NHS
Southport and Formby
Clinical Commissioning Group

Annual Report and Annual Accounts 2013-2014

NHS Southport and Formby Clinical Commissioning Group

Contents

Introduction

Welcome to our first Annual Report and we hope you find it both a useful and interesting overview of our work so far in improving the health and wellbeing of everyone who lives in Southport and Formby.

Whilst we may be a new organisation we have made good progress in the 12 months since becoming the lead commissioner for the majority of local health services. This is recognised not only by our member GP practices that make up our organisation but by our wider partners across health and social care.

We have put clinicians firmly at the heart of commissioning. Through our four practice localities we are seeing our members working collaboratively to improve health and wellbeing at the grass roots - responding to the differing needs of all our residents in different parts of Southport and Formby. Our members are also involved in shaping our wider strategic plans. In these we are setting out an ambitious vision and you will read more about them later in this report.

Fostering better relationships with our major health service providers has led to some good, early service improvements. Alongside this we have greatly strengthened our relationships with community, voluntary and faith organisations and seen the development of some exciting community led initiatives.

Through the Sefton Health and Wellbeing Board, we are working as partners alongside Sefton Council to plan and commission better joined up services right across health and social care. This presents great opportunities for us to improve the health of our local residents and to tackle the differences in health that exist between different communities in Southport and Formby. The joint development of health and social care programmes through the delivery of our Better Care Fund will support us in moving forward with this work.

We cannot advance our work without the collaboration of Southport and Formby residents and we appreciate the contribution they have made so far. We are committed to involving as many people as possible in their care and our work, and we feel that we have made a strong start in doing this through our Big Chats and Mini Chats.

Importantly, we have achieved all this within our budget for 2013-2014. The public sector faces financially challenging times. So, the Governing Body spent some time reflecting on how well we are doing towards these goals and where we could be doing better[1]. We feel that we have the ability and conviction to make the changes needed to ensure that the local NHS stays strong and continues to improve care. We will carry out regular assessments so we can be sure we continue to effectively represent and serve our membership and the people of Southport and Formby.

We will begin our second year on 1 April 2014 with a new Governing Body, following elections amongst our practice members. We thank the outgoing Governing Body for the hard work and dedication shown on behalf of member practices and we look forward to building on our achievements in the year ahead.

Dr Niall Leonard, Chair (2013-2014) **Fiona Clark, Chief Officer**

[1] Information about our organisational development plan can be found on page 32

Strategic report

About us

We are a new kind of NHS organisation made up of all the GP practices in Southport and Formby. Because we are led by local doctors and medical professionals and supported by practice managers, we have a good understanding of the health needs of Southport and Formby residents.

Whilst many local health priorities are similar to those experienced right across the country, we are better informed to concentrate our efforts on the particular challenges faced here in Southport and Formby.

We do not work alone. By working closely with all our partners who have a stake in ensuring good local health and wellbeing, our opportunity to improve services for Southport and Formby residents is greater than ever.

On 1 April 2013 we became fully responsible for planning and buying the majority of local health services – this process is known as commissioning. We are now responsible for:

- Community based services – like district nursing and blood testing
- Hospital care – including routine operations, outpatient clinics, maternity services and accident and emergency care
- GP Out of Hours services – to ensure people still have access to a doctor when their surgery is closed in the evenings, weekends and Bank Holidays
- Mental health – we commission many mental health services apart from very specialised care and treatment

We spent much of 2012-2013 preparing to take over many of the statutory responsibilities of NHS Sefton, the former primary care trust, when it was dissolved at the end of March 2013.

Our preparations were assessed to ensure we were ready to take on our full duties set out in the Health and Social Care Act 2012 through a process known as authorisation. We were authorised with four conditions in January 2013. These minor technical points were fully resolved before 1 April 2013 when we formally came into being as a fully licenced organisation with no operating conditions[2].

[2] You can read more about this on the NHS England website http://www.england.nhs.uk/resources/resources-for-ccgs/auth/

How we work and make decisions

Our organisational structure helps us to work effectively and commission the best healthcare possible, spending our share of NHS funding wisely.

Governing Body

Our organisation has a Governing Body[3] that makes decisions about, and is accountable for, our work. It is made up of doctors and practice staff, lay members and our most senior officers. All GPs and practice staff are elected to the Governing Body by our members to represent their views about the overall running of the organisation. You can see the membership of our Governing Body during 2013-2014 on page 43.

Providing assurance

We have established a number of sub committees that report directly to the Governing Body to provide assurance in areas such as finance, audit, governance and quality. They all include representatives from our wider GP practice membership and you can see a full list on page 42. We meet regularly with the organisations who we commission services from to ensure they are meeting expectations and manage any issues, all of which is reported through our committee structure.

Locality working

There are 20 GP practices across Southport and Formby and these make up our wider membership. We have a constitution which binds us together. This legal document sets out how our member practices work together as part of the CCG, including governance arrangements, responsibilities and meetings.

We support practices to be actively involved in the work of the CCG. Much of this work is carried out in 'localities', covering four geographical areas, so practices can really focus on addressing the health needs of their individual communities.

Each locality is chaired by a GP and provides an opportunity for other professionals in practices, such as nurses and support staff to get involved in our work. Localities also gain commissioning support from our small team of experienced CCG managers to give practical help and advice.

Our four localities are:

North Southport

Central Southport

South Southport

Formby

[3] Agendas, minutes, reports and other papers for our bi-monthly Governing Body meetings, which meet in public, can be found on our website. This includes regular performance dashboards for all key areas such as quality, safety, national and local requirements and finances

Ensuring quality

Our Quality Committee is responsible for monitoring and overseeing performance against national requirements, including those in the NHS Constitution[4], and local quality standards including patient safety and patient experience, as well as health and safety. To do this, the committee receives and assesses a wide range of data and information from the organisations we commission services from, as well as from inside the CCG. This work also reflects our commitment to ensuring we meet the recommendations contained in a number of important recent reviews such as Winterbourne and the Francis report.

Managing and responding to risks

Our Quality Committee is central to providing the Governing Body with assurance that there are structures, systems and processes in place to identify and manage any significant risks that we may face. This helps us to ensure that local health services meet the highest possible standards of quality and patient safety. It also supports us in meeting our statutory duties as well as helping us to plan for a healthcare system which is robust and capable of dealing with unplanned events.

Acting on our patients' experiences

Knowing what patients think of their care and treatment is an important way of understanding the quality of local health services - where they work well and where we need to work with providers to ensure they perform better to meet patients' expectations. Our Quality Committee gains information about patient experience in a number of different ways:

- We require our service providers to supply information about what patients think about the quality and safety of their healthcare – through their own patient surveys as well as the national Friends and Family Test
- We have established a borough wide cross sector Engagement and Patient Experience Group jointly with NHS South Sefton CCG – this group reports to the Quality Committee and gathers patient experience information from Healthwatch Sefton and other independent sources including the voluntary, community and faith sector, and you can read more on page 26
- Our complaints policy and process – these reflect the national guidance, 'Principles for Remedy'[5] and help us to identify trends and spot warning signs of any emerging problems

All this information helps us to make improvements to existing services as well as helping us to shape our plans for the future. Our procurement of the GP Out of hours service last year is a good example of where patient experiences helped us to produce a new service specification that requires higher standards based on people's feedback.

[4] This brings together all the rights of our patients and staff http://www.england.nhs.uk/2013/03/26/nhs-constitution/

[5] This guidance, issued by the Parliamentary and Health Ombudsman, focuses on six key areas of best practice http://www.ombudsman.org.uk/improving-public-service/ombudsmansprinciples/principles-for-remedy

Managing information about you

The Quality Committee also ensures that any information we hold about your care is held securely and in line with data protection legislation and wider Information Governance requirements. If breaches occur, we work hard to strengthen our systems, and our staff carry out regular training to ensure their work complies with national standards and regulations.

Other changes to your local NHS…

There were some other important changes to the NHS on 1 April 2013 when the Health and Social Care Act came into effect. Below is an overview, which helps to explain who is responsible for different parts of the healthcare system and how we work with partners to provide services and improve health locally:

NHS England

We work closely with the NHS Commissioning Board - NHS England - to ensure health services for Southport and Formby residents meet national and local standards. NHS England is now also responsible for directly commissioning primary care services. Locally, the Merseyside Area Team oversees standards and holds the contracts for GP surgeries, dentists, pharmacists and opticians, as well as some screening and immunisation programmes. Cheshire, Warrington and Wirral Area Team commissions specialist healthcare across the North West, whilst Lancashire Area Team is responsible for prison and armed forces healthcare.

Sefton Council

The local authority is now responsible for promoting and protecting good health across Sefton. It works closely with the new national body, Public Health England to do this in partnership with NHS England and ourselves. Our joint aim is to encourage people to live longer, healthier lives, and to reduce the variation in levels of health experienced in different parts of Sefton. Much of this work is now coordinated through the new Health and Wellbeing Board. In addition to this, we are working with Sefton Council to decide how best to spend the portion of existing NHS money being set aside for the new Better Care Fund. The aim of this is to support more seamless health and social care services that work better for patients.

Sefton Health and Wellbeing Board

We are members of Sefton Health and Wellbeing Board. This new committee of Sefton Council brings together everyone with a responsibility for health and social care in the borough, including local councillors and patient representatives. Together, we have devised a Sefton wide strategy for improved health and social care services, and you will read more about this later in our Annual Report.

Other clinical commissioning groups

We work with neighbouring clinical commissioning groups to plan and buy services when there is a benefit for Southport and Formby residents, or where services are provided across a wider geographical area, like hospital care. Our Care Closer to Home programme is one example of this and you can read more about this on page 22. We share a small management team with neighbouring NHS South Sefton Clinical Commissioning Group (CCG) as well as employing staff dedicated solely to our work. This means we are able to maintain efficient running costs and share good practice where it offers benefits to our local residents. It also helps us to work more effectively with Sefton Council and the Health and Wellbeing Board on borough wide programmes and initiatives.

This is particularly important when we are addressing the variations in health that exist in different parts of Sefton, so that no one community is disadvantaged and improvements are experienced by all.

Healthwatch Sefton

This independent organisation works on your behalf to ensure health and social care services are safe, effective and right for you. Healthwatch Sefton gathers and represents the views of people living in the borough. Because it is independent, Healthwatch can challenge those who provide services but it can also work in partnership with us and other statutory bodies to improve frontline health and social care.

Where we are now…

In our first year of operation we had a budget of around £171.9 million to commission health services for 122,147[6] Southport and Formby residents. So, given the current economic climate there is an even greater need to ensure we spend our money wisely. You will read more about how we are doing this throughout this report.

The majority of our budget, around 75%, is spent on hospital based services. Whilst we support people's right to choose where they are treated and who provides their care[7], the majority of the services we commissioned in 2013-2014 were from NHS Southport and Ormskirk Hospital NHS Trust. Since 2012, this has been an integrated care organisation, providing both hospital and community based services.

Our other main service providers include:

- Mersey Care NHS Trust – the leading mental health trust across Merseyside
- North West Ambulance Service NHS Trust –providers of patient transport services as well as its network of emergency response vehicles
- Cheshire and Merseyside Commissioning Support Unit – which provides many of our administrative and operational functions like data management and performance reporting
- Other NHS organisations – like Aintree University Hospital NHS Foundation Trust, The Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool Women's NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, Liverpool Heart and Chest Hospital and Liverpool Community Health NHS Trust
- Community and voluntary sector organisations – like Sefton Carers Centre and the Alzheimer's Society
- Independent and private sector providers – Go To Doc, a GP led organisation providing our Out of Hours service

A number of services have been opened up to new providers through a national scheme called 'Any Qualified Provider'. In 2013-2014 we commissioned musculoskeletal, podiatry and audiology services through this process, with many residents now being able to access these services in locations and at times that are more convenient to them.

[6] Attribution Data Set (CCG level), Department of Health
[7] Choice of place of treatment is one of the rights included in the NHS Constitution

What this means for you

We work hard to make sure that as much of our budget as possible is spent directly on providing people's care and treatment. There are numerous examples of where this is making a difference to people's lives. Some of the services and schemes that we were particularly proud of in 2013-2014 have been developed by our GP practice localities, others from working much more closely with our partners and provider organisations. Here are some examples.

Providing quality care at the busiest times

Over the winter months health services are at their busiest, when the colder weather brings seasonal illnesses like flu, as well as worsening the health of some of our most poorly and vulnerable patients. During 2013-2014 we made some additional investments in our local NHS over the winter months that helped us to cope with the extra pressures that winter traditionally brings. Extra appointments were funded in primary care, so that more people could see a GP if they needed to. We invested in schemes to reduce delays for patients, funded a community hot meal programme for the most vulnerable and a self care programme to help people with long term illnesses to better manage their condition. In addition, we worked closely with Southport and Ormskirk Hospital NHS Trust to secure around £4m worth of one off government funding to reduce seasonal pressure on urgent and emergency services. All these schemes were part of our wider plans to support and monitor local health and social care services over winter, working closely with other partners such as community services, the council, other CCGs, NHS England, other healthcare providers and the voluntary and community sector. This extra support and monitoring resulted in our providers improving care for patients and meeting important targets for Accident and Emergency (A&E) care, which you can read more about on page 36.

Our children, our future

Improving the health and wellbeing of our children and young people is a key priority for us. We are active members of the Health and Wellbeing Forum's 0-19 and in 2013-2014, together we set priorities to address the wider wellbeing needs of our children and young people. Whilst one of the eight main programme areas in our five year strategic plan focuses on children and young people, they are, of course, considered in nearly all of our other work streams. We work with a wide range of partners – from NHS England and Sefton Council, to voluntary, community and faith sector organisations - to address different aspects of health and wellbeing. We have also piloted a new Children's Community Nursing Team working between hospital and primary care. It aims to provide better support in the community to prevent the need for hospital, as well as working with young patients on the ward to get them well and back home as quickly as possible. Early results have been extremely positive and in 2014-2015, we will explore how we can further develop this service to provide more care closer to home.

Living a fuller life with dementia

There is a growing body of evidence to suggest that regular activity can improve the quality of life of people living with dementia. Along with our counterparts in Sefton, Knowsley and Liverpool, we funded an 18 month project led by the Alzheimer's Society to further assess the positive impact that activity can offer those with dementia. It involved six activity programmes – an art group, singing for the brain, music and wellbeing, dance and movement, maintaining skills and reading together. Over 200 people across Sefton took part in the regular sessions and the impact was evaluated. Early findings show great benefits for those who participated. Many people reported improvements in relaxation, concentration and mood, which lasted beyond the duration of the sessions. The full study is expected later in 2014 and will help us to shape a Sefton wide dementia strategy with our partners in the Health and Wellbeing Board.

Hospital Alcohol Team

We invested in a Hospital Based Alcohol Team working within Southport and Ormskirk Trust to support those patients who are admitted to hospital and who may have issues with alcohol. The team can initiate treatment and signpost patients to community services for ongoing support. Early outcome data shows that the team is screening a significant number of patients and reducing the time they spend in hospital by supporting them to get more appropriate treatment from community services.

Better and earlier detection for eye conditions

Working with local optometrists, we launched a Glaucoma Repeat Reading and Visual Field Service at the end of 2013, making it easier to get advice on eye conditions closer to home. It means that people who are spotted with signs of suspected glaucoma or visual field problems during a routine eye check at their high street optician are now able to have new and additional tests for the conditions there, instead of waiting for a referral to hospital. Similar schemes elsewhere have found that most people who are initially suspected of glaucoma or visual field problems prove clear following this further test, saving them the time and unnecessary worry of a wait for a follow up at hospital.

As well as reducing the time people have to wait to have their condition detected, the scheme will also enable hospitals to concentrate on care for those who do need treatment for their conditions once their diagnosis has been confirmed. This new scheme is part of a wider programme to determine what other improvements can be made to local ophthalmology services. In the summer of 2013 providers – including hospitals, opticians and the independent sector- came together in a 'summit' style event to begin to explore where we can provide even more eye services closer to home and this work will continue in 2014-2015.

Formby GP care home pilot

Care home residents in Formby are paid a weekly visit by a local doctor through a new pilot programme that aims to keep them as well as possible, for as long as possible. A GP carries out a weekly 'ward round' at care homes in the area to assess patients and spot early any changes in their conditions. Care home populations are rising, with more vulnerable patients with increasingly complex needs. Four in five care home patients have memory problems or dementia and many have several long term conditions. Regular, proactive GP visits mean that health problems are spotted at an earlier stage, and can often be treated in the home. In this way, emergency admissions to hospital due to a sudden health crisis can be prevented. A similar scheme in Sheffield saw emergency admissions reduce by 9% compared to previous year and in its first 18 months saved £145,000 whilst improving care planning, co-operation between practices and homes, as well as increasing satisfaction levels amongst patients. The Formby pilot will run for 12 months and if results are positive, the scheme will be rolled out across the CCG.

Care home medicines project

Following a successful pilot, a new annual medication review for all care home residents in Southport and Formby was introduced this year. The scheme aims to improve the quality and safety of care for these patients. Through more regular monitoring of patients' medicines we can ensure they are taking the most appropriate ones for their condition at the right time. In the initial pilot of over 750 patients, the scheme helped prevent people from needing hospital treatment on 13 occasions. Over £30,000 was also saved through better and more effective prescribing. In addition, pharmacists will also provide advice to nursing home staff around the safe management of medicines, and act as a bridge between nursing homes, primary care and hospitals – all with the aim of improving the treatment and experience for this vulnerable group of patients.

Investing in our local communities

With NHS South Sefton CCG we awarded over £1 million to local voluntary, community and faith sector organisations, whose work is playing a valuable contribution to achieving better health and wellbeing for our local residents. Through Sefton CVS, organisations were asked to submit bids for one off funding to support specific initiatives. Following a thorough and stringent assessment process, 43 out of 52 bids were successful in gaining awards for one off funding in early 2013-2014. The range of successful organisations included People First Merseyside, Y kids, Brighter Living Partnership, Home Start Southport and Formby and Sefton OPERA. These are exciting schemes, often designed and delivered by local people for others who live in their communities. We anticipate that support will be available to continue the good work in 2014-2015.

One example is the People First Health Champion programme. Funding from the CCG enabled a number of volunteers with learning disabilities to be trained in promoting healthy lifestyles. As well as offering advice and support to others with learning disabilities, the Champions researched and designed an important new resource that will be available in GP practices later in 2014. The information pack is both a resource for patients and practice staff. Its aim is to improve the experience and care patients with learning disabilities receive when they visit their doctor's surgery.

Macmillan Cancer Information Centre

It is nearly two years since the centre, based in Southport's Community Service Station, opened its doors, and in 2013-2014 it supported hundreds more local residents whose lives have been affected by cancer. The centre on Scarisbrick Avenue is run in partnership with the charity Macmillan Cancer Support. It offers a wide range of information, advice and practical assistance to cancer patients, their friends, family and carers. In 2013-2014 our clinical lead for cancer and Macmillan GP, Dr Graeme Allan was bestowed with the prestigious Service Improvement Excellence Award for leading the development of the centre. This award recognizes Macmillan professionals who have achieved definable improvements to the services offered to people affected by cancer.

Improving our GP out of hours service

On 1 October 2013 our new GP out of hours (OOH) service went live. The Sefton wide service uses local doctors to deliver healthcare to patients if they become ill when their surgery is closed overnight, at weekends, or Bank Holidays. Like many other services, OOHs are regularly reviewed and, where necessary, are put out to tender to ensure they continue to offer the highest standards of care. Whilst there was no change in the way patients' access OOH, over time they should benefit from the higher quality standards that we specified when we re-tendered this service.

The new provider is Go To Doc (GTD), a not for profit GP led organisation. GTD grew out of a GP co-operative and has a strong history of providing high quality, high performing and clinically safe out of hours services to over 1 million people in the North West. Anyone who thinks they need to see a doctor when their practice is closed should simply call their surgery's usual telephone number and follow the instructions about how to contact the OOH service.

Better care for people at the end of their lives

We want to improve the quality and experience of care for people nearing the end of their lives and we have made some good progress in doing this during 2013-2014. We partly fund a 'Hospice at Home' style service provided by Queenscourt Hospice, which enables patients to be cared for and die at home in accordance with their wishes. The service offers wraparound support from the moment a patient leaves hospital or the hospice to return home. Alongside this we have made additional funding available to Queenscourt in the year to employ a new Clinical Transformation Coordinator. This role will be pivotal in better joining up hospital and primary care services and Queenscourt intends to build on this further in 2014-2015 to create a Transform Team. We will also be funding an end of life care home facilitator to be part of this new team. This approach is important in working with patients as early as possible to ensure the right support is put in place based on their wishes. As a result of all these initiatives, more Southport and Formby residents are choosing to be cared for and die at home – over 50% in the year, which is higher than the average for many other Merseyside CCGs and compares to 45% nationally.

Community Asperger's service

This service is being developed as a direct result of our local residents. Families and carers came to us and asked why there are too few services locally for people living with Asperger's. We worked with them to look at what was currently available and what was needed in the future to improve the support on offer. We designed a new community based service in partnership with this group and Mersey Care. Initially the service will be piloted for 12 months from May 2014 to help us to understand if it is effective in meeting the needs identified by patients and their families.

Connected Communities

Work began on an exciting new programme developed by Central and South localities in 2013-2014. Connected Communities will help patients with chronic health care problems to connect with a wide range of support networks in the community and voluntary sector. GP practices will be able to refer patients to a single point of contact based with Sefton CVS. The Connected Communities team will then support patients to access services, networks and groups that can help them to better manage their health condition and improve their wider wellbeing. The scheme will initially be piloted during 2014 in a small number of practices to assess its benefits.

Where we want to be…

We want Southport and Formby to be a sustainable and healthy community.

To do this we need to build on what we know already works and plan for health services that continue to meet the needs of local people in the future.

Central to this is collecting and understanding all the information and medical evidence about current health and health services in Southport and Formby, to inform what more we need to do in the future.

Because the work of our partners also impacts on the health of local people, we are working closely together to ensure all our plans are aligned. This means that collectively, we have the opportunity to achieve more by sharing resources, reducing duplication and strengthening our combined efforts whenever we can.

The views of our patients and public are also central to understanding what we need to do to improve health and health services, and we have been involving local people in this process too.

Southport and Formby at a glance

Southport and Formby stretches from Ince Blundell in the south to Churchtown in the north, situated along the North West coast.

There are a number of distinct environmental and social factors that we must take account of when we are planning local health services including:

- Our population is made up of a significantly higher than average proportion of older residents with an estimated 25.5% (approximately 29,300) of the population over the age of 65 compared to 17.5% aged over 65 nationally. This is expected to grow further to more than 33,400 in the next ten years
- Our residents live in economically diverse communities, with areas of affluence and pockets of deprivation. The areas of highest income deprivation affecting older people are concentrated in central Southport with some pockets of income deprived older people in Ainsdale and Norwood

Overall, health in Southport and Formby is getting better but there are clear areas for improvement:

- Life expectancy in our least affluent communities remains unacceptably low
- Levels of some long term health conditions are higher than the national average
- The number of early deaths from heart disease and cancer have reduced over the last decade as smoking rates have declined but we want to do more to close the gap between Southport & Formby and the national average
- Our patients are better educated about risks to their health and the importance of leading a healthy lifestyle and we want this trend to continue

Focusing on the future

By June 2014 we will have finalised our five year strategy for improvement.

Based on all the information we know about health and health services in Southport and Formby we are focusing our work on three broad strategic areas, which we intend to address over the next five years:

- Care and treatment for our older and vulnerable patients
- Unplanned care
- Primary care development

We have eight key programmes of work that will help us to achieve improvements across our priority areas – mental health, cardiovascular disease, respiratory disease, diabetes, cancer, primary care, children and supporting patients at the end of their lives.

We have a number of other plans and strategies that underpin our five year strategy – like Care Closer to Home and our primary care quality strategy – which you will read more about later in this section.

How we plan for better health

Our journey began in 2012 before we became a statutory body.

We worked with Sefton Council, NHS South Sefton CCG and other key partners to map current health and social care services and to identify opportunities for improvement. This exercise was called the Sefton Strategic Needs Assessment, often known as a JSNA.

The information gained through this exercise was used to shape a Sefton wide Health and Wellbeing Strategy, setting out overarching aims and objectives for statutory health and social care bodies across the borough. This strategy is overseen by Sefton's new Health and Wellbeing Board (see page 10).

We have invited local people and patients for their views and involvement throughout this process and you can read about some of the ways we have been doing this on page 27.

Here in the CCG we have used all this information to inform our annual business plans for 2013-2014 and 2014-2015, as well as our longer term five year strategy for improved healthcare.

These plans and strategies ensure we are meeting all our statutory duties, such as those set out in the NHS Outcomes Framework, as well as the overarching Health and Social Care Act 2012.

Care Closer to Home

This is one of our most important programmes of work, cutting across much of what we want to do to improve services for Southport and Formby residents. Care Closer to Home particularly focuses on our most vulnerable older patients, helping them to stay as well as possible, for as long as possible through more streamlined, joined up and effective care. We will need to transform the way hospital, community, primary care and social care services work together if we are to fully meet our vision for better health and wellbeing. It will see more treatments and support provided in community clinics and other venues rather than in hospital. We also want these services to be more flexible, so they can easily adapt to meet the differing needs of our patients – acknowledging that one size does not always fit all. Alongside this we want to better support patients to manage their own illnesses, so they can prevent their condition deteriorating and the need for urgent hospital care. Care Closer to Home brings together a wide range of partners including Southport and Ormskirk Hospital NHS Trust, Sefton Council, Sefton CVS and Mersey Care NHS Trust. Because this programme affects communities beyond Southport and Formby, commissioners from NHS West Lancashire CCG are also involved in this work.

We will use money from the local Better Care Fund towards transforming services in Southport and Formby and we have been working with our partners to develop our action plan, which will be finalised by June 2014.

Care Closer to Home is already making a difference to our patients as the following example shows.

Community Emergency Response Team

The new nurse led, multi-disciplinary Community Emergency Response Team (CERT) provides care to some of our most vulnerable, older patients. CERT acts as a bridge between hospital and primary care, working with those patients who need extra support but who do not need to be in hospital. GPs refer patients whose condition may be deteriorating to CERT, and the team steps in to give additional, more appropriate care. Previously, these patients would have been admitted to hospital and often their recovery would have taken much longer. CERT also works with hospital patients, so they do not stay on the wards any longer than they need to. To do this CERT also works closely with intermediate care – which provides community based beds and treatments - so patients referred to them either by a GP or from hospital benefit from more tailored support to get them well and back home as soon as possible.

Mrs C's experience

Over Christmas, Mrs C who lives alone, fell and fractured her wrist. Her doctor decided to call in the CERT team. Mrs C was initially assessed by rapid response nurses, who brought in a therapist to carry out a further assessment. Because of Mrs C's mobility problems, the therapist suggested that she would benefit from rehabilitation in intermediate care, based at Chase Heys. Whilst at Chase Heys, Mrs C was seen daily by therapists and nurses from CERT. She was also visited three times a week by a GP. Mrs C made good and steady progress and in the week before she went home she attended the morning breakfast club, meeting new people and socialising a bit more than she normally would. Mrs C returned home with four weeks of continued care from CERT, providing regular visits to ensure Mrs C's continued recovery.

Without CERT Mrs C would have been admitted to hospital. Instead her needs were managed in the community, closer to her family, giving her a better experience and more tailored care, prompting a speedier recovery and return to her own home.

Enhancing primary care

We know that primary care must adapt and respond to the changing needs of our local residents if it is to remain effective in the future. Whilst we may not be responsible for commissioning primary care, we do have a duty to ensure that the quality of services provided in local GP practices continually improves.

In 2013 we produced a discussion document, 'A Sense of Purpose' setting the context and current challenges faced by primary care. This helped to focus the debate between our member practices as to how we could move forward. Alongside this, we held conversations with our partners, patient groups and voluntary and community organisations to gain their views on the future of primary care.

All these conversations and discussions helped us to design and agree our primary care quality strategy, 'Energising Primary Care', another element of our wider five year strategy and setting out a vision for enhanced primary care by 2020. Energising Primary Care complements the national Call to Action for primary care and the opportunities that new GP contracting arrangement presents in five areas:

- Practice demographics – planning for the changing health needs of our patients
- Workforce development - to ensure staff have the skills for the future
- Clinical outcomes – improving results for those with long term conditions and other medical problems
- Estates and IT – so our infrastructure is fit for purpose
- Health outcomes – to better support people's wider wellbeing

To oversee this work we have set up a joint primary care programme group with NHS South Sefton CCG, reporting to our quality committee. It brings GP members together with commissioners from NHS England (Merseyside), the Local Medical Committee, Healthwatch Sefton and Merseyside Property Services.

Here are a few examples of our progress in 2013-2014:

Contracting for quality

Whilst NHS England is the lead commissioner of services in primary care, CCGs may also commission a number of practice based initiatives to support their wider strategies with the aim of improving quality. The introduction of the NHS Standard Contract in April 2014 changed the way CCGs contract with practices for these quality schemes. As part of developing our wider strategy, we took this opportunity to review the existing practice based schemes, involving our members and the Local Medical Committee. Our new programme, which includes phlebotomy and improving access to primary care, now complements our wider objectives.

Practice based healthcare assistant apprenticeship scheme

As part of our response to the Francis Report, we devised this exciting apprenticeship programme to support workforce development in primary care. It will enable practices to receive part funding to train and develop an apprentice healthcare assistant, providing trainees with an accredited qualification.

Supporting quality in cervical screening

Our practice nurse facilitators have developed a mentor programme for cervical screening coordinators, matching students with mentors and monitoring their progress. Coordinators are recommended to attend a clinical update session every three years. So our practice nurse facilitators also influence the quality and content of a number of training and clinical update sessions, including a foundation course run in collaboration with Liverpool University.

More effective testing for lung diseases

We have a higher than average number of people living with the lung condition, Chronic Obstructive Pulmonary Disease (COPD). It is diagnosed through a ‘spirometry’ test and we are working with practice nurses to improve the quality of these tests, through training and standardising equipment.

Involving you

Involving Southport and Formby residents in our work is fundamental to achieving better heath and wellbeing. Our patients know the quality of existing health services from first hand experience, and the view of local people can help us to determine what more we need to do to achieve our goals.

Involving you in our daily business

We have a number of statutory responsibilities[8] to make sure good, two way engagement and involvement is part of our daily business and our organisational structures reflect our commitment to this:

- We have a named Governing Body Lay Member lead for public engagement and involvement
- Our Engagement and Patient Experience Group (EPEG) reports to our Quality Committee. It is jointly chaired by our Governing Body lead and their counterpart from South Sefton CCG, along with their elected practice manager leads. It includes representation from the patient's champion Healthwatch Sefton, Sefton Council and Sefton CVS, which represents the voluntary, community and faith sector. This group helps us to maximise the opportunities we have to engage across the different sectors in Sefton by working together in a coordinated way. EPEG gives expert advice about how and where to go to engage people. It collects the information we gather from all our engagement activities to inform our work, and patient experience to help us to gauge how effective our services are and how we can improve them. We have begun developing an electronic system to help us better manage the information we collect through EPEG. This will strengthen our internal systems, making it easier for us to turn people's views into service improvement
- Whenever it is appropriate, we invite patient representatives to get directly involved in our day to day work and so far this has included groups to improve respiratory services, cancer and eye care, along with re-procurement exercises
- A number of GP practices in Southport and Formby have Patient Groups. We are providing support to help more practices to set up their own group. These groups enable patients to have their say about services at their practice and hear about our wider work. In 2014 we will bring those groups together through regular meetings to provide support and share experiences
- We hold regular public Big Chat events where we bring people together to discuss our work and to ask for their views about our plans. The views we have gained from these events have informed both our annual business plans and how we are shaping our five year strategic plan. In early 2014 we began holding 'Mini Chats' to really focus on specific topics and issues and this will help us to finalise our five year plan
- We have supported the development of Healthwatch Sefton's Community Champion network, encouraging more people to get involved in their local health services and helping us to gather their experiences of using the services we commission.

[8] This includes the Health and Social Care Act, the NHS Constitution, the Equality Act 2010 and local council Overview and Scrutiny powers around service changes, along with guidance such as Transforming Participation in Health and Care and Everyone Counts – Planning for Patients

Your involvement in 2013-2014

There are a number of different ways that we involve local people in our work – from tapping into the strong voluntary, community and faith networks, meetings and events that exist, to carrying out more focused work with specific communities or groups of people affected by our work. Here are some examples from 2013-2014.

Big Chats and Mini Chats

Our Big Chat events provide a forum to bring local people together to discuss a wide range of issues relating to their health and wellbeing. As well as updating people about our work, we invite views and comments through workshop sessions and discussion groups. Our Big Chat in November 2013 was a joint event with Sefton Health and Wellbeing Board and we will hold more of these joint events over time. At Big Chat 3 we fed back about some of the projects and initiatives developed from views we gained at earlier Big Chats and other joint public events that helped us to shape our JSNA and Health and Wellbeing Strategy. In early 2014 we held our first 'Mini Chats'. These are focused events giving people more opportunity to explore issues that really matter to them in greater depth – important for us as we finalise our five year strategy for better health and wellbeing. During 2013/14 a total of over 230 delegates have attended the Big Chats and Mini Chats that have discussed services in Southport and Formby.

Improving Access to Psychological Therapies

This service provides a range of talking therapies for mild to moderate mental health conditions. In a similar way to our GP out of hours service, we have retendered the Improving Access to Psychological Therapies (IAPT) programme to ensure it offers the best standards of care and value. Our local IAPT has lower than average waiting times and exceeds Department of Health recovery rates. To make sure the service continues to improve, we asked local people and those who have used the service what they think and how it could be better in the future. This information has helped us to shape the specification of the new service.

Using experience to improve eye care

To help us further develop our ophthalmology strategy, we have been working with a wide range of patients and patient groups and charities to understand where we can provide more testing and treatments for eye conditions locally, rather than in hospital. In the first year of the strategy, 2013-2014, we concentrated on developing and launching the Glaucoma Repeat Readings and Visual Fields Service, which you can read about on page 14 and patients views and experiences contributed to making this a priority. Before the scheme, patients had to wait much longer for these tests and often experienced overcrowded hospital waiting rooms. We will evaluate the service in early 2014-2015 when data is available. However, early feedback suggests that since the service's launch, waiting times for hospital eye services have begun to reduce and patients are giving positive views about their service in their local opticians.

Community Asperger's service

This service is being developed as a direct result of our local residents. Families and carers came to us and asked why there are too few services locally for people living with Asperger's. We worked with them to look at what was currently available, what was needed in the future to improve the support on offer. We designed a new community based service in partnership with and this group and Mersey Care. Initially the service will be piloted for 12 month from May 2014 to help us gauge if it is effective in meeting the needs identified by Asperger's patients and their families.

Working together for carers, those with dementia and older people

Our Health and Wellbeing Board began work to update and refresh our Sefton wide Carers and Dementia strategies in 2013-2014. We are working together with the council and other partners to involve people in this process. There have been some innovative approaches including dementia cafes and carers summits. These strategies are expected to be finalised later in 2014. Our joint Strategy for Older Citizens was submitted to the Health and Wellbeing Board in February 2014, and this work has been driven by the Sefton Partnership for Older Citizens.

Commissioning Policy Review

Our existing commissioning policy covers around 90 procedures that are known to have a medical benefit only in very specific situations, or for a small group of people. In December 2013 we asked our Commissioning Support Unit to review and update the policy to take account of the latest medical evidence and technologies. The review was carried out collaboratively with a number of local CCGs and in early January 2014 we began a three month consultation asking for input from the public. This finished in April and will help us to agree a final version of the policy, which will be implemented later in 2014.

Equality and diversity

We approved an Equality Objective Plan in September 2013 in line with our specific duties and requirements under the Equality Act 2010. An Equality Delivery System Self-Assessment was completed between July and October 2013 and supported the development of a set of objectives. We carried out a self-assessment and rated ourselves as 'developing', reflecting our status as a new commissioning organisation.

Our Equality Objective Plan lays out clear work streams that will support us to meet and pay due regard across our key functions to meet the exacting Public Sector Equality Duty to:

- Eliminate discrimination
- Advance Equality of opportunity
- Foster good community relations

Our Equality Objectives are to:

- Enable us to make fair and transparent commissioning decisions
- Improve access and outcomes across communities and patients who share protected characteristics
- Improve the equality performance of our key service providers
- Support an engaged workforce

Here are some examples of our work in this area:

- Agreeing an Equality and Diversity policy and other relevant policies – these were approved at the joint Cheshire and Merseyside CCG and Commissioning Support Unit Partnership Forum in December 2013. This forum brings CCGs together with our staffside, or union colleagues representing our staff
- Carrying out a Diversity survey in conjunction with NHS England in July 2013
- Active membership of Sefton Equalities Partnership – this brings us together with organisations from across the borough
- Exploring ways to improve health services for Transgender residents, working with the service user group, InTrust – a need that was highlighted in our local JSNA
- Designing a new support service for Military Veterans with our partners that will launch on April 2014 - after the results of a mapping exercise focusing on existing provision highlighted a gap

Working sustainably

We recognise that working in a sustainable way is essential in helping us to improve health and wellbeing. We also know that many of the factors affecting this are outside the direct control of the NHS. So, working with our partners is crucial in achieving a sustainable Sefton and we made good inroads during our first year.

- Joining with our partners through the Health and Wellbeing Board to begin to explore the scope for a Sefton wide vision for sustainability – this will help us to identify areas where we can work together to achieve more and address the requirements set out in the national sustainable development strategy for the NHS, public health and social care, along with the Sustainable Development Unit's strategy for improving health, wellbeing and resilience in a changing climate
- Supporting our service providers to meet their targets around sustainability – through our contracts with them and as part of monitoring their performance
- Adopting sustainable internal principles for the way we run our organisation – such as encouraging staff to be energy efficient in the workplace, sourcing goods and services as locally as possible and promoting a paper free culture whenever possible

The UK Climate Change Act 2008 set out, for the first time, statutory emission cuts. NHS organisations are required to deliver CO2 emission reductions of 10% by 2015, 34% by 2020, 50% by 2025 and 80% by 2050. This is set in the context of the overall NHS carbon footprint arising from buildings (19%), transport (16%) and procurement (65%).

We have a small workforce and a small headquarters, so we are a relatively low carbon emitting organisation. We lease our office in Southport, and we will work with the owners of the building to provide required information about carbon emissions in future years.

Being prepared for emergencies

We have a role to play in supporting the management of emergencies such as major incidents, or natural events like flooding and pandemic flu. Our duties are set out in the Civil Contingencies Act 2004, which names CCGs as 'Category 2' responders. This means we are required to share information and cooperate with other agencies in planning for and responding to emergencies should they happen.

Like Category 1 responders, such as the police, fire service and Sefton Council, we must also produce plans to help us to assess risk and ensure that arrangements are in place for informing and warning the public should this be necessary. The NHS Core Standards for Emergency Planning, Response and Resilience further requires us to ensure that our service providers have plans in place to respond to and recover from emergencies.

We gain operational support in meeting our duties from Cheshire and Merseyside Commissioning Support Unit through its Emergency Planning, Response and Resilience Team. Here are some of the ways we met our duties in 2013-2014:

- We are part of the Local Resilience Forum and the Local Health Residence Partnership – which bring a wide range of agencies together to plan for and coordinate the management of emergencies
- We work with CCGs and service providers across Merseyside to ensure the healthcare system can respond to incidents night and day – we have a 24/7 on call system, so service providers and other agencies can contact us round the clock in the event of emergencies
- We have developed Business Continuity and Incident Response Plans - as well as making sure our own plans are robust, we monitor the plans of our service providers
- Our staff take part in regular training sessions and exercises – so we have the skills and experience to deal with unexpected incidents

Continuing to develop and grow

We want to ensure that NHS Southport and Formby CCG remains to be an effective and innovative organisation into the future. To do this we must continually grow and develop our knowledge and skills in line with the latest developments in healthcare and technologies.

One of our most important documents is our organisational development plan, which was agreed by the Governing Body in November 2013. It was informed by earlier work with members and staff to assess areas for development and focuses on six themes:

- Leadership, workforce and team development
- Public and patient communication and engagement
- Locality development
- Strategy and performance development
- Improving functionality
- Values, style of working and change management

Our members

We support our member practices to carry out their commissioning responsibilities in a number of different ways.

- Continuing professional development sessions are regularly organised for clinical staff and these are called Protected Learning Time (PLT) events
- In 2013, we held our first PLT events for wider practice staff, including reception staff
- We employ two facilitators, who involve and provide support to practice nurses
- We hold quarterly membership meetings where practices come together to discuss wider CCG work
- A weekly e-bulletin provides members with updates on CCG work, along with relevant national publications and development opportunities
- An intranet site provides a wide range of information designed to support our members

Our staff

At the end of March 2014 we employed 77 people (38.7 whole time equivalents) to help us to carry out our work. This includes commissioning and medicines management professionals, doctors, nurses and a small number of administration and support staff. Nearly all of our staff work jointly with NHS South Sefton CCG through our shared management team arrangements. We also have a small number of joint appointments with Sefton Council.

	Governing Body	Very Senior Managers	Other employees
Male	10	0	22
Female	3	0	42
Total	**13**	**0**	**64**

We are committed to supporting and developing our employees and here are some of the ways we do this.

- We are committed to being a fair and equal employer and our workplace policies are in line with all relevant equality, diversity and human rights legislation to ensure none of our staff are disadvantaged by our working, training or recruiting processes
- Because we are a small team, we are able to meet regularly to discuss business and performance, and to share ideas and innovation
- We ensure our staff have the resources and development opportunities to help them carry out their day to day work, including support to complete essential core training requirements, holding regular personal development reviews, promoting and providing staff support and occupational health services focusing on health and wellbeing, as well as ensuring easy access to information through our intranet and weekly ebulletins

The right tools and systems for the job

Having the most up to date information systems and technologies is essential to providing the very best healthcare. As we work towards achieving health and social care services that are better joined up, this will be more vital than ever.

Information technology

We have done a great deal of work in 2013-2014 to further develop our IT strategy, working closely with Informatics Merseyside and our service providers. In the future, there will be an even greater need for our providers to share information to build an electronic healthcare record that will help to improve individual patient care. These systems will be safe and secure and conform to the highest data protection safeguards. We are also working with service providers to explore mobile working for healthcare professionals, helping us to provide more care closer to home.

Managing our programmes more effectively

Our Programme Management Office (PMO) plays an important role in helping us to develop and monitor our three main strategic projects – unplanned care, primary care and older frail people – whilst at the same time tracking the performance of our main work streams, which you can read more about on page 20. This approach has been essential in the development of our five year strategy. The PMO ensures programmes are developed systematically - from the planning stages, continuing right through the entire life of the scheme. It also contributes to providing assurance to our Governing Body about the performance of the services we commission, helping to spot trends and identify early any problems or issues. Our PMO received national recognition in 2013-2014, when its innovative approach was showcased at two national NHS conferences. The PMO is also featured in a best practice ‘casebook’ for commissioners.

Our performance

To make sure we fulfil all our duties, our performance is regularly measured, monitored and scrutinised. This happens in a number of different ways - through our internal structures and processes as described earlier in this report, as well as being regularly assessed by NHS England.

There are also a number of documents that set out targets for different areas of our work. This includes the pledges contained in the NHS Constitution, the NHS Outcomes Framework and local measures developed in line with Everyone Counts – national guidance for CCGs on planning for patients. We have set these local quality measures ourselves. These have been determined by the needs of Southport and Formby residents and focus on where we need to make improvements in key local and specific areas.

Overall, we performed well in 2013-2014 and the work you have been reading about so far in this report has all contributed to this.

An overview of performance follows[9]. More detailed information can be found in the reports presented to our Governing Body at each of its public meetings[10].

[9] This overview of performance is based on data available at the time of writing this report, covering the period April 2013 – end February 2014

[10] All performance reports presented to the Governing Body can be found on our website www.southportformbyccg.org.uk

Performance in health

Nearly all of these measures depend on how well the organisations we commission services from are performing. Where they fall short of expectations, we work with them to improve and this sometimes includes contractual measures to ensure our services meet the best possible standards.

Performance indicator – met or exceeded	Source of measure
Percentage of patients waiting 6 weeks or more for a Diagnostic Test	**NHS Constitution**
Referral To Treatment waiting times for non-urgent consultant led treatment	**NHS Constitution**
Ambulance – Category A (Red 2) 8 minute response time (North West level)	**NHS Constitution**
Ambulance – Category A (Red 1) 8 minute response time (North West level)	**NHS Constitution**
Ambulance - Category 19 transportation time (North West level)	**NHS Constitution**
Cancer waits – 31 days	**NHS Constitution**
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	**NHS Constitution**
Maximum 2 week wait for first outpatient appointment for patients referred urgently with breast symptoms	**NHS Constitution**
Mental Health Measure - Care Programme Approach	**NHS Constitution**
Percentage of patients who spent 4 hours or less in A&E	**NHS Constitution**
10% reduction in the number of patients who have an emergency admission for dehydration.	**Everyone Counts - local**
Patient reported outcomes measures for elective procedures: Hip replacement, knee replacement, groin hernia	**Outcomes Framework**
Emergency admissions for children with lower respiratory tract infections	**Outcomes Framework**
Incidence of the healthcare associated infection, MRSA	**Outcomes Framework**
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	**Outcomes Framework**
20% of patients who have had an alcohol specific hospital admission offered an intervention	**Everyone Counts - local**

Headlines…

When treating our patients, our service providers achieved ‘excellent’ performance for meeting A&E targets, Referral to Treatment Times and all 31 day cancer waiting times measures. There were also no reported cases of the healthcare associated infection, MRSA during the year. As a CCG, we met standards for enhancing quality of life for those with long term conditions. We also achieved excellent for the measure relating to mental health, some of the ambulance response measures, a number of local measures and those related to helping people to recover from episodes of ill health.

Performance indicators – nearly met	Source of measure
Maximum 2 week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – (required target = 93%)	**NHS Constitution**
Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	**NHS Constitution**
Ambulance – Category A (Red 2) 8 minute response time (CCG level data)	**NHS Constitution**
Ambulance clinical quality - Category 19 transportation time (CCG level data)	**NHS Constitution**
* Rate of potential years of life lost from causes considered amenable to healthcare (Males)	**Outcomes Framework**
* Rate of potential years of life lost from causes considered amenable to healthcare (Females)	**Outcomes Framework**

Headlines…

When treating our patients, the North West Ambulance Service (NWAS) nearly met our local CCG target of 8 minutes and 19 minutes for Category A calls. We are continuing to work with NWAS to address this.

Both 2 week and 62 day cancer waits for our patients from the time they are referred by their GP are below the required standard. We are working with hospitals to reduce the number of patients who fail to attend their appointment (DNAs) and by streamlining their systems to make it easier for patients.

* Whilst our internal measurement of these indicators indicates that we nearly met these performance targets, the formal measures relating to potential years of life lost will not be reported nationally until later in 2014.

Performance indicator – not met	Source of measure
Incidence of the healthcare associated infection, C.difficile	**Outcomes Framework**
Mixed Sex Accommodation - Breaches per 1000 Finished Consultant Episodes	**NHS Constitution**
20% reduction in emergency admissions for asthma in under 19 year olds.	**Everyone Counts - local**
Emergency admissions for acute conditions that should not usually require hospital admission	**Outcomes Framework**
Ambulance – Category A (Red 1) 8 minute response time (CCG level data)	**NHS Constitution**

Headlines…

Mixed sex accommodation breaches, emergency admissions for acute conditions which should not usually require admissions and levels of the health care associated infection, C Diff are higher than we would expect for our patients, and we are working closely with our service providers to address these areas.

Childhood asthma admissions for our patients is currently above what we planned.

There are a range of new measures that we will not receive data for until summer 2014. This is because data is only issued on an annual basis. It will cover areas like mortality rates for cancer, cardiovascular disease, respiratory and liver diseases for under 75 year olds. We will report performance for these new measures through our regular reporting processes once it becomes available.

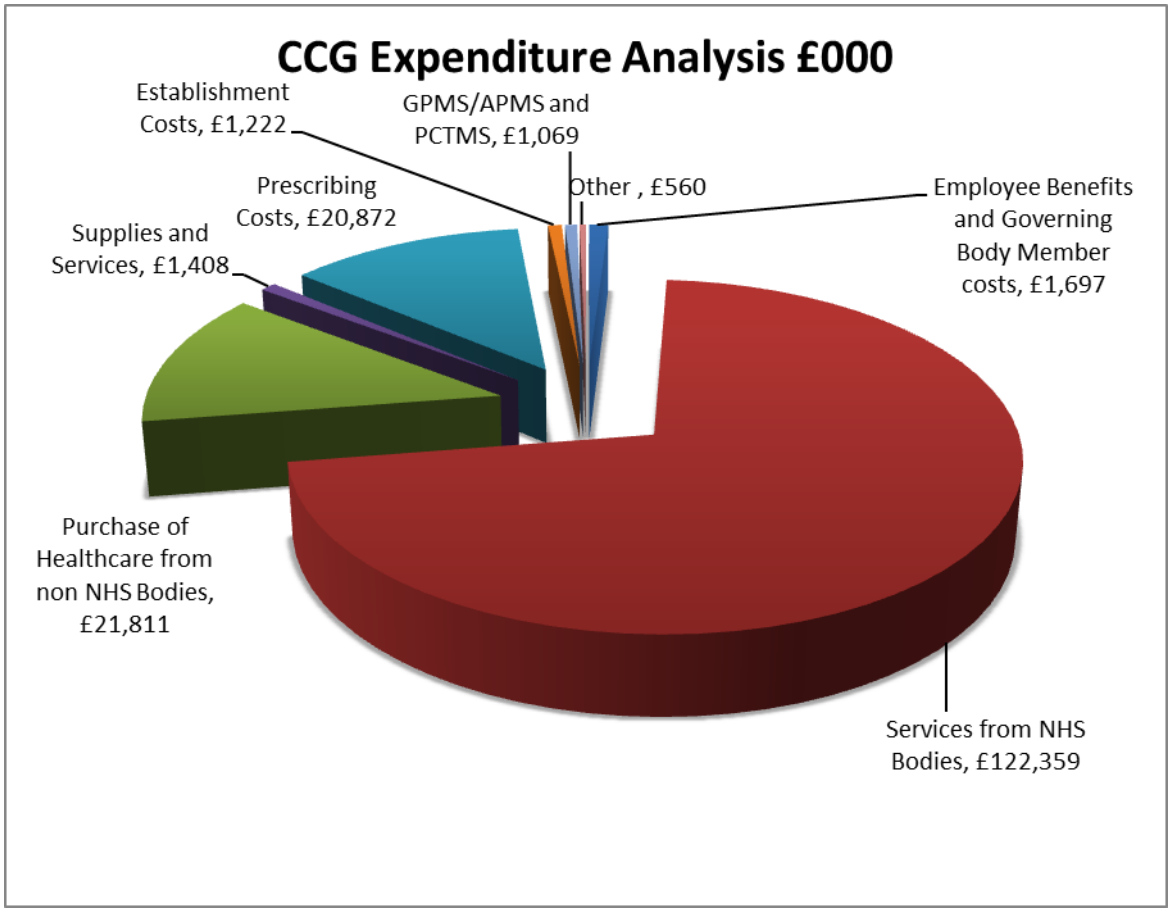
Providing value

Resources Available

In 2013-2014 we received a total revenue resource allocation of £171.9m. This translates into an average of £1,407 per head of population. The funding received is calculated based on a variety of criteria that are primarily based on the demographic make up of the population.

Expenditure

Our net expenditure for the year was £170.13m (see analysis below) and we reported a surplus of £1.75m, which at 1.02% of resources available is consistent with the target surplus for the year of 1.00% of resources available.



Included within the resource allocation is £2.98m for our running costs. The actual expenditure on our running costs was £2.63m, underspent by £0.35m.

Cash Management

Each year we also have a 'Maximum Cash Drawdown Limit', which we are not allowed to exceed. For 2013-2014, the Maximum Cash Draw down limit was £165.06m, representing 96% of our revenue resource allocation. We drew down £163.66m and at the year end we had cash balances of £138k.

Year End Position

Our Statement of Financial Position shows that we have a net liability at the end of the financial year. Whilst this would, in a commercial setting, suggest that an organisation is insolvent, for CCGs NHS England makes adjustments to the amount of cash they have available to them to reflect the timing of cash payments due. The biggest single factor that affects this adjustment relates to the timing of cash payments for prescribing. There is a two month time delay between the end of the month when a prescription is dispensed and the time when a CCG actually pays the cash to clear the liability. Our Maximum Cash Drawdown Limit is adjusted to reflect this. Consequently it is normal for a CCG to have a large prescribing liability at the year end, which will be cleared in the new financial year when the cash required is made available by the Department of Health.

We do not own any land or buildings, so we are not exposed to any risk from land valuation fluctuations.

Future Funding and Expenditure

Our financial resources are influenced by movements in total NHS funding, our distance from our 'fair share' of that funding and the demographic changes to the structure of the population we serve.

NHS England has advised CCGs that whilst the growth for 2014-2015 is 2.14%, the growth allocation for the following four years – 2015-2016 to 2018-2019 will, based on current information, be on average between 1.7% and 1.8% per annum.

The difference between a CCG's actual resources made available and its 'fair share' is known as its distance from target. Across the country CCGs have not, in financial terms, started from a position of equality. The resources made available to CCGs in 2013-2014 were informed by the resources made available to the predecessor PCTs. They do not however represent the 'fair share' of total resources based on demographic make-up of the populations they serve.

This situation has arisen as a result of predecessor PCTs having a number of years of undifferentiated resource growth that did not reflect population and demographic structure changes, coupled with a relatively slow pace of change policy for PCTs. In 2013-2014 the most over target CCG is 36% above target and the most under target CCG is 12% below target.

In the process of moving all CCGs to be closer to their 'fair share' NHS England needs to take account of how quickly any transition can be achieved - taking account of how quickly local health economies can invest or disinvest in services in a manner which ensures value for money and the ongoing sustainable operation of services for patients. NHS England has announced that it intends to move all CCGs towards its 'fair share' position through a process of allocating differential rates of growth that reflect the relative funding position of CCGs relative to their distance from 'fair share'. We are currently funded above our 'fair share' by 6.17% and so we can expect in future years to receive less than the CCG average growth funding.

The Annual Accounts and analysis of expenditure set out above shows how we have invested our resources in 2013-2014. Going forward, we are expecting to invest a growing amount in our community based admission avoidance and early discharge schemes and proportionately less in hospital based services.

Members' report

This section gives you more information about our Governing Body, member practices and staff. It also details the composition of our most important committees.

Our member practices

Here is a list of the practices which make up our organisation.

Name of member practice
Cumberland House Surgery
Curzon Road Medical Practice
St Marks Medical Centre
Kew Surgery
Trinity Practice
Chapel Lane Surgery
The Village Surgery
Freshfield Surgery
The Hollies
Norwood Surgery
Churchtown Medical Centre
Sussex Road Surgery
Roe Lane Surgery
The Corner Surgery
Marshside Surgery
Ainsdale Medical Centre
Ainsdale Village Surgery
Grange Surgery
Lincoln House Surgery
The Family Surgery

Pension liabilities

Our past and present employees are covered by the provisions of the NHS Pension Scheme. The NHS Pension Scheme is an unfunded, defined benefit scheme that covers all 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's 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. The scheme is subject to a full actuarial valuation every four years and an accounting valuation every year. Further details of the accounting treatment of pension contributions by the CCG can be found in the accounting policy note in our accounts. Details of pension benefits for senior managers can be found in the Remuneration Report.

Governing Body membership

The table below shows the people who made up our Governing Body in 2013-2014, their roles and the committees[11] they were a part of.

Name	Role	Governing Body	Audit Committee	Finance and Resources Committee	Remuneration Committee	Quality Committee
Dr Niall Leonard	Chair and GP	Chair				
Fiona Clark	Chief Officer	Yes		Yes		Yes
Martin McDowell	Chief Finance Officer and Deputy Chief Officer	Yes		Yes		Yes
Helen Nichols	Vice Chair and Lay Member (Financial Management and Audit)	Yes	Chair	Chair	Chair	Chair
Dr Robert Caudwell	Clinical Vice Chair and GP	Yes			Yes from 27 March 2014	Yes
Debbie Fagan	Chief Nurse	Yes		Yes		Yes
Dr Martin Evans	GP	Yes		Yes	Yes from 27 March 2014	
Dr Liam Grant	GP	Yes				
Dr Hilal Mulla	GP	Yes		Yes		
Dr Graeme Allan	GP	Yes				
Roy Boardman	Practice Manager	Until 31 March 2014	Until 31 March 2014	Until 31 March 2014	From 27 to 31 March 2014	
Karen Leverett	Practice Manager	Until 28 Feb 2014				Until 28 Feb 2014
Roger Pontefract	Lay Member (Engagement and Patient Experience)	Yes	Yes	Yes	Yes	
Dr Jeff Simmonds	Secondary Care Doctor	Yes				

[11] More details about members of the Governing Body and any conflicts of interest can be found on page 51 in the Remuneration Report. The membership of our other committees and sub-committees can be found on page 57 onwards in our annual Governance Statement.

External auditors

Our external auditor is PricewaterhouseCoopers LLP. During 2013-2014 the external auditor has received fees totalling £79,200 as a result of undertaking the following work:

- Audit services - the statutory audit and services carried out in relation to the statutory audit, fee £79,200
- Further assurance services – nil
- Other services – nil

Sickness absence rates

Rates of sickness absence in our organisation are low. Our annual rolling sickness absence at the end of March 2014 was 1.4% and this equated to an average of 4.1 days absence per employee over the year. We have policies in place that set out how we manage and support staff through periods of illness or other types of leave.

Disclosure of serious untoward incidents

In 2013-2014, we had no serious untoward incidents involving the loss of personal data or confidentiality breaches to declare to the Care Quality Commission or to the Information Commissioner's Office.

Principles for Remedy

We have designed our complaints policy and other internal processes to fully take account of the national guidance, 'Principles for Remedy' issued by the Parliamentary and Health Ombudsman and the six areas of best practice it outlines.

Employee consultation

We are active members of the Cheshire and Merseyside Staff Partnership Forum, bringing us together with staffside representatives to foster positive two way employee relations. This committee is authorised to agree, revise and review policies and procedures which may relate to changes affecting our staff around employment legislation and regulation or the terms and conditions of their employment. More details of how we work in partnership with our staff can be found on page 33.

Disabled employees

We ensure our disabled staff are treated equality, without discrimination and shown due regard. More information can be found on pages 29 and 33.

Remuneration report

The Remuneration Committee membership is made up of four Governing Body Members.

The Committee has met three times during the year (November 2013, January 2014 and March 2014). For the first two of those meetings the Committee membership was not fully confirmed and the Governing Body approved the co-option of two Sefton Health and Well Being Board, Strategic Advisers to ensure that the Committee could complete its work. No fee was paid for this advice.

Name	Title	Membership Period	Attendance at Meetings eligible to attend
Helen Nichols	Chair	All Year	3/3
Roger Pontefract	Lay Member	To 7 January 2014	2/2
Robert Caudwell	GP	From 27 March 2014	1/1
Martin Evans	GP	From 27 March 2014	1/1
Roy Boardman	Practice Manager	From 27 to 31 March 2014	1/1

Policy on Remuneration of Senior Managers

In the absence of national guidance, we worked with other CCGs in the North West and commissioned the Hay Group to provide guidance on appropriate remuneration for the GP's and Practice Managers of our Governing Body (Remuneration for CCG Lay members of our Governing Body is based on National Guidance).

In developing this guidance the Hay Group used the following principles:

- A simple approach
- Promotes consistency across the region.
- Allows CCGs to recruit and retain the expertise and calibre of individuals they need, now and in the future.
- Is clear and defensible to stakeholders, media and the public.
- Recognises that not all Board member contributions have the same value.
- Reflects the commitment and risk involved for individuals and the disruption involved for practices.
- Offers value for money, supporting policy objectives at minimum and controllable cost.

The NHS Commissioning Board issued guidance on the remuneration of Chief Officers and Chief Finance Officers. This guidance has been followed in setting the remuneration of the CCGs Chief Officer and Chief Finance Officer.

The performance of senior managers is measured using our Personal Development Review Policy, which is used for all employees.

Both NHS England and the Hay Group guidance took the pay and employment conditions of other employees into account when determining the framework for senior manager's remuneration. The terms and conditions of service for all NHS staff, except very senior managers (VSMs) are nationally agreed by the NHS Staff Council. These terms and conditions include, pay and allowances; terms of employment such as leave and hours of

working; the process for ensuring effective employee relations; and regulations with regard to equality and diversity.

NHS staff pensions are covered separately under the NHS rules on superannuation. In essence, individuals who are employed by the NHS automatically become a member of the NHS Pension Scheme. However, membership is voluntary and individuals can currently opt not to join and leave the scheme at any time.

In line with other CCGs, all employees other than Very Senior Managers who have transferred to the CCGs from one of the former PCTs (under a Transfer Scheme/Order) have transferred on the same terms and conditions as they were previously on.

Senior Managers' Performance Related Pay

Senior Mangers' Performance is managed through the application of our Personal Development Review Policy. This process ensures all staff have a clear understanding of their duties, responsibilities and objectives and their developments needs are formally identified. The NHS Framework forms the basis of the PDR process, supporting career and pay progression.

Policy on Senior Managers' Service Contracts

Our policy is that all senior manager contracts are in line with Agenda for Change (AfC). There is no fixed duration and there are no provisions for termination payments within the contract. Consequently there are no senior managers that hold a fixed duration contract nor do we have any liability in terms of potential future termination payments.

Payments to Past Senior Managers

We have not made any significant awards to past senior managers.

Salaries and Allowances

The table below sets out the salaries and allowances we have paid, or that are payable to our Senior Managers in 2013-2014 in relation to their services to this CCG.

Senior Managers are defined in the Government Financial Reporting Manual as 'Those persons in senior positions having authority or responsibility for directing or controlling our major activities. This means those who influence the decisions of the CCG as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members'.

Name	Title	Salary & Fees*	Taxable Benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonuses	All Pension Related Benefits*	Total
		(bands of £5,000)	(Rounded to the nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£000	£00	£000	£000	£000	£000
Dr Niall Leonard	Chair	105 – 110	0	0	0	402.5-405.0	510 – 515
** **Dr Rob Caudwell**	Clinical Vice-Chair	30 – 35	0	0	0	0	30 – 35
** **Helen Nichols**	Lay Member, Financial Management and Audit	10 – 15	0	0	0	0	10 – 15
Fiona Clark	Chief Officer	60 - 65	0	0	0	197.5-200.0	260 – 265
Martin McDowell	Chief Finance Officer / Deputy Chief Officer	50 – 55	0	0	0	70.0-72.5	120 – 125
Debbie Fagan	Chief Nurse	35 – 40	0	0	0	35.0-37.5	70 – 75
** **Dr Graeme Allan**	GP	55 – 60	0	0	0	0	55 – 60
** **Dr Hilal Mulla**	GP	25 – 30	0	0	0	0	25 – 30
** **Dr Martin Evans**	GP	25 – 30	0	0	0	0	25 – 30
** **Dr Liam Grant**	GP	10 – 15	0	0	0	0	10 – 15
** **Dr Jeff Simmonds**	Secondary Care Clinician	20 – 25	0	0	0	0	20 – 25
** **Roy Boardman until 31 March 2014**	Practice Business Manager	0 – 5	0	0	0	0	0 – 5
** **Karen Leverett until 28 Feb 2014**	Practice Manager	0 – 5	0	0	0	0	0 – 5
** **Roger Pontefract**	Lay Member, Engagement and Patient Experience	5 – 10	0	0	0	0	5 – 10

The remuneration report table above has been prepared in line with the CCG 2013/14 Annual Reporting Guidance. The 2013/14 guidance requires a new basis for the calculation of pension related benefits.

As explained in more detail below, the new basis of calculation shows the change in the pension entitlement between the opening and closing entitlements multiplied by a factor of 20. This has resulted in large pension related benefits being shown in the remuneration report table above.

The basis of calculation for pension related benefits is in line with the CCG 2013/14 Annual Reporting Guidance and follows the 'HMRC method' which is derived from the Finance Act 2004 and modified by Statutory Instrument 2013/1981. The calculation required is:

Pension Benefit Increase = ((20 x PE) + LSE) – ((20 x PB) + LSB) - EC

Where:

PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year;

PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;

LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year;

LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year; and,

EC is the employee's contribution paid during the year.

In summary, the new basis of calculation shows the pension accrued in year multiplied by a factor of 20. This has resulted in large pension related benefits as shown in the remuneration report table as above.

** Certain members do not receive pensionable remuneration for their CCG Governing Body activities therefore there will be no entries in respect of pensions in the 'All Pension Related Benefit' column in the table above nor in the Pension Benefit table below for these members.

* We have a joint management arrangement with neighbouring NHS South Sefton CCG. The Chief Officer (Fiona Clark), Chief Financial Officer (Martin McDowell) and Chief Nurse (Debbie Fagan) receive remuneration for undertaking these roles for both CCGs. Their total banded remuneration from these roles is:

- Fiona Clark £130,000 to £135,000 salary and £397,500 to £400,000 all pension related benefits
- Martin McDowell £100,000 to £105,000 salary and £140,000 to £142,500 all pension related benefits
- Debbie Fagan £70,000 to £75,000 salary and £72,500 to £75,000 all pension related benefits

The total remuneration of our Chief Officer and Chief Financial Officer includes a 20% supplement on their basic salary paid in accordance with NHS England guidance and jointly agreed by our Remuneration Committees in March 2013 to recognise the joint roles that they undertake, as officers covering two CCGs. They hold the same positions with NHS South Sefton CCG.

Pension Benefits

Name	Title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31st March 2014	Lump sum at age 60 related to accrued pension at 31st March 2014	Cash equivalent transfer value at 31st March 2013	Cash equivalent transfer value at 31st March 2014	Real increase in cash equivalent transfer value	Employers contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£000	£000	£000	£000	£000	£000	£000	£000
Dr Niall Leonard	Chair	20.0-22.5	(20.0)-(22.5)	20-25	70-75	594	477	(117)	0
Fiona Clark	Chief Officer	15.0-17.5	50.0-52.5	50-55	150-155	575	902	327	0
Martin McDowell	Chief Finance Officer / Deputy Chief Officer	5.0-7.5	17.5-20.0	20-25	70-75	269	368	99	0
Debbie Fagan	Chief Nurse	2.5-5.0	7.5-10.0	20-25	65-70	287	343	56	0

Pension benefits stated above represent the total accrued pension entitlements from an individual's total career employment in NHS posts.

The calculation of accrued pension and lump sums is based upon the salary received by an individual in the most recent year. Where an individual has a lower salary when compared to previous years, it is possible that the accrued pension entitlement and/or lump sum values will reduce. All data provided in the above table has been calculated and supplied by the NHS Pensions Agency.

The information in the table above for our Chief Officer (Fiona Clark), Chief Finance Officer (Martin McDowell) and Chief Nurse (Debbie Fagan) relates to their total Pension Benefits arising from their roles in both CCGs.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their 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 CETV

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

Pay multiples

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

The banded remuneration of the highest paid member of our Governing Body in the financial year 2013-2014 was £125,000 to £130,000. This was 3.11 times the median remuneration of the workforce, which was £40,558.

In 2013-2014, no employees received remuneration in excess of the highest paid member of the Governing Body. Banded Remuneration ranged from £5,000 to £10,000 to £125,000 to £130,000.

Total remuneration includes salary, non-consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Off Payroll Engagements

Off payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months are as follows:

The number that have existed:	Number
• For less than one year at the time of reporting	1
• For between one and two years at the time of reporting	0
• For between two and three years at the time of reporting	0
• For between three and four years at the time of reporting	0
• For four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2014	1

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
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	1
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

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
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)	14

Governing Body Profiles

The table below sets out for the Governing Body Members the declared interests and conflicts together with the date declared. Details of Committees that individual Governing Body Members were a member of during the year can be found in the Members Report.

Name	How long been based / working in Southport and Formby	Clinical / Business role on the Governing Body	Declared Interests and Conflicts	Nature of Interest	Date Declared
Dr Niall Leonard	20 Years	Governing Body Chair & GP Clinical lead for cardiology. Chair of the Merseyside CCG Network Sefton Health and Wellbeing Board Member.	GP Partner, Roe Lane Surgery Assessor Sector 12(2) Mental Health Act, Merseycare NHS Trust and Lancashire Care NHS FT Director, Exacta Medico-Legal Limited Partner works as a GP in a CCG Practice	Personal Personal Personal Family	Pre 1 April 2014 Pre 1 April 2014 Pre 1 April 2014 Pre 1 April 2014
Dr Rob Caudwell	GP in Southport for 8 years, trained in S&O and elsewhere in Merseyside prior to that.	Governing Body Clinical Vice Chair & GP Lead for IT, Children and Young People, Maternity, Musculoskeletal medicine and vice-medical chair	GP Partner, Marshside Surgery Director, Caudwell Medical Services Ltd Director, Allbright Domestic Services	Personal Personal Family	Pre 1 April 2014 Pre 1 April 2014 Pre 1 April 2014
Helen Nichols	Lived in Sefton since 2002 and worked in Sefton since 2006	Governing Body Vice Chair and Lay Member	Governor & Vice Chair, St Luke's Church of England Primary School, Formby Shadow Governor of Southport and Ormskirk Hospitals NHS Trust (on behalf of the CCG) Professor, Chemistry Dept, University of Liverpool	Personal Personal Family	Pre 1 April 2014 14 Jan 2014 14 May 2013
Dr Graeme Allan	Worked many years in Southport	GP Governing Body Member Cancer Lead	GP Partner, St Marks Medical Centre	Personal	Pre 1 April 2014
Dr Hilal Mulla	worked in S+F area 14 years	GP Governing Body Member	GP Partner, Corner Surgery	Personal	Pre 1 April 2014
Dr Martin Evans		GP Governing Body Member Lead contracting GP with S&O	GP Partner, Grange Surgery Member of Sefton LMC	Personal Personal	Pre 1 April 2014 8 May 2013

Dr Liam Grant		GP Governing Body Member	GP Partner, Dr Reddington & Partners, Formby Practice receives rental income for Renacres Outreach Clinics GP Associate, Liverpool Community Health NHS Trust, Out of Hours Service	Personal Personal Personal	Pre 1 April 2014 10 Sept 2013 16 May 2013
Roy Boardman	Practice Manager at Chapel Lane Surgery, Formby 2002-2011	Practice Manager Governing Body Member until 31 March 2014 Chair of S & F Practice Managers	Business Manager, St Marks Medical Centre Business Manager Trinity –Southport Health Centre	Personal	Pre 1 April 2014 1 May 2013
Karen Leverett		Practice Manager Governing Body Member until 28 Feb 2014	Practice Manager, The Village Surgery Practice receives rental income for Renacres Outreach Clinics Southport & Ormskirk Hospitals NHS Trust Employee	Personal Personal Family	Pre 1 April 2014 1 May 2013 1 May 2013
Dr Jeff Simmonds	Consultant physician at Southport and Ormskirk Acute Trust from 1981-2010.	Governing Body Member Hospital Medical Representative	Liverpool Community Health NHS Trust	Family	6 May 2013
Roger Pontefract	Former Strategic Director for Sefton Council and Non Executive Director of Sefton PCT 2006-2012	Lay Member Governing Body	Owner, Roger Pontefract &Associates Chair, Sefton Partnership for Older Citizens Trustee, Formby Pool Trust Trustee, Formby Land Trust	Personal Personal Personal Personal	Pre 1 April 2014 Pre 1 April 2014 Pre 1 April 2014 Pre 1 April 2014
Fiona Clark	Over 33 years' experience in the NHS, the last 14 at Board level, has worked in Sefton for the last 7 years	Chief Officer Governing Body Member	Dual role as Chief Officer between Southport and Formby CCG and South Sefton CCG	Personal	Pre 1 April 2014
Debbie Fagan	Over 24 years' experience in the NHS,	Chief Nurse Governing Body Member	Dual role as Chief Nurse between Southport and Formby CCG and South	Personal	20 May 2013

	joined the CCG in October 2012		Sefton CCG		
Martin McDowell	Over 20 years' experience in NHS Finance, joined the CCG in August 2012.	Chief Finance Officer and Deputy Chief Officer Governing Body Member	Dual role as Chief Finance Officer and Deputy Chief Officer between Southport and Formby CCG and South Sefton CCG Liverpool Community Health NHS Trust Employee	Personal Family	Pre 1 April 2014 Pre 1 April 2014

Certifications by our accountable officer

We certify that the Strategic Report, Members Report and Remuneration Report presented as part of the CCGs Annual Report have been prepared in accordance with the guidance contained in the CCG Annual Reporting Guidance 2013-14 issued on 27 March 2014.

We certify that the CCG has complied with the statutory duties laid down in the NHS Act 2006 (as amended).

We certify that the classification as a senior manager as defined by the Government Financial Reporting Manual, only extends to membership of the CCGs Governing Body.

We certify that the CCG has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

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

Each individual who is a member of the Governing Body at the time that the Members' Report is approved confirms:

- So far as the member is aware, that there is no relevant audit information of which the CCG's external auditor is unaware: and,
- That the member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

Fiona Clark

Chief Officer (Accountable Officer)

NHS Southport and Formby CCG

June 2014

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 the Chief Officer to be the Accountable Officer of the Clinical Commissioning Group.

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

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

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

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

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

Fiona Clark

Chief Officer (Accountable Officer)

NHS Southport and Formby CCG

June 2014

Governance statement

Introduction and context

We were licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

We operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to taking on our full powers. As at 1 April 2013, we were licensed **without** conditions.

We are a clinically led membership organisation made up of general practices. The functions that we are responsible for exercising are set out in the Health and Social Care Act 2012.

1. commissioning certain health services (where NHS England is not under a duty to do so) that meet the reasonable needs of:
   a) all people registered with member GP practices, and
   b) people who are usually resident within the area and are not registered with a member of any clinical commissioning group
2. commissioning emergency care for anyone present in the group's area;
3. paying its employees' remuneration, fees and allowances in accordance with the determinations made by its Governing Body and determining any other terms and conditions of service of the group's employees
4. determining the remuneration and travelling or other allowances of members of its Governing Body

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter. I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the UK Corporate Governance Code

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

Our Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L (2)(b) states:
"The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it."

The CCG comprises membership from the following practices:

Name of member practice
Cumberland House Surgery
Curzon Road Medical Practice
St Marks Medical Centre
Kew Surgery
Trinity Practice
Chapel Lane Surgery
The Village Surgery
Freshfield Surgery
The Hollies
Norwood Surgery
Churchtown Medical Centre
Sussex Road Surgery
Roe Lane Surgery
The Corner Surgery
Marshside Surgery
Ainsdale Medical Centre
Ainsdale Village Surgery
Grange Surgery
Lincoln House Surgery
The Family Surgery

Our member practices are responsible for determining the governing arrangements for the organisation which are set out in our Constitution[12]. The Constitution has been developed to reflect and support the objectives and values defined by the CCG and to ensure that all business functions discharged by the CCG are discharged in an open and transparent manner this Constitution has been developed with the member practices and Localities.

We function in respect of the geographical area defined as Southport and Formby comprising.

The Governing Body comprises a diverse range of skills from Executive and Lay members and there is a clear division of responsibility between running the Governing Body and running the operational elements of our business. The Chair is responsible for the leadership

[12] NHS Southport and Formby Clinical Commissioning Group *Constitution* (July 2013)

of the Governing Body and ensures that Directors have had access to relevant information to assist them in the delivery of their duties. The Lay Members have actively provided scrutiny and challenge at Governing Body and sub-committee level. Each committee comprises membership and representation from appropriate officers and Lay Members with sufficient experience and knowledge to support the committees in discharging their duties.

The Governing Body has been well attended by all Directors and Lay Members throughout the year ensuring that the Governing Body has been able to make fully informed decisions to support and deliver the strategic objectives.

The Governing Body is assured of its effectiveness in terms of performance management through the regular corporate performance reports on finance, quality and key performance indicators as set out in national guidance. Throughout the year performance has continued to be maintained or improved which represents a significant achievement.

The Governing Body undertook an assessment of its effectiveness during June 2013 this was by way Review of Performance against Domains for Assurance of Organisational Health and Capability. The assessment took account of clinical focus, stakeholder engagement, planning to meet health and wellbeing needs, governance and capability, partnerships and leadership.

The Governing Body is supported by a sub-committee structure comprising the committees listed below.

Quality Committee

This committee has delegated responsibility for monitoring the quality of commissioned services, considering information from governance, risk management and internal control systems and; provides corporate focus, strategic direction and momentum for governance and risk management.

The committee reviews and scrutinises the Governing Body Assurance Framework (GBAF) and the Corporate Risk Register. The committee has delegated responsibility for the approval of corporate policies and during the year has received updates and requests for approvals on the key following policies and processes:

- Information Governance
- Serious Incidents
- Health and Safety
- Adult and Children Safeguarding
- Risk Management
- Governing Body Assurance Framework

The committee also reviewed and scrutinised the following:

- Early Warning Dashboards
- Provider Quality Reports
- Safeguarding Arrangements

The committee comprises the Accountable Officer, Chief Nurse, CCG Officers, Lay Members, clinicians and other CCG officers to ensure that the committee is appropriately skilled and resourced to deliver its objectives.

The Quality Committee has been well attended by all CCG Officers, Lay Members and clinicians throughout the year ensuring that there has been robust scrutiny and challenge at all times. This has enabled the Quality Committee to provide robust assurances to the Governing Body and to inform the Governing Body of key risk areas.

Key highlights: During the year the Quality Committee:

- Provided assurance to the Governing Body on the objectives and controls within the Governing Body Assurance Framework and Corporate Risk Register.
- Provided assurance of compliance with the Information Governance Toolkit
- Approved Safeguarding arrangements
- Approved corporate and clinical policies

The committee is supported by a Corporate Governing Sub Group, Engagement and Patient Experience Group and Serious Incident Review Group.

Audit Committee

The Codes of Conduct and Accountability, issued in April 1994, set out the requirement for every NHS Board to establish an Audit Committee. That requirement remains in place today and reflects not only established best practice in the private and public sectors, but the constant principle that the existence of an independent Audit Committee is a central means by which a Governing Body ensures that effective internal control arrangements are in place. In addition, the Committee provides constructive support to Senior Officers to achieve the strategic aims of the CCG.

The principal functions of the Committee are as follows:

i) To support the establishment of an effective system of integrated governance, risk management and internal control, across the whole of our activities to support the delivery of our objectives
ii) To review and approve the arrangements for discharging our statutory financial duties

The committee met as follows:

- 1 May 2013
- 11 September 2013
- 15 January 2014

The Committee comprises three members of our Governing Body:

- Lay Member (Governance) (Chair)
- Lay Member (Patient Experience & Engagement)
- Practice Manager Governing Body Member

The Audit Committee Chair and one other member are necessary for quorum purposes. In addition to the Committee Members, Officers from the CCG are also asked to attend the committee. The core attendance comprises:

- Chief Finance Officer
- Chief Nurse
- Chief Accountant
- Chief Corporate Delivery and Integration Officer

In carrying out the above work, the Committee has primarily utilised the work of Internal Audit, External Audit, the work of the other sub committees of the board and other assurance functions as required. A number of representatives from external organisations attend to provide expert opinion and support:

- Audit Manager, Mersey Internal Audit Agency (MIAA)
- Audit Manager/Director PwC
- Local Counter Fraud Officer, MIAA

Attendance at the meetings during 2013-2014 was as follows:

Post	Name	1 May 2013	11 Sep 2013	15 Jan 2014
Audit Chair	Helen Nichols	✓	✓	✓
Lay Member - Patient Experience and Engagement	Roger Pontefract	✓	✓	✓
Practice Manager - Governing Body Member Resigned 31.03.2014	Roy Boardman	✓	✓	✓
Chief Finance Officer	Martin McDowell	✓	✓	✓
Chief Nurse	Debbie Fagan	✓	✓	x
Chief Accountant From 15 July 2013	Ken Jones	n/a	✓	✓
Chief Corporate Delivery and Integration Officer	Tracy Jeffes	x	x	✓
Internal Audit (MIAA)	Adrian Poll	✓	✓	✓
External Audit (PwC)	Stuart Baron/Rachel McIlwraith	✓	✓	✓

Local Counter Fraud Service (MIAA)	Stewart Davidson/Bernard McNamara/Roger Causer			

The Audit Committee supports the Governing Body by critically reviewing governance and assurance processes on which the Governing Body places reliance. The work of the Audit Committee is not to manage the process of populating the Assurance Framework, or to become involved in the operational development of risk management processes, either at an overall level or for individual risks - these are the responsibility of the Governing Body supported by line management. The role of the Audit Committee is to satisfy itself that these operational issues are being carried out appropriately by line management.

1. Internal Audit

Role - An important principle is that internal audit is an independent and objective appraisal service within an organisation. As such, its role embraces two key areas:

- The provision of an independent opinion to the Accountable Officer (Chief Officer), the Governing Body, and to the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's agreed objectives
- The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements

During 2013-2014 MIAA has reviewed our operations. It found no major issues and concluded that overall we have met our requirements. MIAA has reported back on a number of areas. In all cases action plans have been implemented and are being monitored. In all areas reviewed to date ***'Significant Assurance'***, has been reported i.e. although some weaknesses their impact would be minimal or unlikely.

There were no areas reported by MIAA where weaknesses in control, or consistent non-compliance with key controls, could have resulted in failure to achieve the review objective. Regular progress reports will continue to be provided to each Audit Committee meeting.

2. External Audit

Role - The objectives of the External Auditors are to review and report on our financial statements and on our Statement on Internal Control.

At this stage of the year External Audit (PwC) is in the early stages of its first audit of our annual accounts. It is anticipated that the ISA260 Audit Highlights Memorandum will be reported to the June Meeting as part of the Annual Accounts approval process.

This will be followed by the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting.

3. Counter Fraud Specialist

Role – To ensure the discharge of the requirements for countering fraud within the NHS, the role is based around seven generic areas, creating an antifraud culture, deterrence, prevention, detection, investigation, sanctions and redress. The Local Counter Fraud Specialist presented the plan for approval in May 2013 and provided regular updates at subsequent meetings. The Local Counter Fraud Service have also presented to Practice Manager Meetings, Protected Learning Time for GPs, and to the Governing Body. A proposed Counter Fraud Strategy has also been presented to Audit Committee.

4. Regular Items for Review

The Audit Committee follows a work plan approved at the beginning of the financial year, which includes, as required:

- Losses and special payments
- Outstanding debts
- Financial policies and procedures
- Tender waivers
- Declarations of interest
- Self-assessment of Committee's effectiveness
- Information Governance Toolkit
- Minutes of the sub committees of the Board

5. Conclusions

The Audit Committee is a key committee of the Governing Body, with significant monitoring and assurance responsibilities requiring commitment from members and support from a number of external parties. The work plan has been developed in line with best practice described in the Audit Committee Handbook and forms the basis of our meetings. In all of these areas the Audit Committee seeks to assure the CCG that effective internal controls are in place and will remain so in the future.

In summary the work of the Audit Committee, in the first full financial year in which we have been in existence, can provide assurance to the Governing Body:

- an effective system of integrated governance, risk management and internal control is in place to support the delivery of our objectives and that arrangements for discharging our statutory financial duties are now established
- there were no areas reported by MIAA where weaknesses in control, or consistent non-compliance with key controls, could have resulted in failure to achieve the objective
- ISA260 Audit Highlights Memorandum will be reported by PwC to the June Meeting as part of the Annual Accounts approval process. This will be followed by the publication of the Annual Audit Letter to the Governing Body in its July 2014 meeting

Remuneration Committee

The committee ensures compliance with statutory requirements and undertook reviews of Very Senior Managers remuneration and to comply with the requirements set out in the NHS Codes of Conduct and Accountability and the Higgs report.[13] The Committee reviews and agrees appraisal and remuneration of CCG Officers.

During the year the committee has agreed levels of remuneration for GP attendance at meetings.

The Committee has met three times during the year (November 2013, January 2014 and March 2014). For the first two of those meetings the Committee membership was not fully confirmed and the Governing Body approved the co-option of two Sefton Health and Well Being Board, Strategic Advisers to ensure that the Committee could complete its work. No fee was paid for this advice.

Finance and Resources Sub Committee

The Committee oversees and monitors financial and workforce development strategies; monitors the annual revenue budget and planned savings; develops and delivers capital investment; is responsible for reviewing financial and workforce risk registers; and financial, workforce and contracting performance.

Our Constitution was assessed by competent individuals as part of the CCG Authorisation process and has been subject to review by BMA Law and NHS England. NHS England confirmed that it is compliant with relevant laws and legislation and that there are arrangements in place for us to discharge our statutory duties.

Our arrangements have also been subject to a review by our internal auditors (Mersey Internal Audit Agency) that offered "significant assurance" on the arrangements.

Our Risk Management Framework

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

- identify and prioritise the risks to the achievement of the organisation's 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 Governing Body has developed the corporate objectives, and the evaluation of the risks to achieving these objectives are set out in the Governing Body Assurance Framework

[13] D, Higgs (January 2003) *Review of the Role and Effectiveness of non-executive directors* section 13.8 at page 61 – available at http://www.berr.gov.uk/files/file23012.pdf

which is regularly reviewed and scrutinised by the Senior Management Team, Corporate Governance Sub Group, Quality Committee and the Governing Body.

The Governing Body Assurance Framework is a key document whose purpose is to provide the Governing Body with 'reasonable' assurance that internal systems are functioning effectively. It is a high level document that is used to inform and give assurance to the Governing Body that the risks to achieving key objectives are recognised and that controls are in place or being developed to manage these risks.
Risks are rated, and controls that will address these risks are identified, gaps in control or assurance are noted and action plans to close gaps summarised and updated. Potential and actual sources of assurance are identified and the latter are also rated for the level of assurance provided. A summary of the assurance levels for all assurance framework entries is updated each quarter and accompanies the full document.

The Corporate Risk Register provides the Governing Body with a summary of the principal risks facing the organisation, with a summary of the actions needed and being taken to reduce these risks to an acceptable level. The information contained in the Corporate Risk Register should be sufficient to allow the Governing Body to be involved in prioritising and managing major risks. The risks described in the Corporate Risk Register will be more wide-ranging than those in the Governing Body Assurance Framework, covering a number of domains.

Where risks to achieving organisational objectives are identified in the Corporate Risk Register these are added to the Governing Body Assurance Framework; and where gaps in control are identified in the Governing Body Assurance Framework, these risks are added to the Corporate Risk Register. The two documents thus work together to provide the Governing Body with assurance and action plans on risk management in the organisation.

The Corporate Risk Register is updated and presented for review and scrutiny at the same time as the Governing Body Assurance framework.

We commission a range of training programmes which include specific mandatory training for particular staff groups which aims to minimise the risks inherent in their daily work. Information Governance, Counter Fraud, Fire, Health and Safety, Equality and Diversity and Safeguarding Training are mandatory training requirements for all staff.

Targeted training is provided to designated risk leads to support development of risk registers, and one to one sessions are available for all managers responsible for updating the Governing Body Assurance Framework.

Our Internal Control Framework

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

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

Information Governance

All key information assets have been identified by the Information Assets Owners on an Information Asset Register. The data security and confidentiality risks to each asset have been identified, and controls identified to mitigate risks.
The risks to the physical information assets are minimal, and pose no significant Information Governance concern for us.

All inbound and outbound flows of data have been identified through a Data Flow Mapping tool. All data flows are being transferred appropriately.

The risks to the inbound and outbound flows of data are minimal, and pose no significant Information Governance concern for us.
The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and we are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

Pension obligations

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

Equality, diversity and human rights obligations

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

Sustainable development obligations

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

Risk assessment in relation to governance, risk management and internal control

We have a comprehensive Risk Management Strategy. The following key elements are contained within the Strategy:

- Risk Management Strategy, Aims and Objectives
- Roles, Responsibilities and Accountability
- The Risk Management Process – Risk Identification, Risk Assessment, Risk Treatment, Monitoring and Review, Risk Prevention
- Risk Grading – Criteria
- Training and Support

We have established a number of mechanisms for identifying and managing risks including risk profiling methodology, incident reporting, complaints and litigation data, and staff concerns / whistleblowing.

Risk management and the ensuing development of risk registers is generally achieved using a dual ‘top-down’ and ‘bottom-up’ approach to identifying and managing risks. The ‘top-down’ element has been addressed through the development of a Governing Body Assurance Framework and Corporate Risk Register identifying strategic high-level risks. These two documents are based on models which have previously been accepted as meeting audit requirements.

The ‘bottom-up’ element of the risk management system best fits with organisational structures and this has therefore been based on the directorate arrangements and subsequently on the NHS Merseyside director portfolios and integrated teams. All functional leads have identified their arrangements for developing and reviewing risk registers and escalating risks.

Key new risks identified during 2013-2014 are:

- Continuing Healthcare Retrospective Claims and the associated financial risk
- Processing of patient identifiable information (which is mitigated by the arrangements with Cheshire and Merseyside Commissioning Support Unit (the CSU) and its licence to process and pseudonymisation)
- Safeguarding reporting arrangements between Safeguarding hosted service, providers and the CSU (this has now been resolved and a reporting protocol agreed)

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

We seek to gain best value through all of our contracting and procurement processes. We have approved a Scheme of Delegation, Prime Financial Policies and a Schedule of Financial Limits that ensures there are proper controls in respect of expenditure.
The agreed limits for quotation and tendering are detailed in those policies and staff are required to properly assess bids for services in accordance with the policies.

We buy procurement expertise and support from the CSU and this service is delivered by appropriately trained and accredited individuals.

All newly acquired services are subject to robust assessment to ensure that patients are able to benefit from quality, value for money services.

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

As Accounting Officer I have responsibility for reviewing the effectiveness of the system of internal control within the CCG.

Capacity to handle risk

The Chief Officer has accountability for ensuring there are robust arrangements in place for the identification and management of risk. The Chief Officer is supported in this role by the Head of Corporate Delivery and Integration. Expertise and support is also procured from Cheshire and Merseyside Commissioning Support Unit (the CSU) who offer advice to all staff on the identification and management of risk.

The Senior Management Team have received training on the development and management of the Governing Body's Assurance Framework and all staff are able to access "hands on" support at all times. All SMT members have received the Risk Management Strategy and have also had training on incident reporting procedures.

We foster a culture of openness and encourage the sharing of good practice and learning when things go wrong.

Review of effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the Senior Management Team, managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

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

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

The Governing Body receives the minutes of all committees including the Audit Committee, Quality Committee and Finance and Resources Committee.

The Quality Committee approves relevant policies and the Audit Committee monitors action plans arising from Internal Audit reviews.

Internal Audit is a key component of internal control. The Audit Committee approves the annual internal audit plan, and progress against this plan is reported to each meeting of the Committee. The individual reviews carried out throughout the year assist the Director of Audit to form his opinion, which in turn feeds the assurance process.

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of our systems of risk management, governance and internal control. The Head of Internal Audit concluded that:

"*Significant Assurance, can be given that 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 weaknesses in the design or inconsistent application of controls put the achievement of particular objective at risk."*

During the year the Internal Audit did not issue any audit report with a conclusion of limited or no assurance.

Data quality

The CSU is commissioned to provide us with *inter alia,* Performance Reports, Contract Monitoring Reports, Quality Dashboards and other activity and performance data. The CSU's Data Management Information Centre (DMIC) processes and quality assures the data

that is received from providers and works with us to challenge providers if inconsistencies are identified.

Our Chief Analyst also assesses the quality of the data provided and ensures that concerns are addressed through the provider Information Sub Group meetings.

These processes provide assurances that the quality of the data upon which the Membership and Governing Body rely, is robust. The DMIC is also licenced by the Health and Social Care Information Centre to lawfully process Patient Identifiable information.

Business critical models

Our internal auditors have undertaken a review of management accounting practices including estimation techniques and forecasting and reported that significant assurance is in place in respect of the control environment operating in this area.

Data security

We have submitted a level 2 compliance with the information governance toolkit assessment. Our Internal Auditors (MIAA) provided an assessment of “Significant Assurance” on the submission.

We have put in place policies, procedures, guidance and support to ensure that personal and corporate information is handled legally, securely, efficiently and effectively, in order to deliver high quality services. Performance is monitored through the completion of the annual Information Governance (IG) Toolkit return and reports to the Corporate Governance Group and Quality Committee.

Controls include:

- Mandatory induction and refresher IG training for all staff
- Identifying the movement of personal data and assessing associated risks, and minimising where possible
- Ensuring the encryption of all confidential data stored on portable devices
- Reporting, investigation and escalation of all information governance incidents

Discharge of statutory functions

During establishment, the arrangements we put in place and which are explained within our constitution 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, we have reviewed all of the statutory duties and powers conferred on us 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 CCG's statutory duties.

Conclusion

During the year no significant control issues have been identified. This is confirmed by the Head of Audit Opinion and also by the Internal Audit Reviews that have provided the CCG with significant assurance on the arrangements in place.

Fiona Clark
Accountable Officer
June 2014

Independent auditors' report to the Members of Southport and Formby Clinical Commissioning Group

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 Southport and Formby 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 accounting policies; and
- the notes to the financial statements, which include 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 and Annual Accounts 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 Directors' 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.

- 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 55, 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 Southport and Formby CCG 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, Southport and Formby 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 the governance arrangements, financial management, asset and information management and workforce management.

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 Southport and Formby 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.

Rachel McIlwraith (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Manchester
10 June 2014

(a) The maintenance and integrity of the Southport and Formby 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.

Data entered below will be used throughout the workbook:

Entity name:	Southport & Formby Clinical Commissioning Group
This year	2013-14
This year ended	31 March 2014
This year commencing:	1 April 2013

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The Primary Statements:

Notes to the Accounts

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

	Note	2013-14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	4	**1,350**
Other costs	5	**169,647**
Other operating revenue	2	**(866)**
Net operating costs before interest		**170,131**
Investment revenue		**-**
Other (gains)/losses		**-**
Finance costs		**-**
Net operating costs for the financial year		**170,131**
Net (gain)/loss on transfers by absorption		
Net operating costs for the financial year including absorption transfers		**170,131**
Of which:		
Administration Costs		
Gross employee benefits	4	**1,003**
Other costs	5	**1,622**
Other operating revenue		**-**
Net administration costs before interest		**2,625**
Programme Expenditure		
Gross employee benefits	4	**347**
Other costs	5	**168,025**
Other operating revenue	2	**(866)**
Net programme expenditure before interest		**167,506**

Other Comprehensive Net Expenditure	2013-14 £000
Impairments and reversals	**-**
Net gain/(loss) on revaluation of property, plant & equipment	**-**
Net gain/(loss) on revaluation of intangibles	**-**
Net gain/(loss) on revaluation of financial assets	**-**
Movements in other reserves	**-**
Net gain/(loss) on available for sale financial assets	**-**
Net gain/(loss) on assets held for sale	**-**
Net actuarial gain/(loss) on pension schemes	**-**
Share of (profit)/loss of associates and joint ventures	**-**
Reclassification Adjustments	
On disposal of available for sale financial assets	**-**
Total comprehensive net expenditure for the year	**170,131**

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment	13	**45**
Intangible assets		**0**
Investment property		**0**
Trade and other receivables		**0**
Other financial assets		**0**
Total non-current assets		**45**
Current assets:		
Inventories		**0**
Trade and other receivables	17	**6,613**
Other financial assets		**0**
Other current assets		**0**
Cash and cash equivalents	20	**138**
Total current assets		**6,751**
Non-current assets held for sale		**0**
Total current assets		**6,751**
Total assets		**6,796**
Current liabilities		
Trade and other payables	23	**13,198**
Other financial liabilities		**0**
Other liabilities		**0**
Borrowings		**0**
Provisions		**0**
Total current liabilities		**13,198**
Total Assets less Current Liabilities		**(6,402)**
Non-current liabilities		
Trade and other payables		**0**
Other financial liabilities		**0**
Other liabilities		**0**
Borrowings		**0**
Provisions		**0**
Total non-current liabilities		**0**
Total Assets Employed		**(6,402)**
Financed by Taxpayers' Equity		
General fund	SoFP	**(6,402)**
Revaluation reserve		**0**
Other reserves		**0**
Charitable Reserves		**0**
Total taxpayers' equity:		**(6,402)**

The notes on pages 77 to 121 form part of this statement

The financial statements on pages 73 to 76 were approved by the Governing Body on 3rd June 2014 and signed on its behalf by:

Chief Accountable Officer
Fiona Clark

Chief Finance Officer
Martin McDowell

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

	Note	General fund	Revaluation reserve	Other reserves	Total reserves
		£000	£000	£000	£000
Changes in taxpayers' equity for 2013-14					
Balance at 1 April 2013		**-**	**-**	**-**	**-**
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition	13	65	-	-	65
Transfer between reserves in respect of assets transferred from closed NHS bodies		-	-	-	-
Adjusted CCG balance at 1 April 2013		**65**	**-**	**-**	**65**
Changes in CCG taxpayers' equity for 2013-14					
Net operating costs for the financial year	SoCNE	(170,131)	-	-	**(170,131)**
Net gain/(loss) on revaluation of property, plant and equipment		-	-	-	**-**
Net gain/(loss) on revaluation of intangible assets		-	-	-	**-**
Net gain/(loss) on revaluation of financial assets		-	-	-	**-**
Total revaluations against revaluation reserve		**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets		-	-	-	**-**
Net gain (loss) on revaluation of assets held for sale		-	-	-	**-**
Impairments and reversals		-	-	-	**-**
Net actuarial gain (loss) on pensions		-	-	-	**-**
Movements in other reserves		-	-	-	**-**
Transfers between reserves		-	-	-	**-**
Release of reserves to the Statement of Comprehensive Net Expenditure		-	-	-	**-**
Reclassification adjustment on disposal of available for sale financial		-	-	-	**-**
Transfers by absorption to (from) other bodies		-	-	-	**-**
Transfer between reserves in respect of assets transferred under absorption		-	-	-	**-**
Reserves eliminated on dissolution		-	-	-	**-**
Net Recognised CCG Expenditure for the Financial Year		(170,066)	-	-	**(170,066)**
Net funding	SoCF	163,664	-	-	**163,664**
Balance at 31 March 2014		**(6,402)**	**-**	**-**	**(6,402)**

Statement of Cash Flows for the year ended 31 March 2014

	Note	2013-14 £000
Cash Flows from Operating Activities		
Net operating costs for the financial year		**(170,131)**
Depreciation and amortisation	13	**20**
Impairments and reversals		**-**
Other gains (losses) on foreign exchange		**-**
Donated assets received credited to revenue but non-cash		**-**
Government granted assets received credited to revenue but non-cash		**-**
Interest paid		**-**
Release of PFI deferred credit		**-**
(Increase)/decrease in inventories		**-**
(Increase)/decrease in trade & other receivables		**(6,613)**
(Increase)/decrease in other current assets		**-**
Increase/(decrease) in trade & other payables		**13,198**
Increase/(decrease) in other current liabilities		**-**
Provisions utilised		**-**
Increase/(decrease) in provisions		**-**
Net Cash Inflow (Outflow) from Operating Activities		**(163,526)**
Cash Flows from Investing Activities		
Interest received		**-**
(Payments) for property, plant and equipment		**-**
(Payments) for intangible assets		**-**
(Payments) for investments with the Department of Health		**-**
(Payments) for other financial assets		**-**
(Payments) for financial assets (LIFT)		**-**
Proceeds from disposal of assets held for sale: property, plant and equipment		**-**
Proceeds from disposal of assets held for sale: intangible assets		**-**
Proceeds from disposal of investments with the Department of Health		**-**
Proceeds from disposal of other financial assets		**-**
Proceeds from disposal of financial assets (LIFT)		**-**
Loans made in respect of LIFT		**-**
Loans repaid in respect of LIFT		**-**
Rental revenue		**-**
Net Cash Inflow (Outflow) from Investing Activities		**-**
Net Cash Inflow (Outflow) before Financing		**(163,526)**
Cash Flows from Financing Activities		
Net funding received		**163,664**
Other loans received		**-**
Other loans repaid		**-**
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		**-**
Capital grants and other capital receipts		**-**
Capital receipts surrendered		**-**
Net Cash Inflow (Outflow) from Financing Activities		**163,664**
Net Increase (Decrease) in Cash & Cash Equivalents	20	**138**
Cash & Cash Equivalents at the Beginning of the Financial Year		**-**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		**-**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**138**

Notes to the financial statements

1 Accounting Policies

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

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 13 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements.

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

1.2 Accounting Convention

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

1.3 Acquisitions & 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.

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

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

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

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

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

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

1.7.2 Key Sources of Estimation Uncertainty

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

· Prescribing Expenditure - The CCG will not receive final confirmation of its February and March Prescribing Expenditure until after the annual accounts have been drafted. An estimate of this charge has been included in the accounts based on information supplied by the NHS Business Services Authority and local information on the prescribing profiles of individual practices

· Partially Completed Spells - The CCG has not received complete information from all providers on the value of Partially Completed Spells at the 31st March 2014. It has included in the accounts an estimate based on the opening value of partially completed spells at 1st April 2013 and provider specific information that has been supplied at the 31st March 2014

· Continuing Healthcare Costs - Include some estimation where the actual costs of an individual package of care have not yet been confirmed. These estimates have been based on knowledge gathered on the costs of similar packages of care for other individuals

1.8 Revenue

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

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

Notes to the financial statements

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

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 clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 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 clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

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

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

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

Notes to the financial statements

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 clinical commissioning group'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 clinical commissioning group;
- 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.

Notes to the financial statements

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 clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group 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 clinical commissioning group 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.

Notes to the financial statements

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 Clinical Commissioning Group as Lessee

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17.2 The Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 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 clinical commissioning group 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 IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

Notes to the financial statements

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 clinical commissioning group'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 Clinical Commissioning Group 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 clinical commissioning group's Statement of Financial Position.

1.18.6 Other Assets Contributed by the Clinical Commissioning Group to the Operator

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group 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 clinical commissioning group, 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 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

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

Notes to the financial statements

1.21 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

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

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct 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 clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.23 Non-clinical Risk Pooling

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

1.24 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 clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.25 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 clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

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

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

Notes to the financial statements

1.26 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.26.1 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 clinical commissioning group'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.

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

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Notes to the financial statements

1.27 Financial Liabilities

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

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

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

1.29 Foreign Currencies

The clinical commissioning group'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 clinical commissioning group'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 accounts since the clinical commissioning group 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 clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

Notes to the financial statements

1.32 Subsidiaries

Material entities over which the clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

1.36 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

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Recoveries in respect of employee benefits	**-**	-	-
Patient transport services	**-**	-	-
Prescription fees and charges	**-**	-	-
Dental fees and charges	**-**	-	-
Education, training and research	**3**	-	3
Charitable and other contributions to revenue expenditure: NHS	**-**	-	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-	-
Receipt of donations for capital acquisitions: NHS Charity	**-**	-	-
Receipt of Government grants for capital acquisitions	**-**	-	-
Non-patient care services to other bodies	**304**	-	304
Income generation	**-**	-	-
Rental revenue from finance leases	**-**	-	-
Rental revenue from operating leases	**-**	-	-
Other revenue	**559**	-	559
Total other operating revenue	**866**	**-**	**866**

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.

3 Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
From rendering of services	**866**	**-**	**866**
From sale of goods	**-**	**-**	**-**
Total	**866**	**-**	**866**

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2013-14	Total			Admin			Programme	
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	**1,058**	978	80	**791**	711	80	**267**	267	-
Social security costs	**114**	114	-	**83**	83	-	**31**	31	-
Employer Contributions to NHS Pension scheme	**178**	178	-	**129**	129	-	**49**	49	-
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**-**	-	-	**-**	-	-	**-**	-	-
Gross employee benefits expenditure	**1,350**	**1,270**	**80**	**1,003**	**923**	**80**	**347**	**347**	**-**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	-	-	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**1,350**	**1,270**	**80**	**1,003**	**923**	**80**	**347**	**347**	**-**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**1,350**	**1,270**	**80**	**1,003**	**923**	**80**	**347**	**347**	**-**

4.1.2 Recoveries in respect of employee benefits

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

4.2 Average number of people employed

2013-14	Total	Permanently employed	Other
	Number	Number	Number
Total	**28**	26	2
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	-	-

4.3 Staff sickness absence and ill health retirements

	2013-14 Number
Total Days Lost	60
Total Staff Years	29
Average working Days Lost	2

	2013-14 Number
Number of persons retired early on ill health grounds	**-**
Total additional Pensions liabilities accrued in the year	**-**

Ill health retirement costs are met by the NHS Pension Scheme

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.

4.4 Exit packages agreed in the financial year

2013-14	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	**-**	**-**
£10,001 to £25,000	-	-	-	-	**-**	**-**
£25,001 to £50,000	-	-	-	-	**-**	**-**
£50,001 to £100,000	-	-	-	-	**-**	**-**
£100,001 to £150,000	-	-	-	-	**-**	**-**
£150,001 to £200,000	-	-	-	-	**-**	**-**
Over £200,001	-	-	-	-	**-**	**-**
Total	**-**	**-**	**-**	**-**	**-**	**-**

	Departures where special payments have been made	
	Number	£
Less than £10,000	-	-
£10,001 to £25,000	-	-
£25,001 to £50,000	-	-
£50,001 to £100,000	-	-
£100,001 to £150,000	-	-
£150,001 to £200,000	-	-
Over £200,001	-	-
Total	**-**	**-**

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval*	-	-
Total	**-**	**-**

4.5 Pension costs

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

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

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to 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:

4.5.1 Full actuarial (funding) valuation

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

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

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

4.5.2 Accounting valuation

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

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

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

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

4.5 Pension costs

4.5.3 Scheme Provisions

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

• The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

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

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

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

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

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

5. Operating expenses

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits			
Employee benefits excluding governing body members	1,208	861	347
Executive governing body members	142	142	-
Total gross employee benefits	**1,350**	**1,003**	**347**
Other costs			
Services from other CCGs and NHS England	**1,512**	883	629
Services from foundation trusts	**13,518**	-	13,518
Services from other NHS trusts	**107,183**	-	107,183
Services from other NHS bodies	**146**	-	146
Purchase of healthcare from non-NHS bodies	**21,811**	5	21,806
Chair and lay membership body and governing body members	**346**	280	66
Supplies and services – clinical	**890**	1	889
Supplies and services – general	**518**	171	347
Consultancy services	**203**	3	200
Establishment	**1,223**	84	1,139
Transport	**1**	-	1
Premises	**25**	25	-
Impairments and reversals of receivables	**-**	-	-
Inventories written down	**-**	-	-
Depreciation	**20**	8	12
Amortisation	**-**	-	-
Impairments and reversals of property, plant and equipment	**-**	-	-
Impairments and reversals of intangible assets	**-**	-	-
Impairments and reversals of financial assets	**-**	-	-
· Assets carried at amortised cost	**-**	-	-
· Assets carried at cost	**-**	-	-
· Available for sale financial assets	**-**	-	-
Impairments and reversals of non-current assets held for sale	**-**	-	-
Impairments and reversals of investment properties	**-**	-	-
Audit fees	**-**	-	-
Other auditor's remuneration			
· Internal audit services	**32**	32	-
· Other services	**61**	61	-
General dental services and personal dental services	**-**	-	-
Prescribing costs	**20,872**	-	20,872
Pharmaceutical services	**-**	-	-
General ophthalmic services	**5**	-	5
GPMS/APMS and PCTMS	**1,069**	1	1,068
Other professional fees excl. audit	**25**	25	-
Grants to other public bodies	**-**	-	-
Clinical negligence	**-**	-	-
Research and development (excluding staff costs)	**-**	-	-
Education and training	**150**	33	117
Change in discount rate	**-**	-	-
Other expenditure	**40**	10	30
Total other costs	**169,647**	1,622	168,025
Total operating expenses	**170,997**	**2,625**	**168,372**

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

6.1 Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	4,595	19,617
Total Non-NHS Trade Invoices paid within target	4,013	16,948
Percentage of Non-NHS Trade invoices paid within target	87.33%	86.40%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,472	128,560
Total NHS Trade Invoices Paid within target	1,233	127,893
Percentage of NHS Trade Invoices paid within target	83.76%	99.48%

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.

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

	2013-14 £000
Amounts included in finance costs from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-
Total	-

7 Income Generation Activities

The clinical commissioning group does not undertake any direct income generation activities.

8. Investment revenue

The clinical commissioning group does not generate any investment revenue.

9. Other gains and losses

The clinical commissioning group has not experienced any other gains or losses.

10. Finance costs

The clinical commissioning group has not incurred any financing costs.

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

The clinical commissioning group has not experienced any gains or losses on absorption transfers.

12. Operating Leases

The clinical commissioning group does not hold any operating leases, either as a lessee or lessor.

12.2.1 Rental revenue

The clinical commissioning group does not have any lease arrangements in this capacity.

13 Property, plant and equipment

2013-14	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	57	-	8	-	65
Adjusted Cost or valuation at 1 April 2013	-	-	-	-	57	-	8	-	65
Addition of assets under construction and payments on account	-	-	-	-	-	-	-	-	-
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	57	-	8	-	65
Depreciation 1 April 2013	-	-	-	-	-	-	-	-	-
Adjusted depreciation 1 April 2013	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	12	-	8	-	20
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	12	-	8	-	20
Net Book Value at 31 March 2014	-	-	-	-	45	-	0	-	45
Purchased	-	-	-	-	45	-	0	-	45
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2014	-	-	-	-	45	-	0	-	45
Asset financing:									
Owned	-	-	-	-	45	-	0	-	45
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total PFI & LIFT assets	-	-	-	-	-	-	-	-	-
Total at 31 March 2014	-	-	-	-	45	-	0	-	45

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-
Revaluation gains	-	-	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-	-	-
Release to general fund	-	-	-	-	-	-	-	-	-
Other movements	-	-	-	-	-	-	-	-	-
At 31 March 2014	-	-	-	-	-	-	-	-	-

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The clinical commissioning group does not have any interest in assets under construction.

13.2 Donated assets

The clinical commissioning group has not received any donated assets.

13.3 Government granted assets

The clinical commissioning group has not received any government granted assets.

13.4 Property revaluation

The clinical commissioning group has not been subject to any property revaluations.

13 Property, plant and equipment cont'd

13.5 Compensation from third parties

The clinical commissioning group has not received any compensation from third parties.

13.6 Write downs to recoverable amount

The clinical commissioning group has not written down any assets to their recoverable amount.

13.7 Temporarily idle assets

The clinical commissioning group does not hold any temporary idle assets.

13.8 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2013-14 £000
Land	-
Buildings excluding dwellings	-
Dwellings	-
Plant & machinery	-
Transport equipment	-
Information technology	-
Furniture & fittings	-
Total	-

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	4
Transport equipment	-	-
Information technology	-	-
Furniture & fittings	-	-

14 Intangible non-current assets

The clinical commissioning group does not hold any intangible non-current assets.

14 Intangible non-current assets cont'd

14.1 Donated assets

The clinical commissioning group does not hold any intangible donated non-current assets.

14.2 Government granted assets

The clinical commissioning group does not hold any intangible government granted non-current assets.

14.3 Revaluation

The clinical commissioning group does not hold any intangible non-current assets.

15 Investment property

The clinical commissioning group had no investment property as at 31 March 2014

16 Inventories

The clinical commissioning group had no inventories as at 31 March 2014

17 Trade and other receivables

	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	**6,510**	**-**
NHS receivables: Capital	**-**	**-**
NHS prepayments and accrued income	**51**	**-**
Non-NHS receivables: Revenue	**45**	**-**
Non-NHS receivables: Capital	**-**	**-**
Non-NHS prepayments and accrued income	**-**	**-**
Provision for the impairment of receivables	**-**	**-**
VAT	**5**	**-**
Private finance initiative and other public private partnership arrangement prepayments and accrued income	**-**	**-**
Interest receivables	**-**	**-**
Finance lease receivables	**-**	**-**
Operating lease receivables	**-**	**-**
Other receivables	**2**	**-**
Total	**6,613**	**-**
Total current and non-current	**6,613**	
Included above:		
Prepaid pensions contributions	**-**	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

17.1 Receivables past their due date but not impaired

	2013-14 £000
By up to three months	**-**
By three to six months	**-**
By more than six months	**-**
Total	**-**

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2014.

17.2 Provision for impairment of receivables

The clinical commissioning group held no provisions for the impairment of receivables at 31 March 2014

18 Other financial assets

18.1 Current

	2013-14 £000
Balance at 1 April 2013	**-**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**-**
Adjustment balance at 1 April 2013	**-**
Additions	**-**
Revaluation	**-**
Impairments	**-**
Impairment reversals	**-**
Transferred from non-current financial assets	**-**
Disposals	**-**
Transfer (to)/from other public sector body	**-**
At 31 March 2014	**-**

18.2 Non-current

	2013-14 £000
Balance at 1 April 2013	**-**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**-**
Adjustment balance at 1 April 2013	**-**
Additions	**-**
Revaluation	**-**
Impairments	**-**
Impairment reversals	**-**
Transferred from non-current financial assets	**-**
Disposals	**-**
Transfer (to)/from other public sector body	**-**
At 31 March 2014	**-**

18.3 Non-current: capital analysis

	2013-14 £000
Capital revenue	**-**
Capital expenditure	**-**

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2014.

20 Cash and cash equivalents

	2013-14 £000
Balance at 1 April 2013	**-**
Net change in year	**138**
Balance at 31 March 2014	**138**
Made up of:	
Cash with the Government Banking Service	**138**
Cash with Commercial banks	**-**
Cash in hand	**0**
Current investments	**-**
Cash and cash equivalents as in statement of financial position	**138**
Bank overdraft: Government Banking Service	**-**
Bank overdraft: Commercial banks	**-**
Total bank overdrafts	**-**
Balance at 31 March 2014	**138**
Patients' money held by the clinical commissioning group, not included above	**-**

21 Non-current assets held for sale

The clinical commissioning group does not have any non-current assets held for sale at 31 March 2014

22 Analysis of impairments and reversals

The clinical commissioning group has not incurred any impairments or reversals in the year to 31 March 2014

23 Trade and other payables

	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	-	-
NHS payables: revenue	3,348	-
NHS payables: capital	-	-
NHS accruals and deferred income	1,619	-
Non-NHS payables: revenue	1,378	-
Non-NHS payables: capital	-	-
Non-NHS accruals and deferred income	6,734	-
Social security costs	-	-
VAT	-	-
Tax	-	-
Payments received on account	-	-
Other payables	119	-
Total	13,198	-
Total payables (current and non-current)	13,198	

24 Other financial liabilities

	Current 2013-14	Non-current 2013-14
Embedded derivatives at fair value through the statement of comprehensive net expenditure	-	-
Financial liabilities carried at fair value through profit and loss	-	-
Amortised cost	-	-
Total	-	-
Total current and non-current	-	

25 Other liabilities

	Current 2013-14	Non-current 2013-14
Private finance initiative/LIFT deferred credit	-	-
Lease incentives	-	-
Other	-	-
Total	-	-
Total current and non-current	-	

26 Borrowings

The clinical commissioning group does not have any borrowings at 31 March 2014

27 Private finance initiative, LIFT and other service concession arrangements

The clinical commissioning group does not have any direct interest in any PFI or LIFT arrangements.

28 Finance lease obligations

The clinical commissioning group does not have any finance lease obligations.

29 Finance lease receivables

The clinical commissioning group does not hold any receivables in respect of finance leases.

30 Provisions

	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	-	-
Pensions relating to other staff	-	-
Restructuring	-	-
Redundancy	-	-
Agenda for change	-	-
Equal pay	-	-
Legal claims	-	-
Continuing care	-	-
Other	-	-
Total	-	-

Total current and non-current

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Agenda for Change £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Arising during the year	-	-	-	-	-	-	-	-	-	-
Utilised during the year	-	-	-	-	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-	-	-	-	-
Unwinding of discount	-	-	-	-	-	-	-	-	-	-
Change in discount rate	-	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	-	-	-	-	-	-	-
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	-	-	-
Between one and five years	-	-	-	-	-	-	-	-	-	-
After five years	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	-	-	-	-	-	-	-

The clinical commissioning group does not hold any provisions 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 clinical commissioning group. However, the legal liability remains with the CCG.
The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £1.1.m

31 Contingencies

Contingent liabilities

The clinical commissioning group does not have any contingent liabilities.

32 Commitments

32.1 Capital commitments

The clinical commissioning group has no capital commitments at 31 March 2014

32.2 Other financial commitments

The clinical commissioning group has not entered into any non-cancellable contracts.

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

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

33.1.3 Credit risk

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

33.1.3 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	2013-14 £000	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	6,510	-	6,510
· Non-NHS	-	45	-	45
Cash at bank and in hand	-	138	-	138
Other financial assets	-	3	-	3
Total at 31 March 2014	-	6,696	-	6,696

33.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-
Payables:	-	-	-
· NHS	-	4,967	4,967
· Non-NHS	-	8,113	8,113
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	-	-
Other financial liabilities	-	-	-
Total at 31 March 2014	-	13,080	13,080

34 Operating segments

The clinical commissioning group consider they have only one operating segment: Commissioning of Healthcare Services.

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning of Healthcare Services	170,997	(866)	170,131	6,796	(13,198)	(6,402)
	170,997	(866)	170,131	6,796	(13,198)	(6,402)

34.1 Reconciliation between Operating Segments and SoCNE

	2013-14 £'000
Total net expenditure reported for operating segments	170,131
Total net expenditure per the Statement of Comprehensive Net Expenditure	170,131

34.2 Reconciliation between Operating Segments and SoFP

	2013-14 £'000
Total assets reported for operating segments	6,796
Total assets per Statement of Financial Position	6,796

	2013-14 £'000
Total liabilities reported for operating segments	(13,198)
Total liabilities per Statement of Financial Position	(13,198)

35 Pooled budgets

The clinical commissioning group were not party to any formal pooled budget arrangements during 2013-14.

36 NHS Lift investments

The clinical commissioning group does not hold any LIFT investments at 31 March 2014.

37 Intra-government and other balances

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	5	-	-	-
· Local Authorities	-	-	977	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	32	-	924	-
· NHS Trusts and Foundation Trusts	6,529	-	4,043	-
Total of balances with NHS bodies:	6,561	-	4,967	-
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	47	-	7,254	-
Total balances at 31 March 2014	6,613	-	13,198	-

38 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Dr Niall Leonard				
Roe Lane Surgery	45	0	3	0
Dr Robert Caudwell				
Marshside Surgery	25	0	0	0
Caudwell Medical Services	31	0	0	0
Dr Liam Grant				
Dr Reddington & Partners	213	0	4	0
Dr Martin Evans				
Kilshaw & Partners	214	0	0	0
Dr Graeme Allan				
St Marks Medical Centre	40	35	16	0
Hedley & Partners	175	0	0	0
Dr Hilal Mulla				
The Corner Surgery	79	0	0	0
Karen Leverett				
Reddington & Partners	213	0	4	0
Mr Roy Boardman				
St Marks Medical Centre	40	35	16	0
Trinity - Southport Health Centre	24	0	0	0

The majority of the related party payments listed above relate to locally enhanced services that the CCG assumed responsibility for with effect from 1st April 2013 and which are paid to all the participating practices in the CCG.

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

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

In addition, the clinical commissioning group 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 Sefton Metropolitan Borough Council in respect of joint enterprises.

39 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 clinical commissioning group or consolidated group.

40 Losses and special payments

The clinical commissioning group has not incurred and losses or special payments in the year to 31 March 2014.

41 Third party assets

The clinical commissioning group held no cash or cash equivalents on behalf of other parties during the year to 31 March 2014.

42 Financial performance targets

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended).
The clinical commissioning group's performance against those duties was as follows:

	2013-14 Maximum £'000	2013-14 Performance £'000
Expenditure not to exceed income	171,881	170,131
Capital resource use does not exceed the amount specified in Directions	0	0
Revenue resource use does not exceed the amount specified in Directions	171,881	170,131
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	170,163	170,131
Revenue administration resource use does not exceed the amount specified in Directions	2,980	2,625

43 Impact of IFRS

	2013-14 £'000
Depreciation charges	-
Interest expense	-
Impairment charge: Annually Managed Expenditure	-
Impairment charge: Departmental Expenditure Limit	-
Other Expenditure	-
Revenue receivable from subleasing	-
Total IFRS Expenditure (IFRIC 12)	-
Revenue consequences of private finance initiative/LIFT schemes under UK GAAP/ESA95 (net of any sublease revenue)	-
Net IFRS Change (IFRIC 12)	-
Capital Consequences of IFRS: private finance initiative/LIFT and other service concession arrangements under IFRIC 12	
Capital expenditure 2013-14	-
UK GAAP capital expenditure 2013-14 (reversionary interest)	-

44 Analysis of charitable reserves

The clinical commissioning group does not hold any charitable reserves at 31 March 2014.

NHS Southport and Formby CCG

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