M Thompson, Lay Member</td>
<td>Healthwatch Darlington</td>
<td>10</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

All of these transactions were undertaken under standard terms and conditions in the normal course of business.

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

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Darlington Borough Council.
24. Financial performance targets

CCGs have a number of financial duties under the NHS Act 2006 (as amended).

The CCG’s performance against those duties was as follows:

<table>
<thead>
<tr>
<th>NHS Act Section</th>
<th>Duty</th>
<th>2013/14</th>
<th></th>
<th></th>
<th>Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>223H (1)</td>
<td>Expenditure not to exceed income</td>
<td></td>
<td>135,502</td>
<td>135,177</td>
<td>Yes</td>
</tr>
<tr>
<td>223I (2)</td>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>223I (3)</td>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>135,502</td>
<td>135,177</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>223J (1)</td>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>223J (2)</td>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>223J (3)</td>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>2,610</td>
<td>2,362</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

The CCG received no capital resource during the year ended 31 March 2014 and incurred no capital expenditure.

Performance against the revenue expenditure duties is further analysed below:

<table>
<thead>
<tr>
<th></th>
<th>2013/14 Programme Resource £000</th>
<th>2013/14 Administration Resource £000</th>
<th>2013/14 Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue resource</td>
<td>132,892</td>
<td>2,610</td>
<td>135,502</td>
</tr>
<tr>
<td>Net operating cost for the financial year</td>
<td>132,815</td>
<td>2,362</td>
<td>135,177</td>
</tr>
<tr>
<td>Underspend against revenue resource</td>
<td>77</td>
<td>248</td>
<td>325</td>
</tr>
</tbody>
</table>