NHS
South Sefton
Clinical Commissioning Group

Annual Report and Annual Accounts 2014-2015

NHS South Sefton Clinical Commissioning Group

Contents

Introduction

Welcome to our Annual Report and we hope you find it an interesting overview of our work so far in improving the health and wellbeing of everyone who lives in south Sefton. You will read about some of our most notable achievements over the past 12 months throughout this report.

In particular, our GP practice members have made good progress in developing some exciting schemes, based around the needs of the communities they serve - like our health checks programme for housebound patients, and reviews for patients with breathing conditions to check they are using their inhalers correctly – although relatively small schemes, these are making a real difference to patients. We have also begun to make progress to improve primary care, through the introduction of our local quality contact for our member GP practices. One of the schemes focuses on improving access and this has resulted in many more appointments being made available to south Sefton residents.

Good progress has been made over the past 12 months in our work to better 'integrate' or join up services right across health and social care. Through the Health and Wellbeing Board, we have launched Shaping Sefton towards securing the delivery of more integrated and effective care across the borough. We believe this approach will result in much more individualised support for our patients and carers, so they have a better experience of the services involved in their care, as well as benefiting from improved medical results. For the first time we have joint funding with Sefton Council through the Better Care Fund that will also support this work. This approach is also at the heart of our 5 year strategy, which we finalised this year with the help of patients, carers, other south Sefton residents and partners.

We are committed to working with our local communities to ensure services are the best they can be, and we would like to thank all those who have shared their views and experiences with us so far. We have learned a great deal and we have used people's feedback to inform how we develop future healthcare.

We know there are great challenges ahead for the NHS and we will continue to work hard to meet our duties over the coming 12 months towards improving health and wellbeing of local people. We are proud that our commitment and ability was recognised at the end of 2014 at the NHS North West Leadership Academy Awards, when our chief officer was named Inspirational Leader of the Year. Fiona Clark won against some extremely strong competition from the four other finalists in the category to take the top title.

There will be some changes in the membership of the Governing Body, with a new chair and clinical vice chair from 1 April 2015 and forthcoming practice manager elections. So we would like to take this opportunity to thank the current Governing Body and our member practices for the hard work and dedication shown during the past 12 months, and we look forward to building on our achievements in the coming year.

Dr Clive Shaw, Chair **Fiona Clark, Chief Officer**

Strategic report

About us

We are a membership organisation bringing together all the GP practices in south Sefton. As we are led by local doctors and other health professionals, we are ideally placed to understand of the health needs of south Sefton residents.

Whilst many local health priorities are similar to those experienced right across the country, the way we are formed helps us to better concentrate our efforts on the particular challenges faced here in south Sefton.

We plan and buy the majority of local health services and this process is known as commissioning. The range of services we are responsible for includes:

- 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 services – we commission many mental health services apart from very specialised care and treatment

We cannot do this alone and we work closely with a wide range of partners who have a stake in ensuring the good health and wellbeing of all south Sefton residents.

The Health and Social Care Act sets out our full statutory duties. This came into effect on 1 April 2013 when we took over many of the responsibilities of NHS Sefton, the former primary care trust, when it was dissolved at the end of March 2013.

What we do

In 2014-2015 we had a budget of £231.342 million to spend on commissioning health services for 155,213[1] South Sefton residents. A breakdown of how this is spent is provided on page 54.

The majority of our budget, around 65%, is spent on hospital based services. Whilst we support people's right to choose where they are treated and who provides their care[2], the majority of the services we commissioned in 2014-2015 were from Aintree University Hospital NHS Foundation Trust and Liverpool Community Health NHS Trust.

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
- North West Commissioning Support Unit – which provides many of our administrative and operational functions like data management and performance reporting
- Other NHS organisations – like Southport and Ormskirk Hospital NHS Trust, Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool Women's NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust and Liverpool Heart and Chest Hospital
- Community and voluntary sector organisations – like Sefton Carers Centre and the Alzheimer's Society
- Independent and private sector providers – including Go To Doc that is led by doctors and provides our GP Out of Hours service

Last year we also saw a number of new providers delivering services like musculoskeletal, podiatry and audiology through a national scheme called 'Any Qualified Provider'. As a result, many residents are now able to access these services in locations and at times that are more convenient to them.

[1] 2014-15 estimated GP weighted population for south Sefton
[2] Choice of place of treatment is one of the rights included in the NHS Constitution

How we do this

We work with the local community and other partners, to improve the health and healthcare of everyone living in south Sefton, spending money wisely and supporting clinicians to do the best job they can.

To do this we need to understand all the information and medical evidence about current health and health services in south Sefton, to inform what more we need to do. This is so we can plan for health services that continue to meet the needs of local people in the future.

Our plans also have to meet a number of nationally set standards and requirements like the NHS Outcomes Framework[3], the Five Year Forward View[4] and the NHS Constitution[5], which set out what everyone can expect from their national health service and what is expected from them in return.

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 patients, carers and the 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.

[3] NHS Outcomes Framework - http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/
[4] Five Year Forward View - http://www.england.nhs.uk/ourwork/futurenhs/
[5] NHS Constitution - http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

How we 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[6] 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 2014-2015 on page 60.

Providing assurance

We have 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 59. 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.

Our wider membership

There are 33 GP practices in south Sefton and these made 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 our clinical commissioning group (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:

Bootle

Crosby

Maghull

Seaforth and Litherland

[6] 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

Who we work with

There are a number of other organisations that are involved in planning, buying, providing or overseeing your health and social care services, and we work closely with them all.

NHS England

We work closely with NHS England to ensure health services for south Sefton residents meet national and local standards. Whilst we are responsible for improving quality in primary care, NHS England is the commissioner of these services. Locally, the Cheshire and Merseyside Area Team oversees standards and holds the contracts for GP surgeries, dentists, pharmacists and opticians, as well as some screening and immunisation programmes. Other Area Teams commission some other services you may need, including specialist, prison and armed forces healthcare.

Sefton Health and Wellbeing Board

We are core members of Sefton Health and Wellbeing Board. This committee of Sefton Council brings us together with others who have a lead responsibility for health and social care in the borough, including local councillors, council officers and Healthwatch Sefton. Together, we have devised a Sefton wide strategy for improved health and social care services. This was based on our Joint Strategic Needs Assessment, which brings together all the information we have about current health and social care services locally, to highlight where we need to do more in the future.

Sefton Council

The local authority is responsible for promoting and protecting good health across Sefton. It works closely with the 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 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.

Other clinical commissioning groups

We work with neighbouring clinical commissioning groups to plan and buy services when there is a benefit for south Sefton residents, or where services are provided across a wider geographical area, like hospital care. We share a small management team with neighbouring NHS Southport and Formby 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.

Provider organisations

The majority of services we commission are from other NHS organisations like hospital and community services trusts. In addition, we also commission some services from the voluntary, community and faith sector and private providers. We closely monitor the work of all our providers to ensure their services meet the high standards of quality we expect for our patients. We also involve our providers in planning how we might improve care in the future, and a number of these organisations are represented on some of our most important working groups.

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. The chair of Healthwatch Sefton is a co-opted member of our Governing Body. The organisation also has representation on some of our other committees and working groups, including our Engagement and Patient Experience Group.

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. Some of the services and schemes that we were particularly proud of in 2014-2015 have been developed by our GP localities, others from working much more closely with our partners and provider organisations. Here are some examples.

Health checks for housebound patients

We know that there are more Seaforth and Litherland residents living with long term conditions than in other areas of south Sefton and it has higher rates of deaths from smoking related diseases. This is also an area with a higher number of older residents who prefer to access information and services through face to face contact. So, our locality GP practices devised a personalised health care check for housebound residents focusing on coronary heart disease, dementia, hypertension and heart failure. Practice nurses will carry out a one hour check with patients, along with home based support from the stop smoking service when needed. Back at the GP practice, the patient's doctor will review the results of the health check to take account of any adjustments that need to be made to each patient's ongoing care, such as a change in medication. This is a one year project and similar schemes are now being adopted across our other GP locality areas.

Making Every Contact Count

Reception staff in our GP practices are generally the first point of contact for anyone wanting help for a health problem. Across south Sefton they speak with hundreds of people every day. Our Bootle locality wants to harness the potential of reception staff to 'Make Every Contact Count' (MECC) in helping people to make healthier lifestyle choices. MECC is a national programme developed by the NHS and local government and in Bootle practices are introducing electronic signing in systems, designed to free up time for reception staff so they can spend more time putting this approach into action. Working with public health, practice staff will receive training in the MECC approach. This will give them the knowledge and skills to initiate supportive conversations and offer advice to patients around improving levels of physical activity and mental wellbeing, along with sensible drinking, stopping smoking, eating more healthily and looking after their sexual health. This approach has shown positive results in other areas of the country and we hope this will be replicated in Bootle during 2015-2016, with a view to rolling this out across south Sefton in the future.

Well North

Our Bootle and Seaforth and Litherland localities have begun to work with Public Health England on a new programme to improve the health of those living in some of our most deprived communities fastest. The five year programme is called Well North and it is working with nine councils across the north of the country to bring funding of around £1million to each of the pilot areas, which includes Sefton. Locally this work is involving a wide range of partners and it will also focus on devising new approaches to greatly increase life expectancy in these two locality areas, as well as tackling worklessness.

Falls prevention pilot

Seaforth and Litherland locality have begun to develop a falls prevention pilot for 2015-2016. It will see a falls risk assessments carried out with some of our most vulnerable residents, followed by a programme of chair based exercises to further reduce their risk of falling. The criteria and locations for the pilot are currently being agreed.

Care home medicines project

This is the second year of the project, which carries out an annual medication review for care home residents. 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 2014-2015 we reviewed around 450 patients, the scheme helped prevent people from needing hospital treatment on 56 occasions. Just under £50,000 was also saved through better and more effective prescribing. In addition, pharmacists 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.

Care at the Chemist

We re-launched this scheme in 2014-2015, giving more people easier access to free advice and treatment by simply visiting their local chemist. The new scheme offers over the counter help for a much wider range of conditions and saves people a trip to their GP surgery. Anyone who joins Care at the Chemist can be assessed by an expert pharmacist, who will advise them about how to treat their condition. This includes supplying people with any medicines they might need, which are free for anyone who does not pay for prescriptions and costing no more than a prescription charge for everyone else. From speaking to people when we were developing our 5 year strategy, many told us they would like more services to be available at their local pharmacy and Care at the Chemist helps to achieve this. Around 17,500 medicines were dispensed through Care at the Chemist this year.

Award for stoma pilot

The pilot, developed last year by our Bootle locality, has been gaining national and local attention due to its success. It involved a review of all post operative stoma[7] patients to ensure their care and prescribing needs were brought in line with best practice. There were just over 100 stoma patients across the seven participating practices and around a third of these were identified as requiring a specialist stoma review. On average it had been six years since patient's had their last specialist review. Some patients had not been prescribed the best appliances for their individual needs, which meant their day to day lives were severely restricted. With improved prescribing, they are now able to lead a more normal life for the first time since their operation. As well as greatly improving the quality of each patient's care, the project saved around £10,000 through improved prescribing. The project was presented last year at the national Royal College of GPs annual conference, as well as winning a partnership award in the 'Proud of Aintree Hospital Excellence Awards'. We are now in the process of rolling out the project across all localities in south Sefton.

[7] A stoma is an artificial opening of your bowel on the front your stomach, created during an operation, to collect either faeces or urine.

Supporting better health and wellbeing

VCF Direct

We have been working with Sefton CVS to develop a new online directory of services - currently known as VCF Direct - provided by the voluntary, community and faith sector. This system is aimed at primary care professionals to help them signpost and directly refer patients to a wide range of support to improve their health and wellbeing offered by this sector. It is being tested in a number of GP practices with the aim of rolling it out more widely over the year ahead.

Examine Your Options

This campaign supports our wider plans to deal with the additional demands on NHS services over the busy winter months. It aims to raise awareness amongst Sefton residents of the options available to them when they are ill. The campaign is evaluated each year and as a result, in 2014-2015 we placed even greater focus on the support available from GP practices, the GP out of hours service and local pharmacies. The campaign included newspaper adverts promoting holiday opening times over Christmas and New Year and it could also be seen on buses and at a number of Merseyrail stations. Supporting information materials were also distributed to a wide range of local organisations.

New app and digital TV system

We launched a new information system in spring 2014, making health advice and information available to our residents via an app for smartphones and digital interactive TV systems. Looking Local gives local information to help people live a healthy lifestyle, or to find their nearest health service. Some people can also book appointments at their GP practice using Looking Local.

- Sky - Go to the Community Channel (539) and press the RED button. Then search for your area or choose: Northern England, North West, Merseyside then NHS South Sefton CCG
- Virgin media - Press the HOME button on your remote control, choose INTERACTIVE, select “Local & Directory Enquiries”, select “Looking Local”, or Go to the Community Channel (233) and press the RED button.
- Online / Wii / mobile web - www.lookinglocal.gov.uk/southseftonccg
- To download the app - go to either Google Play or the iTunes App Store – then search for NHS SSCCG

Investing in our local communities

For the second consecutive year, and together with NHS Southport and Formby CCG, we awarded around £1 million to local voluntary, community and faith sector organisations. We recognise the valuable role these groups play in achieving better health and wellbeing for our residents. This is reinforced by what local people consistently tell us, that these groups are important in providing them with support.

Through Sefton CVS, organisations were asked to submit bids for one off funding to support specific initiatives. There were 20 successful bids in 2014-2015, specifically addressing the following priorities in line with our 5 year strategy, Sefton Health and Wellbeing Strategy and the Sefton Strategic Needs Assessment:

- Ensure all children have a positive start in life
- Supporting older people and those with long term conditions and disabilities to remain independent and in their own homes
- Promote positive mental health and wellbeing

The range of successful organisations included Feelgood Factory, Parenting 2000, Expect Ltd and Sefton Children's Trust and nearly all are working with other VCF groups to deliver their projects. These are exciting schemes, often designed and delivered by local people for others who live in their communities. Here are some examples of how these grants have been put to use so far:

Redi

During its 10 years of existence Ykids has come a long way and its Redi programme focusses on topics such as education and employment and offering young people support so they can build a positive future. The grant was used to continue nine different groups within the programme. Children and young people from different age groups were involved in a variety of activities from a drumming workshop, a sponsored charity run and writing a pantomime, to achieving a first aid certificate with St John Ambulance and working on an 'Art is Rubbish' project. By offering a range of activities, the project builds emotional resilience within the children and young people. Overall, 61 children and young people took part from October to December 2014.

This is what they thought of the Redi programme:

- 46% of young people who attended Redi X groups this term have improved self esteem
- 55% of 15-16 year olds on Redi Extreme are engaging in less risky behaviour than before
- 67% of teenage girls on Redi Extra have improved self esteem and feel better about themselves than they before
- 48% of children who attended a 9 week Redi project feel more active in the community as a result

Case study - Redi Max is a specific group for year 7 children who have just moved into secondary school. A number were referred to Redi by local schools and housing agencies as they were getting involved in anti social behaviour. They attended a Friday night project. At the end of the 10 weeks one learning mentor commented about a young person in the group: "He has really struggled with the transition from primary to secondary, he is often in tears begging to go back to his primary school... Redi is great for him to have that consistency when everything else is changing for him."

Case study - One young person aged 15 attending Redi Affex, for young women, has a difficult home life and is often living in different places. She is involved in risky behaviour, is self harming and struggling to find a place she belongs. Redi has provided a constant in her life through the upheaval and chaos. Whilst her behaviour can be challenging she is calming down and her scores on risky behaviour reduced at the end of the term.

Social Inclusion

Netherton Feelgood Factory has been working to combat social isolation and to improve people's health and mental wellbeing, especially for older people. It offered 'Feelgood Fridays' from December and the members who are now attending are aged over 65. One of them has early onset dementia and the others have had mental health problems. One of them is now confident enough to attend follow-on activities and another has improved mental health because her GP has remarked there has been a positive improvement in their health.

Case study - "The Feelgood Friday has had a huge impact on my life, it has brought me out of myself. I never went to any groups before coming to the Feelgood Friday, now I attend quite a few groups at the Feelgood Factory" - BH, who is partially paralysed and semi housebound before attending Feelgood Friday."

Sefton Veterans

This is a new one stop shop for Sefton's military veterans that opened its doors in May 2014, offering advice and assistance on a range of issues including health, housing and employment by working with a range of specialist organisations to provide personalised support under one roof at the Bowersdale Resource Centre in Seaforth. This free and confidential service is open to all military veterans and former reservists no matter what their age, or how long they have served in the armed forces – even if it was just for one day. The service also provides support to families in the armed forces community, as well as current serving personnel.

Case study - a former member of the parachute regiment said of the service: "Just over a year ago I was really down on my luck - I had no job, I was angry at myself and I was struggling to support my girlfriend and kids. A couple of guys I know told me about the Sefton Veterans Project. Because it is run by an ex squaddie I went to see them. I knew they would understand and I knew I could talk to them without being embarrassed or feeling like I was a loser or a waster. It was great talking to vets again. The project manager, Dave Smith, managed to find some funding and training for me. I now have a full time job and I can now hold my head up again and support my family."

Transforming healthcare

We know that demands on health services are increasing, whilst at the same time the public sector is being required to work within tighter financial boundaries. The approach we set out in our strategy responds to these challenges and goes further - committing us to make much needed improvements to the health and wellbeing of all local residents.

Whilst the performance of local health services has been good since we became responsible for commissioning in April 2013, we know we have to change the way we currently do things if we are to achieve our vision and make a real difference in the future. Central to this is ensuring that the health needs of Sefton residents are at the heart of everything we do.

To do this, we believe that we need services which work more closely, or 'integrated', right across health and social care and the following three schemes will support this.

Shaping Sefton

Through the Health and Wellbeing Board, we are embarking on a system wide programme to improve and transform health and social care. Shaping Sefton launched in February 2015 with an event supported by the independent and highly respected think tank, the King's Fund. The event brought together leaders from across the system and focused on how we might work better together to coordinate care around the needs of our patients, carers and their families. The King's Fund sets out compelling evidence which highlighted the great benefits for patients when organisations and services work better together. This work will progress in 2015-2016 to include more detailed work about how we might achieve this locally.

Locality model of care

We know from speaking to local people that they really value the care they receive from GP practices and community services, provided close to where they live. We believe there are great benefits in wrapping services around our local communities, so we are developing a locality model of care that mirrors our **GP practice localities** – Bootle, Seaforth and Litherland, Crosby and Maghull – to really focus on the needs of these four distinct communities. We see a variety of professionals from across health and social care playing a greater role in these locality teams, in line with our vision for Shaping Sefton.

Better Care Fund

For the first time health and social care have been required to pool a proportion of their budgets together through the Better Care Fund and we believe this presents us with great opportunities to meet our shared objectives. In 2015-2016 our joint Better Care Fund will total around £24 million and we have agreed with Sefton Council to use this towards reducing unplanned admissions to hospital. One of our overarching transformational programmes, **community centred care**, will support this work. The fund will also be used to develop an **integrated wellness service** and to improve **intermediate care and reablement**. Voluntary, community and faith sector organisations are important partners in this work and we recognise their valuable role in creating a more innovative and effective local health and social care system now and in the future.

Why things need to change

South Sefton stretches from Bootle in the south, Hightown in the north and Melling and Lydiate in the east.

Here are some things we know about south Sefton residents that we must take into account when we are planning services:

- Our population is made up of a significantly higher number of older residents with an estimated 19.8% (approximately 31,600) of the population over the age of 65, compared to 17.5% nationally
- Over the next 10 years the number of over 65 year olds in south Sefton is expected to grow to more than 35,400
- We also expect to see significant growth in the number of people aged 85 and over from an estimated 4,000 in 2015 to an estimated 4,500 by 2019, representing an increase of almost 14%
- South Sefton has significantly higher levels of deprivation and child poverty

Overall, health in south Sefton is getting better, but there are clear areas for improvement:

- Within the areas of south Sefton that are most deprived, average life expectancy is 11 years less than in the more affluent communities
- Levels of long term health conditions are much higher than the national average; particularly heart disease, respiratory disease, kidney disease, mental health conditions and obesity
- Levels of early deaths from heart disease have reduced over the last decade as smoking rates have reduced and our patients are better educated about risks to their health and the importance of leading a healthy lifestyle

Our 5 year strategy

We finalised our 5 year strategy for improving health and health services in the summer of 2014. We have developed our strategy jointly with NHS Southport and Formby CCG, so we can work across a wider area when we need to but also concentrate on our very local priorities.

This joint approach also makes it easier for us to work with partners like Sefton Council and better join up or 'integrate' our plans and services whenever we can, to work more efficiently in this challenging time. Importantly, it means we have the potential to achieve more for local residents than we could do individually, as there is greater strength in working together.

A great deal of work went into the design of our 5 year strategy to ensure it focuses on improving those aspects of healthcare that will make the most difference to the health and wellbeing of our local residents.

It has been shaped by the Sefton Strategic Needs Assessment, often known as a JSNA and our Sefton Strategy for Health and Wellbeing, so it is aligned to the plans of our partners from Sefton Council and responds to what we know is needed most in south Sefton.

We also spoke with local residents to gain their views and we added three new programme areas to our 5 year strategy as a result of what we were told.

Our 5 year strategy helps us to 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.

Our vision is to:

"To create a sustainable healthy community based on health needs, with partners; focused on delivering high quality and integrated care services to all, to improve the health and wellbeing of our population"

Our priorities

We have identified three main strategic priority areas as the focus for all of our work:

1. Care for our older and vulnerable residents

2. Unplanned care

3. Primary care

To make improvements across all of these areas, we believe we need to organise many services around our **GP practice localities**. We have devised a number of **transformational** and underpinning **health programmes** to support this way of working. You will notice there are connections between nearly all of these workstreams.

All of our programmes are led by clinicians, and this means that in general they will also be GP members of our Governing Body.

Transformational programmes

The following two transformational areas of work are aimed at ensuring health services adapt so they can meet the healthcare challenges of the future.

Community centred care

This is currently known as Virtual Ward and involves a wide range of partners from across health and social care to provide more joined up or 'integrated', locally focused and personalised services.

Primary care transformation

Whilst NHS England is the commissioner of GP practices, CCGs have a role in improving quality in primary care. We have a strategy for primary care which works alongside our wider five year strategy for all services.

Health programmes

The following specific health programmes underpin our transformational programmes:

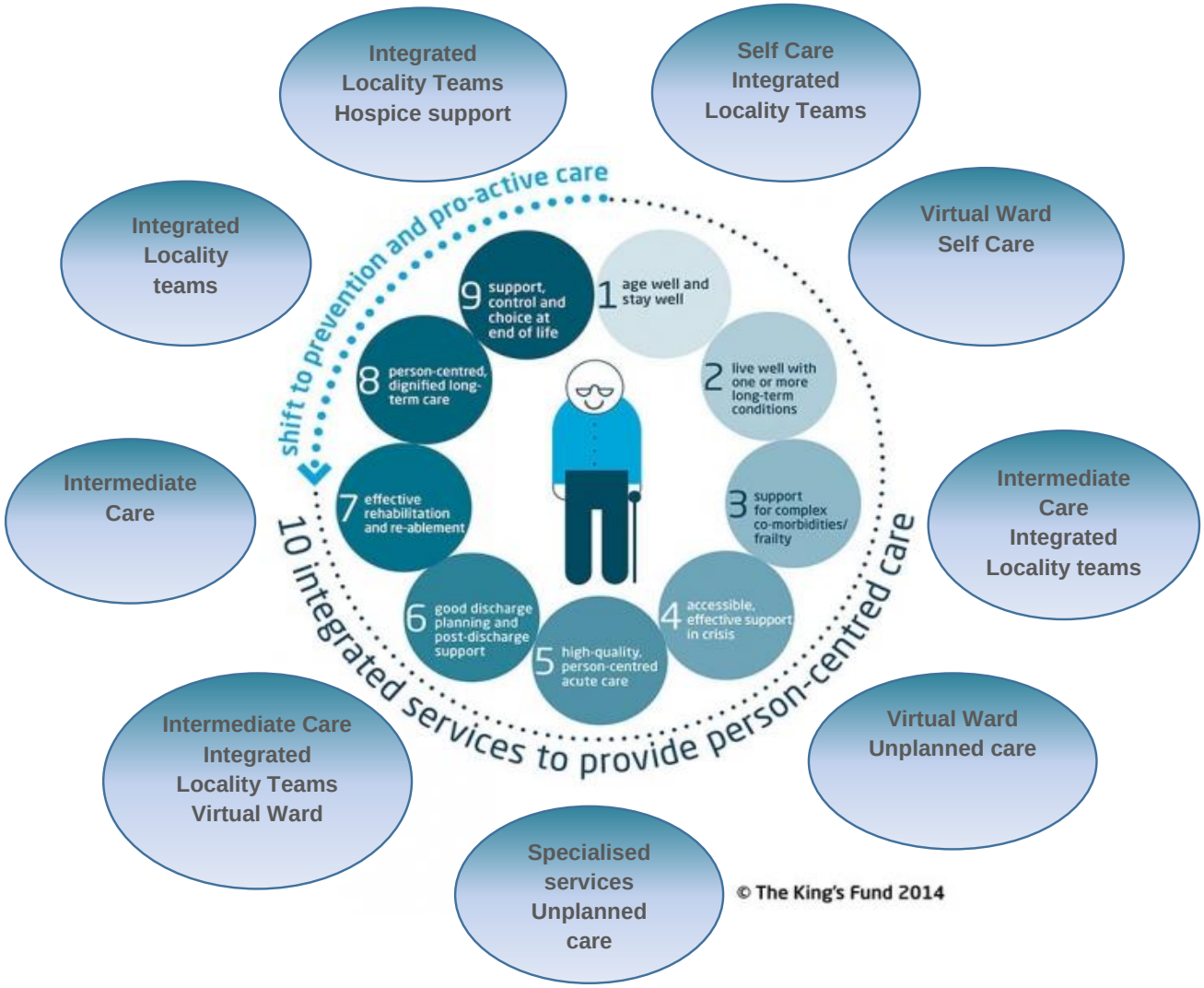
- Mental health, cardiovascular disease, respiratory disease, diabetes, cancer, children and care for people at the end of their lives

We added the following three programmes to our strategy as a result of our discussions with local people:

- Liver disease, kidney disease and neurology – including conditions like Parkinson's and Motor Neurone diseases and epilepsy

Our strategy is already evolving and during the last part of 2014-2015 we began work developing a blueprint, which will set out how we will turn our strategy into action in the years ahead to tackle all of these health priorities. In line with our joint Better Care Fund programme with Sefton Council we will also be focusing on improving **intermediate care**.

What will this look like?



Transformational programmes

Community centred care

We want to transform services, so care is more effectively wrapped around our patients, particularly those who are older and frail. This means creating a healthcare system where professionals across organisations work closely together as part of the same team. The partners involved in this work are from right across health and social care and include Liverpool Community Health NHS Trust, Aintree Hospital, Sefton Council, Sefton CVS, Mersey Care NHS Trust and North West Ambulance Service. We will use money from the local Better Care Fund in the year ahead towards further developing this work to transform the way hospitals, community services, social services and voluntary, community and faith organisations work together with GP practices to provide more effective, person centred care. These **proactive** and **urgent care** programmes look to tackle the high numbers of emergency admissions to hospital, particularly over the busy winter months, for some of our older and most vulnerable residents. There were some important developments for our patients in 2014-2015.

Virtual Ward

This is one of our most important programmes and it has two elements – an established proactive 12 week intensive support service and a new community urgent care team, introduced at the end of 2014.

Proactive care

This proactive 12 week intensive support programme is now in its second year and is for those with long term conditions, particularly older patients, helping them to stay as well as possible, for as long as possible. It focuses on patients who are at most risk of being admitted to hospital and aims to address and improve their health, as well as their wider wellbeing. Pro-active care works to prevent the health of these patients from deteriorating, which can otherwise result in them needing urgent or emergency care. Doctors identify patients who will benefit from pro-active care and refer them to their locality pro-active care team. There are four teams, one for each of our GP practice localities. The teams bring together a wide range of health and social care professionals to coordinate and tailor support based on each patient's individual needs – this could be medical treatment provided by a nursing team, or help and advice about improving their lifestyle from a community health and wellbeing trainer, who works with patients and carers to access services such as befriending, reablement, community activities, welfare rights and social services. In October 2014, health and wellbeing trainers helped their patients to set up a new support group in Seaforth and Litherland. It provides people with the chance to socialise, share their experiences and better manage their ongoing conditions. A second support group is now being established, also led by a former pro-active care patient, along with their carer.

In 2014-2015, over 1,000 people benefited from this service. Over 200 of these were already diagnosed with dementia. However, a further 68 people were supported to gain a dementia diagnosis, which meant they and their carers could also benefit from more appropriate services and support.

We know from feedback that both patients and health professionals greatly value the pro-active care team.

Former pro-active care patient - “I am now back to running my home efficiently and joining in various outings, lunches and I have joined the University of the Third Age. Not bad for an 84 year old!”

GP - “My patient felt isolated due to family issues, her medical conditions, isolation and depression were impacting on her ability to undertake activity's on a daily basis. Occupational Therapy provided aids around the home which enabled her to cook again, take a bath alone, and to stand from sitting without support. Physiotherapy helped build strength in her legs resulting in increase of confidence. A Health Trainer worked helped build her confidence, motivation and sign posting even accompanying her to support groups/craft classes. Counselling was organised along with advice and support sorting financial issues out. My patient found the programme really beneficial, to the point where she is pursuing training with a view to employment. I hardly ever see her now.”

Community urgent care team

This team was established at the start of winter 2014 and provides a rapid response to patients who need urgent healthcare but who do not need to go to hospital. For patients, this means more appropriate care, often in their own home. Being admitted to hospital can be distressing for some patients and may also not provide people with the most effective care for their condition. So, the team works alongside community intermediate care to continue to monitor and manage patients in their own home whenever possible. The urgent care team also works closely with GP practices, ambulance crews, hospitals, the pro-active care team and other community based service to identify, care and monitor patients. Over the winter, the team responded to patients with a range of worsening conditions including mobility problems, infections, dehydration and shortness of breath. Over the coming year we plan to widen the care provided by the team, so it can deal with chronic obstructive pulmonary disease (COPD), intravenous cellulitis treatments, heart failure deterioration and specialist palliative care.

Acute Visiting Scheme and Pathfinder

Both schemes launched in early January 2015 and are managed by our out of hours provider Go To Doc, working together with the North West Ambulance Service (NWAS). In normal working hours, GP practices could refer their acutely unwell care home patients to the Acute Visiting Scheme (AVS) who will carry out a home visit, reducing the risk of patients being admitted to hospital and increasing practices’ capacity . Out of hours, Pathfinder sees Go To Doc working with NWAS to divert patients to more appropriate care instead of A&E whenever possible – this could be the **community urgent care team**, or by carrying out a home visit. In less than 12 weeks of operation, the programmes diverted 85 patients away from A&E. It’s estimated that the schemes prevented 43 people from being admitted to hospital with 300 bed days avoided. In addition, there were 245 care home visits during the same period. This is greatly beneficial for our most frail patients and at the same time helped to reduce pressure in general practices at this busy time for primary care. Both AVS and Pathfinder pilots run until mid June 2015, when their effectiveness will be fully assessed.

Community liaison with A&E

We have introduced community liaison nurses into A&E to support hospital staff. Their role is to work alongside the A&E medical team to ensure patients move on to more appropriate and often community based care as quickly as possible. This has proved valuable, especially during the busiest times. Importantly, this has led to more coordinated care for patients, which addresses their ongoing needs after they have left hospital. We will build on this 'jigsaw' way of working over the coming year. One example is a new integrated heart failure pathway where ongoing consultant care is provided in the community, with the same hospital nurses also continuing to see patients when they are back at home.

Acute frailty unit

Many of our older patients who are taken to hospital for an urgent health problem often have to wait a long time before seeing the specialist medical staff who can support them back home, where they will often make a better recovery. To address this, Aintree Hospital has set up an acute frailty unit to move these patients more quickly from A&E and into a more dedicated care setting. The unit has a much broader array of staff than a usual ward. This means patients are able to be assessed, stabilised and move back home much quicker with reablement support. Building on this approach, we are working with Liverpool CCG and Knowsley CCG to commission a common integrated frailty pathway that incorporates community, hospital and social care from home to hospital and home again.

Care Homes Innovation Programme

We call this our CHIP initiative and it involves all 34 care homes in south Sefton. This evidence based scheme aims to ensure that care home residents enjoy the best quality of life within their usual place of residence whenever possible. CHIP encompasses a wide range of initiatives including medicines management, the AVS, a bespoke quality improvement collaborative, as well as direct access to an urgent care team and access to an expert community geriatrician. In the year ahead we will also be introducing a new telemedicine video system that will connect care homes with round the clock medical support.

Strengthening community services

We have worked closely with Liverpool Community Health over the past year to boost our community services and key developments include:

- Increasing the number of district nurses by 30% - we now have the right amount of district nurses to ensure they can fully play their important and underpinning role in providing high quality community based care

- Aligning district nursing closer to primary care – we now have district nurses assigned to each of our GP practices, so they can work more closely together and be more responsive to patient's needs

- Increasing community geriatrician care – A new consultant post has been a great success over the last 12 months providing underpinning support to many of the services and initiatives that you have read about in this section. As a result we have committed to recruit a further community geriatrician, to further strengthen this important transformational programme of work

Intermediate care

This is sometimes called a ‘halfway home’ service for people who do not need hospital care but who need some additional support to help them recover fully from illness or injury. Intermediate care brings together a range of services to promote faster recovery from illness, prevent unnecessary urgent admission to hospital, premature admission to long term residential care, or to support timely discharge from hospital – all with the aim of maximising people’s independent living. We are working closely with Sefton Council to improve intermediate care through our Better Care Fund programme. During 2014-2015 we reviewed current services and began work to draft a blueprint for how these might be improved in the year ahead. We want future services to give increased focus on ‘step up’ care, for those people who may not have been admitted to hospital but who need additional support for their condition. We expect future intermediate care to be largely provided in a person’s own home but these services will need to be flexible so that some people with additional needs can be treated in a community based intermediate care setting when they need it.

Primary care transformation

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. As a clinical commissioning group, 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 there is a joint primary care programme group with NHS Southport and Formby CCG, reporting to our quality committee. It brings GP members together with commissioners from NHS England, the Local Medical Committee, Healthwatch Sefton and Merseyside Property Services.

Here are a few examples of our progress in 2014-15.

Local Quality Contract

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 August 2014 changed the way CCGs contract with practices for these quality schemes. Practices can choose to sign up to a range of schemes including reviewing A&E attenders, phlebotomy and ankle brachial pressure indicator testing. Our improving access to primary care scheme has seen at least an additional 114 appointments per week being offered to patients across south Sefton practices this year. A review of schemes will take place annually taking into consideration national changes to primary care services. Work is currently being progressed to introduce a frail elderly scheme to complement our wider objectives.

Healthcare assistant apprenticeship scheme

As part of our response to the Francis Report, we devised an exciting 15 month apprenticeship programme in conjunction with Hugh Baird College to support workforce development in primary care. This was introduced in November 2014 to enable practices to receive part funding to train and develop an apprentice healthcare assistant. There are 10 trainees in total across Sefton and at the end of the course they will gain an accredited qualification validated by Edge Hill University.

Primary care co-commissioning

NHS England is giving CCGs the opportunity to assume greater influence over the commissioning of primary medical care from April 2015. CCGs are GP led organisations who understand primary care and are passionate about improving its quality, across all practices in their own geographical areas. In order to harness the benefits of co-commissioning, yet guard against any conflicts of interest, NHS England has developed robust new and transparent arrangements for managing perceived and actual conflicts of interest.

There are various levels of co-commissioning for CCGs to become involved in.

NHS South Sefton CCG has opted for 'Greater involvement in primary care co – commissioning'

This will enable us to collaborate more closely with NHS England to ensure that decisions taken about healthcare services are strategically aligned across the local health economy. This form of co-commissioning will assist us to fulfil our duty to improve the quality of primary medical care.

Health programmes

We have been strengthening our health programmes this year towards improving care for our patients.

Some developed services and initiatives that are focused at locality level to target specific groups of patients, whilst others looked across south Sefton or beyond to address some of the issues that affect us all. In 2015-2016 we will be giving additional focus to our mental health, cardiovascular disease (CVD) and respiratory programmes, where we know we need to make much quicker advances.

Mental health

Respiratory health

Cardiovascular disease

Diabetes

Cancer

Children's health

Care for people at the end of their lives

Liver, neurological and kidney health

Mental health

We believe that improving mental health is just as important as improving physical health. This is an area we will give greater focus to in the year ahead, so we can make quicker progress to bring it in line with our other areas of priority. We know this will mean transforming mental health and dementia services so they can more effectively deal with the challenges of our ageing population, unacceptable inequalities in health and wide variations in the quality of and access to these services. As well as continuing to develop services this year, we carried out a major review of mental health and dementia care and this will to shape how we move forward in 2015-2016.

Mental health task group

In May 2014 we formed a mental health task group to look at how we might begin to transform current services, so they offer south Sefton residents much better treatment, care and support.

This task group was clinically led by a GP and its initial aim was to gain a thorough understanding of current services and what outcomes they offer our patients. The group was also tasked with examining what works and what does not, supported by evidence and best practice, to identify a vision for mental health and dementia care that we can begin to introduce in 2015-2016.

A comprehensive report was presented to our Governing Body in March 2015, who approved the task group's recommendations to shift mental health and dementia services towards:

- Increased efforts to embed prevention in services starting from primary care, in line with our GP locality model of care
- Earlier diagnosis and intervention that result in people being less dependent on intensive services
- When people become ill, recovery and care takes place in the most appropriate setting and enable people to regain their wellbeing and independence
- Services that work seamlessly and more cohesively together

Next steps

In 2015-2016 we will establish a mental health transformation board to advance this work and which will make decisions on the future of mental health and dementia services.

Alongside this we will continue to work with providers to shape services, so they are more responsive to the needs of our patients and carers, and which are work more closely with our GP practice localities.

Improving psychological therapies

In 2014-2015 we reviewed and revised the contract for this service, so it will give people greater access to a much wider range of psychological therapies. This is a Sefton wide service, which we commission jointly with NHS Southport and Formby CCG and in early 2015 we awarded the new contract to Cheshire and Wirral Partnership NHS Trust. From April 2015, this service is known as Access Sefton. It will continue to operate from the same locations, so patients will not notice any difference to the quality of these services but there will be noticeable differences in the months ahead. For the first time, people will be able to access these services directly without having to be referred to them by their GP. People will also be able to get help for a wider range of problems including long term conditions.

New Asperger service launches

This Sefton wide service was launched at the start of December 2014, providing support and diagnosis for those living with Asperger Syndrome. Along with NHS Southport and Formby CCG, we commissioned the service after hearing from local carers and patients, many of whom had previously struggled to get diagnosis and support. Over 100 referrals were made to the specialist service, run by Mersey Care NHS Trust, in weeks and months ahead of its launch. The service is available to adults aged 17 years and over. The service will also give advice, support and education to partners and families of people with Asperger Syndrome.

Improving dementia diagnosis rates

This is a national priority for all CCGs and locally we are working to improve dementia diagnosis rates in a number of different ways, working with our member GP practices and service providers. Dementia screening takes place in many of the programmes, schemes and services you have read about in this report, including our Virtual Ward and our Care Homes Innovation Programme. We expect all these initiatives to help us increase dementia diagnosis rates in the year ahead.

Child and adolescent mental health award

Along with NHS Southport and Formby CCG, we were awarded a £75,000 grant in December 2014 for an innovative pilot to transform services for children and young people with mental health issues. A consortium, bringing us together with Sefton Council and the voluntary, community and faith sector, will use the funding to put in place youth focused emotional wellbeing services in the community which will deliver specific services that meet the needs of young people. Ours is one of only eight schemes in the country to have been awarded a share of £500,000 to improve child and adolescent mental health services, known as CAMHS. The pilots aim to create time for staff to reassess the systems in place to commission - from schools up to inpatient beds - and try to affect change through new ideas involving children, young people and their families in the process.

Respiratory health

There are around 14,500 people in south Sefton who have been diagnosed with two of the biggest breathing conditions - chronic obstructive pulmonary disease, better known as COPD and asthma. We know the real number is likely to be much higher because many more people will not as yet have had their condition detected.

Respiratory conditions are the cause of thousands of emergency hospital admissions each year and we know that many of these could have been prevented if patients had more support to better manage their condition. From speaking to local residents and carers we know this is what they want too.

In 2014–2015, our respiratory team, led by a GP member and involving a patient representative, looked at how current services might be improved. Alongside this, the team devised a number of initiatives that offer patients practical support to stop their condition deteriorating with the aim of improving their lives.

Inhaler technique project

This pilot project was devised by our Bootle locality due to the high numbers of respiratory patients regularly being admitted to hospital as a result of their condition worsening. Practices have identified over 500 of their patients who would benefit from an inhaler review and around 100 of these are housebound. A trained pharmacist has begun carrying out one to one sessions with patients, also offering them advice and referral to smoking cessation, pulmonary rehabilitation and further lung tests where necessary. In its first six months, just over 208 patients were reviewed and more than half of these were found to have poor inhaler technique. Nearly all of those who were then trained in correct techniques showed vast improvements during a follow up assessment, improving the self management of their condition. We will be rolling out this project across the three other south Sefton GP localities in the year ahead.

Self management course

Our new respiratory self management course was developed as a direct result of what patients and carers told us would make a difference to them. We worked closely with a patient representative to design the course and the first 6 week programme took place in early 2015, led by Sefton CVS on our behalf. Sessions offered practical advice and support to those attending including psychological therapies to help them cope and manage their conditions positively and pulmonary rehabilitation. During a session on inhaler technique nearly all of the attendees were found to using their device incorrectly and some were using the wrong inhalers for their condition. We plan to hold a further three self management courses in 2015-2016 and if they continue to evaluate positively, we will look at how we can further roll out this approach in the future.

Everyone who attended the course felt it had been an extremely positive experience and for some, this was the first time they had been given any information to help them manage their conditions. As a result they were keen to develop an ongoing support group and we are now looking at ways we can help them to do this.

Breath well bus captures unidentified need

In early December 2014 we encouraged shoppers at Bootle Strand to climb on board the ‘breathe well bus’ for a free lung health check. Over the winter months we know that breathing conditions are worsened by the colder weather. So, the respiratory team took to the streets to give people advice about looking after their lungs and to spot any problems they may have, no matter how small, as early as possible. More than 80 people had a lung health check over the two days, with over 50 of these identified for the first time as having a lung problem, resulting in them being referred for further tests. We plan further breath well bus events in different parts of south Sefton during 2015- 2016.

Respiratory training programmes

This year we have been developing an extensive training programme that will support practices across our four localities to better manage their COPD and asthma patients in 2015-2016. It will initially focus on three practices with the highest emergency hospital admissions for these conditions. Intensive support will be given to practice nurses, healthcare assistants and doctors and if this proves successful, the programme will be rolled out to other practices.

Cardiovascular disease

We want a community based model of care for cardiovascular disease, as part of a wider integrated approach to long term conditions within community services. Our work towards this in 2014-2015 includes:

Cardiac rehabilitation

We have been working with Aintree Hospital, Liverpool Community Health and the council's Active Sefton team to improve rehabilitation services for cardiology patients. This includes greater choice of community venues, which are more accessible. There will be earlier access to a local rehabilitation programme for patients who have had a recent cardiac event or cardiac surgery to improve their quality of life. It is also crucial that this programme is bespoke and tailored to the needs of the individual, with achievable personal goals and expertise to help them to adopt positive long term lifestyle changes.

Better treatment for heart failure patients

We have been working with local services to improve heart failure treatment and management for our patients in south Sefton. We plan to provide specialist cardiology outreach services to support patients and community clinicians to manage patients more effectively, closer to home. Early specialist intervention is key to ensuring that patients remain at home and in control of symptoms which can often lead to a prolonged stay in hospital. We are also planning educational programmes for patients to enable greater understanding of their condition, to aid their self management and independence.

Atrial fibrillation and stroke prevention

People with an irregular heartbeat are at greater risk from stroke. As part of our work around stroke prevention we have been working with public health and wider health care professionals to identify patients who are living with an irregular heartbeat to improve management of their condition. This includes:

- Identifying more patients through the NHS health check programme for those aged 40 to 74
- Carrying out more opportunistic pulse checks in GP surgeries and clinics
- Using modern technologies such as hand held electrocardiogram machines to help clinicians diagnose atrial fibrillation more easily
- Installing specialist software – called GRASP AF - in practices to assist with the identification and management of patients with an irregular heartbeat
- Working with pharmacies and medicines management to optimise patients' medications to reduce their long term risk of stroke

Diabetes

We know that local diabetes care ranks amongst some of the best in the country for supporting people to control their diabetes and we want to build further on this. Work is progressing to develop a more integrated service, with an enhanced diabetes nursing team at its core. We envisage much closer connections between community services and our GP practice localities, so patients can receive more of their care close to home.

Other areas of focus during 2014-2015 included:

Joining-up care for patients with other conditions

We are exploring opportunities to establish two specialist clinics next year for diabetes patients with kidney conditions or who might be planning a pregnancy, so they can benefit more holistic care. We are currently working with service providers to scope possibilities for these new clinics.

Diabetes working group

We have come together with partners from across the borough to increase awareness of preventable type 2 diabetes and to better identify those at risk of this condition and support them to take steps to prevent it. The group brings us together with colleagues from NHS Southport and Formby CCG, Sefton Council's public health team and voluntary, community and faith groups. In the year ahead the group will further develop a work plan towards achieving these goals.

Training and education

We are examining ways to improve training opportunities for health professionals and better education for patients, both of which are essential to a high quality diabetes service. Both of these aims will be progressed in 2015-2016.

Better footcare for diabetes patients

Cheshire and Merseyside Diabetes Network began a project during the year that will improve footcare for our local diabetes patients. The project focuses on three elements of footcare - a primary care pathway, a hospital care pathway and antibiotic guidelines and over the coming 12 months, we will be working with our member practices, community services and hospitals to begin to put the recommendations into practice.

Cancer

Like services for all of our other health programmes, we expect future cancer care to be more joined up between hospitals, community and primary care. We also know that early detection is crucial in improving people's chances of making a good recovery.

Progress during the year included:

Quicker diagnosis of lung cancer

All patients with an abnormal chest x-ray and a high suspicion of lung cancer will now routinely have a scan. This avoids the time delay and anxiety of patients having to consult their GP and then waiting to be seen in a cancer clinic. Many patients will not have cancer at all and will be reassured much sooner than was the case with the old system.

Ovarian cancer

We are carrying out some focused work with Aintree Hospital to explore how detection of ovarian cancer can be improved. This has highlighted some simple areas of improvement which ensure that women with suspected ovarian cancer will now receive an urgent ultrasound scan to detect any problems.

Better support for cancer survivors

We have agreed funding with Macmillan Cancer Care for a community based cancer coordinator. This new role will provided increased support to our patients to help them better live with and beyond cancer.

Children’s services

With our partners in the Health and Wellbeing Board we have been developing a children and young people’s strategy that will be finalised in 2015-2016. This will set out overarching goals for improved health and wellbeing of all our children and young people.

We want an integrated community model of care for children and young people, underpinned by community nursing, support and therapies. We also want enhanced palliative care and psychological services for children and young people, as well as services that are better equipped to deal with a child’s transition to adult care.

During the year we have been working with a wide range of partners – from NHS England, service providers and Sefton Council, to voluntary, community and faith sector organisations - to review current services, identify how they can work better in the future and to address different aspects of health and wellbeing.

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. We know there is more we can achieve for this group of patients but encouragingly we are now supporting more people than ever before to be cared for and to die at home when they choose this.

Hospice at Home

Provided by Woodlands Hospice, this service supports patients at the end of their life to be cared for and to die at home in accordance with their wishes. The consultant led service offers wraparound support from the moment a patient is referred to the team – from hospitals, GPs or community service. It provides a day and night sitting service to support patients and their families and home visits when care is needed quickly. Hospice at Home has continued to see a rise in referrals and in the number of people it supports.

Better end of life care across our services

Improvements to many of the services and programmes that you have read about in this report so far will also contribute to better care for our patients nearing the end of their lives and during 2015-2016 we want to build further on this. Our care home innovation programme – CHIP (p22) - is a good example. We expect the programme to lead to earlier, more dedicated support for this group of care home residents. Better care planning across all of our services is crucial to this, helping to ensure people's wishes are respected and acted upon and their individual needs can be met more quickly in a more coordinated way.

Liver, neurological and kidney health

We added these three new areas to our list of health programmes as a direct result of what people told us when we were developing our 5 year strategy. Work began in 2014-2015 to look at how we might make improvements and this will continue over the year ahead.

Liver disease

Nationally liver disease is increasing. This is often associated with alcohol abuse, which is evident within areas of Sefton. The long term health and economic consequences of alcohol abuse and liver disease are well recognised. Alcohol consumption amongst young people has been identified as a challenging area for us to address. We will review and assess local needs to inform this new work programme.

Kidney disease

Acute kidney problems are common amongst our older patients, often resulting in admission to hospital and prolonged but preventable stays. Kidney problems can occur for a number of reasons including poor fluid intake, which can cause dehydration and make existing conditions such as heart problems, diabetes and hypertension worse. So, to help us meet our strategic priority of reducing unplanned care we have included kidney disease as one of our health programmes.

Neurological conditions

Services for Sefton residents with neurological conditions like Motor Neurone disease, Parkinson's disease, headaches and epilepsy need to improve. Because our population is ageing, we expect the number of people with these conditions to grow. The implications this will have on individuals, families, carers and health services will be significant. So, it is right that we should provide additional focus on this area as part of our strategic plan.

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

Working with Informatics Merseyside and our service providers, we have made good progress towards ensuring our IT systems are fit for purpose and enable us to work seamlessly across different organisations. 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. Our Merseyside wide programme called iLinks will help us to achieve this. We have also been working during the year with Aintree Hospital to increase usage of the national electronic referral booking system Choose and Book, making it easier for patients to make choices about where they receive treatment. All these systems are safe and secure and conform to the highest data protection safeguards and are essential in helping us to provide more care closer to home.

Managing our programmes effectively

We now have a well established Programme Management Office (PMO) which helps us to develop and monitor the main strategic programmes we have set out in 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.

Ensuring quality

Our Quality Committee is responsible for monitoring and overseeing performance against national requirements, including those in the NHS Constitution[8], 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 provides 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.

Our quality strategy

Every patient and person that we support can and should expect high quality care. This year our quality team developed a quality strategy, which underpins how we commission services to ensure they are amongst the safest and most effective in the NHS, provided reliably to every patient, every time. It also describes our approach to ensuring that everyone has the care and compassion they need and where they are empowered to have their voice heard. There are six fundamental values at the core of our strategy - care, compassion, competence, communication, courage and commitment - known as the 6Cs. These six areas support us in commissioning excellent care and promoting enduring positive values and behaviours across the local NHS. Our strategy also reflects our commitment to working in partnership with local residents, engaging with people to make choices about their health and care, and where there is ‘no decision about me, without me’.

Promoting and using research to improve care

We understand that commissioning the best possible care for our residents, means that we must also be an organisation that promotes research and innovation and uses research evidence in designing and planning services. This will help us to achieve the best health outcomes and reduce the differences in health that exist across our diverse communities. Our research strategy was approved at the end of 2014 and this will ensure that our decisions around commissioning and transforming services are informed by the best available research and evidence. Our strategy also outlines our commitment to encouraging all our partners and providers in adopting this approach whenever possible to improve local healthcare and preventive services.

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

Improving Continuing Healthcare

Our quality team is leading a major piece of work to improve systems and decision making around continuing healthcare (CHC) assessments. CHC is the name given to packages of ongoing care, which are arranged and funded solely by the NHS, and where patients aged over 18 have a 'primary health need', as a result of disability, accident or illness. This is a highly complex area of healthcare for some of our most vulnerable patients and it requires specialist skills and knowledge to ensure effective decision making about each patient's eligibility and what ongoing care will be appropriate for their needs. During 2014-2015 we began to examine how we might streamline existing CHC structures, so the decision's made about a patient's eligibility and care happen much quicker.

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 experience** surveys as well as the national Friends and Family Test
- We have a borough wide cross sector **Engagement and Patient Experience Group** (EPEG) jointly with NHS Southport and Formby 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 40
- Our complaints policy and process – these reflect the national guidance, 'Principles for Remedy'[9] and help us to identify trends and spot warning signs of any emerging problems. Our **patient experience team**, part of the commissioning support unit, provides help to people with any queries or concerns they have about their health or their treatment. The team also collects complaints, queries and concerns, and reports them to EPEG and our quality committee

All this information helps us to make improvements to existing services as well as helping us to shape our plans for the future.

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. There were no data breaches in 2014-2015. If breaches do 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.

[9] 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

Involving you

We believe that involving south Sefton 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 aims.

Involving you in our daily business

We have a number of statutory responsibilities[10] 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 NHS Southport and Formby 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 where we can improve them. We have made progress in developing an electronic system to help us better manage the information we collect through EPEG and we expect this to be operational in 2015-2016. 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 in 2014-2015 this included groups to improve respiratory services, cancer and procurement exercises
- A number of GP practices in south Sefton 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
- We hold regular public **Big Chat** events where we bring people together to discuss our work, ask for their views about our plans and feedback how we have used people's comments and experiences so far. We also hold **Mini Chats** to really focus on specific topics and Healthwatch Sefton has led a number of **Community Chats** on our behalf to specifically help us in finalising our 5 year strategy
- Our **annual general meetings**, open to all residents, provide another opportunity for people to hear more about our work and how they can get involved

[10] 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 2014-2015

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, to carrying out more focused work with specific communities or groups of people affected by our work. Here are some examples from 2014-2015.

Big Chat 4

Our fourth Big Chat in late November 2014 focused on moving our 'strategy into action'. It was also chance for people to hear how views from earlier Big Chats have been used to shape our 5 year strategy and people were invited to give their views on plans setting out our next steps. We shared our plans to develop a locality model of care – with GP practices and their patients at their core - based around our four geographical 'localities'. Working in this way allows practices in each locality to shape services that meet the distinct needs of the communities they serve. Our aim is to further strengthen this way of working, so that other services like district nursing and mental health are also more focused around localities. People at the Big Chats broadly agreed with the locality model. They talked about some of the other services that they would like to see delivered closer to home in their communities, and about those which they felt should be provided on a wider footprint, or in hospital. All the views we gained will help us to further shape our locality model. You will find reports for all our Big Chats on our website.

Out of Hours Pharmacy review

We made a decision to close the out of hours pharmacy service at the end of March 2015 following an extensive consultation and equality assessment. As a direct result of what people told us, we devised an alternative replacement system to make sure people can still get any urgent medicines they need after seeing an out of hours doctor from the Hatton Hill Road health centre. The Out of Hours Pharmacy was restricted to patients using the GP Out of Hours (OOH) service, dispensing relatively small amounts of medicines. Because of its links to the GP OOH service, the Out of Hours Pharmacy also had much shorter opening times than regular high street chemists. A great deal has changed since the Out of Hours Pharmacy was set up and these days there are plenty of chemists nearby that closely match the opening times of the Out of Hours Pharmacy late at night and at weekends. We know that a number of respondents appreciated the convenience of the service and as a result of their feedback we developed an alternative GP prescribing and supply service. So, when other local chemists are closed doctors from the GP OOH service supply medications directly to patients during their consultation. This already happened when people attending the GP OOH service need medicines after 11pm when the Out of Hours Pharmacy is closed. In addition, anyone who finds it difficult to travel to an alternative chemist are also eligible for the GP prescribing and supply system throughout the entire out of hours period, so they are not disadvantaged by this decision. We will regularly review the new wraparound GP prescribing and supply service to ensure patients continue to get their prescriptions when they need them during the out of hours period.

Practice patient groups

We believe that practice patient groups are a good way to involve our residents in their local NHS. They offer a chance for people to get involved in making improvements to their GP practice as well as offering a gateway to being involved in our wider CCG work. From 2015-2016, all GP practices will be required to establish a patient group as part of their contract with NHS England and many south Sefton surgeries already have well established and thriving groups. Over the past year we have been promoting practice patient groups at our events and a range of other meetings, encouraging people to get involved in theirs. In the year ahead we will be looking at how we might support those practices who do not already have a group to set up their own.

Systems to collect views and involve people

We have been developing two new electronic systems this year, which will help us to better involve people in our work and to ensure their views can more quickly inform our commissioning decisions. The first is a new database that stores contact information for all the people who have asked to be kept updated about our work, and in our day to day work we have been asking more residents if they would like to join. This system is already helping us to extend the number of people we are in contact with. The second system will record all the views and feedback we gain about services making it easier to spot trends and themes, so we can act quicker on people's information. Both of these systems hold information securely and safely and we expect them to be in full operation in 2015-2016.

Using experience to develop services

This year our commissioners have been working directly with patients, carers and their representatives on specific service areas. Examples include:

- Our Virtual Ward proactive care service - resulting in the development of a patient led support group
- Our respiratory health programme – leading to a new self management course and roadshows offering free lung health checks
- Our ophthalmology strategy – working with groups that represent people with visual impairments to further explore where we might provide more testing and treatments for eye conditions locally, rather than in hospital

Patient experience team

Part of the commissioning support unit, this team is there to help people with any queries or concerns they have about their health or their treatment. It offers a Freephone telephone number - 0800 218 2333 – and last year 415 south Sefton residents used this service. The team helped people to find information about local dentists, access GP services and patient transport, resolve individual issues and provided general health information. The team also supported our Out of Hours Pharmacy consultation.

Equality and diversity

Promoting equality is at the heart of everything we do. We want to ensure that we commission services fairly, so that no community or group is left behind in the changes that we make to health services as we work towards the vision set out in our 5 year strategy and the NHS England's 'Five Year Forward View'.

We will continue to work internally, and in partnership with our providers, community and voluntary sector and other key organisations to ensure that we advance equality of opportunity and meet our exacting requirements of the Equality Act 2010.

Our duties

The Equality Act requires us to meet our Public Sector Equality Duty (PSED) across a range of protected groups including age, gender, race, sex, sexual orientation, religion and belief, gender identity, marital and civil partnership status and pregnancy and maternity status. Failure to pay due regard to and comply with our duties has legal, financial and reputational risks. So, we must demonstrate that the needs of protected groups have been considered in all aspects of our work – from commissioning and procuring services, consulting and engaging local people and setting quality performance measures, to our internal governance systems and how we treat our staff.

Our equality objectives

We are required to prepare and publish equality objectives to meet our specific duty set out in the Equality Act. Our plan is specific and measurable and it is updated on an annual basis. We understand that at sometimes in our lives we may face barriers when accessing health services or experience different outcomes than what we would expect. So, we want to reduce the health differences across our diverse communities and our equality objectives will support us in doing this:

They are:

- To make fair and transparent commissioning decisions
- To improve access and outcomes for patients and communities who experience disadvantage
- To improve the equality performance of our providers through robust procurement and monitoring practice
- To empower and engage our workforce

Equality delivery systems 2

To help us set our equality objectives we are currently undertaking equality delivery systems 2 (EDS 2). We have been assessed as 'developing', reflecting the need to fully embed equality and diversity. We are now working to improve our performance around the following EDS 2 indicators over the next two years:

- Services are commissioned, procured, designed and delivered to meet the health needs of local communities
- People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
- Papers that come before the Governing Body and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed

We will know the outcomes and recommendations of this assessment in June 2015.

Our service providers

All our key NHS providers have undertaken the EDS 2 assessment and have set equality objectives in line with their requirements. We are working closely with our providers to improve equality performance, access and outcomes for protected groups through robust contract monitoring.

Responding to other new duties

We are also working towards the new National Workforce Race Standard. This aims to address the lack of black and minority ethnic (BME) representation at senior levels in the NHS to galvanise cultural and organisational change. The standard, underpinned by commissioning and regulatory action, will also help to address the treatment of BME staff including adverse outcomes throughout recruitment and promotion, access to non-mandatory training, over-representation in disciplinary procedures, bullying and harassment. The new standard supports the vision set out in the Five Year Forward View and the need to ensure NHS workforces experience inclusive and non-discriminatory opportunities.

Working sustainably

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. We acknowledge this responsibility to our patients, local communities and the environment by working hard to minimise our footprint.

As part of the 2013 authorisation process, CCGs have self-certified compliance to the statement: "We declare that at the point of authorisation our CCG will demonstrate commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner."

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Commissioning (environmental)	Yes
Commissioning (social impact)	Yes
Suppliers' impact	Yes
Travel	No

One of the ways in which an organisation can embed sustainability is through the use of a sustainable development management plan (SDMP). We will be putting together an SDMP in the near future for consideration by the board. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff. Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events

Partnerships

As a commissioning and contracting organisation, we will need effective contract mechanisms to deliver our ambitions for sustainable healthcare delivery. The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a CCG, evidence of this commitment will need to be provided in part through contracting mechanisms.

For commissioned services here is the sustainability comparator for our largest providers: [11]:

Organisation Name	Sustainable Development Management Plan	Good Corporate Citizen Tool	Board Lead for Sustainability	Adaptation	Sustainable Development Reporting score
Aintree University Hospital NHS Foundation Trust	Yes	No	Yes	Yes	Good
Alder Hey Children's NHS Foundation Trust	Yes	No	No	No	Good
Southport and Ormskirk Hospital NHS Trust	Yes	No	Yes	No	Poor
Royal Liverpool and Broadgreen University Hospitals NHS Trust	Yes	Yes	Yes	Yes	Minimum
Liverpool Heart and Chest Hospital NHS Foundation Trust	No	No	Yes	Yes	Poor
Mersey Care NHS Trust	No	No	Yes	No	Good

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 10% by 2015 using 2007 as the baseline year.

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.

[11] More information on these measures is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx

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 North West Commissioning Support Unit through its Emergency Planning, Response and Resilience Team. Here are some of the ways we met our duties in 2014-2015:

- 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 South Sefton 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 has been informed by work with our 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

Going forward into 2015-16, the development of our locality model is the priority area for organisational development and a plan is in place for implementation over the next six to 12 months.

Our Governing Body

Our Governing Body participates in monthly development sessions, either alone or with NHS Southport and Formby CCG, which provide an opportunity for reflection on national and local developments to inform our strategy and how it is delivered. Governing Body members have also been able to access a range of personal development opportunities, with some participating in national development programmes or network events with other CCGs.

Our members

Our member practices are supported 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
- We have begun a programme of training for wider practice and reception staff that will see the ‘Making Every Contact Count’ training begin to be rolled out. In addition there will be dedicated, regular PLT sessions focusing on topics such as dementia and learning disabilities
- Our two nurse facilitators plan and support the development and access to education, training and mentoring for practice nurses and healthcare assistants
- 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, which we will be updating in 2015-2016 based on member’s feedback

Our staff

At the end of March 2014 we employed 93 people (39 whole time equivalents) 4 lay members and chairs included in these figures.) 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 Southport and Formby 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	25
Female	4	0	54
Total	**14**	**0**	**79**

Our staff also continue to access a broad range of development programmes relevant to their roles to assist them in their day to day work:

- 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 e-bulletins

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 south Sefton residents and focus on where we need to make improvements in vey local and specific areas.

Overall, we performed well in 2014-2015 and the work you have been reading about so far in this report has all contributed to this.

An overview of performance follows[12]. More detailed information can be found in the reports presented to our Governing Body at each of its public meetings[13].

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

[13] All performance reports presented to the Governing Body can be found on our website www.southseftonccg.nhs.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[14].

Performance Indicator	Source of measure and performance status (RAG)
Friends and Family Test Scores: Inpatients	Outcomes Framework
Emergency admissions for children with Lower Respiratory Tract Infections (LRTI)	Outcomes Framework
Patient Reported Outcome Measures (PROMS): Groin Hernia, Hip and Knee Replacement (2012/13)	Outcomes Framework
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	Constitution
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	Constitution
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	Constitution
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	Constitution
Maximum 31-day wait for subsequent treatment where that treatment is surgery	Constitution
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	Constitution
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	Constitution
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	Constitution
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	Constitution
Mixed Sex Accommodation (MSA) Breaches per 1,000 Finished Consultant Episodes	Constitution
Admitted patients to start treatment within a maximum of 18 weeks from referral	Constitution

[14] Note: This overview of performance is based on data available at the time of writing this report, covering the period April 2014 - end of January 2015. Further information on these indicators, along with the full year performance can be found in the Integrated Performance report of the Governing Body papers, which are available on our website.

Non-admitted patients to start treatment within a maximum of 18 weeks from referral	Constitution
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	Constitution
Percentage of patients who spent 4 hours or less in A&E	Constitution
% of patients waiting 6 weeks or more for a Diagnostic Test	Constitution
Ambulance clinical quality – Category A (Red 1) 8 minute response time (North West)	Constitution
Ambulance clinical quality – Category A (Red 2) 8 minute response time (North West)	Constitution
Ambulance clinical quality - Category 19 transportation time (North West)	Constitution
Local Quality Premium measure: proportion of diabetes patients who receive all 9 diabetes care processes	Local Measure
Incidence of healthcare associated infection (HCAI) MRSA	Outcomes Framework
Incidence of healthcare associated infection (HCAI) C.difficile	Outcomes Framework
Emergency Admissions Composite Indicator (and supporting measures)	Outcomes Framework
Increasing Access to Psychological Therapies (IAPT) (Prevalence & Recovery)	Outcomes Framework
Emergency admissions for acute conditions that should not usually require hospital admission	Outcomes Framework
Patient experience of primary care i) GP Services, ii) Out of Hours Services	Outcomes Framework
Rate of potential years of life lost (PYLL) from causes considered amenable to healthcare 2013 (Persons)	Outcomes Framework
Friends and Family Test Scores: A&E	Outcomes Framework
Under 75 mortality rate from cancer	Outcomes Framework (158.7)
Under 75 mortality rate from cardiovascular disease	Outcomes Framework (72.6)
Under 75 mortality rate from liver disease	Outcomes Framework (22.6)
Under 75 mortality rate from respiratory disease	Outcomes Framework (38.0)

Key

Met or exceeded

Did not meet

No target/new indicator

Providing value

Financial performance overview

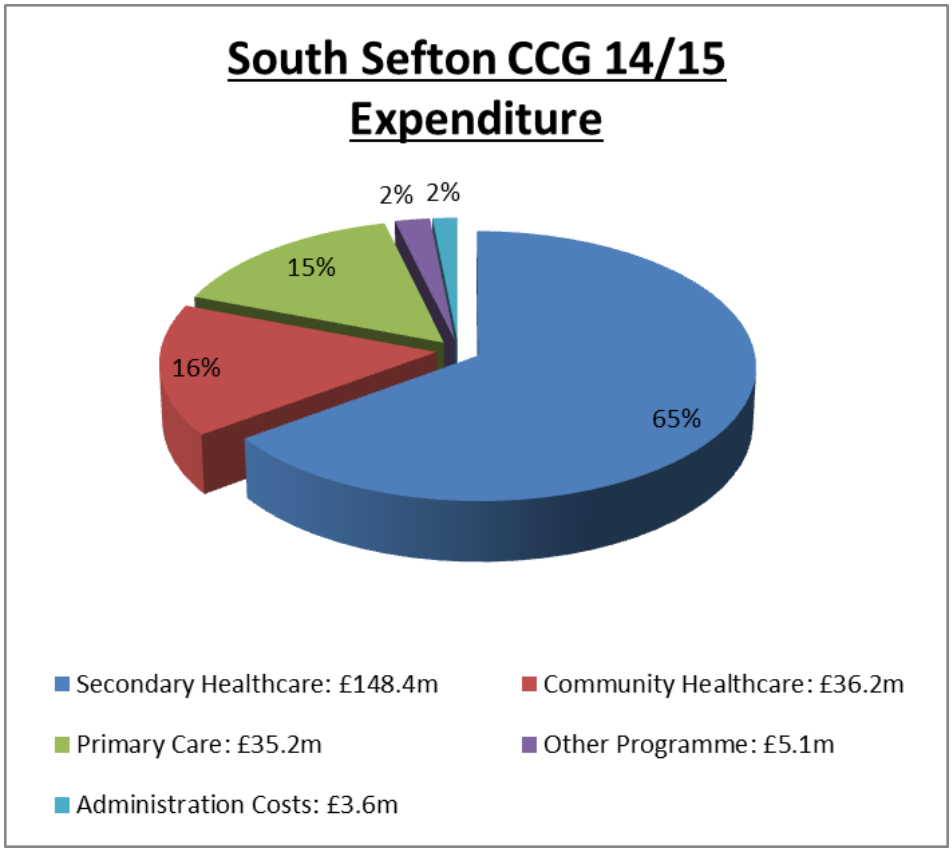
The following summary financial statements set out the performance of NHS South Sefton CCG during the financial year 2014-15. For a full understanding of our financial position and performance, a full set of financial statements is available on request from the chief finance officer (please phone 0151 247 7071).

We are pleased to report that all of our statutory financial duties 2014-15 have been achieved, notably:

- Achieved 'operational financial balance' and reported a revenue surplus of £2.848m which is carried forward for investment in future years;
- Managed within our cash limits;
- Operated within our running cost allowance (administrative cost budget set by NHS England).

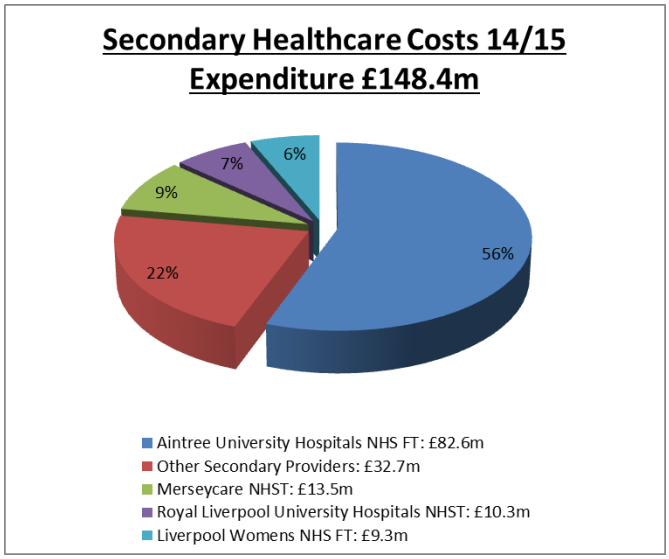
Analysis of funding and expenditure

We received £231.342m of parliamentary revenue funding in 2014-15. We carried forward £2.848m of this forward for future year investment in healthcare services, and we spent the remaining £228.495m as follows.

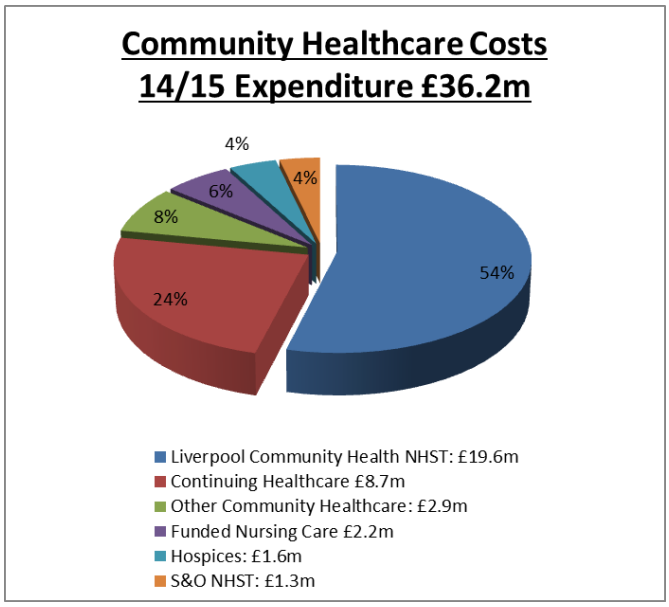


Our main areas of spend were as follows;

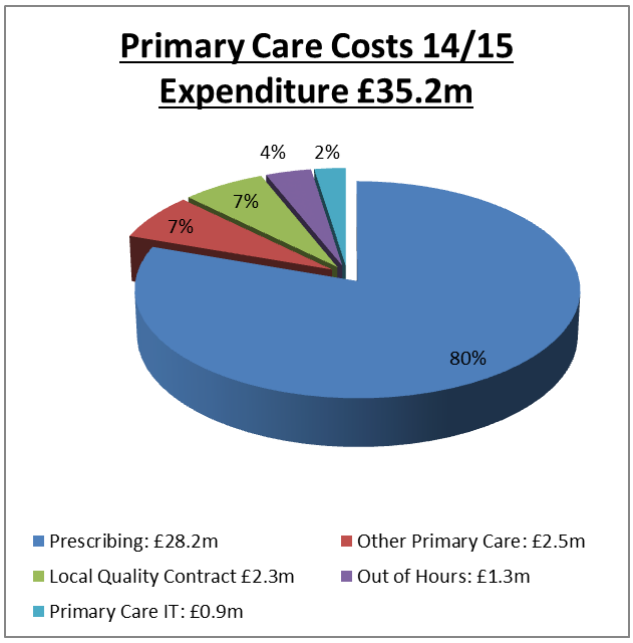
Secondary healthcare - represents the cost of contracts we have with hospitals to provide services for the residents in our community. Examples of these services include accident and emergency, maternity, mental illness and general and acute services. A breakdown of this spend by provider is shown below.



Community healthcare - is the cost of services provided in a community setting. Examples of this are district nursing, physiotherapy and community clinics. It also includes the cost of providing long term packages of care for people at home and in nursing and residential homes. A breakdown of this spend is shown below.



Primary care costs - mainly represent the cost of drugs prescribed by GPs. They also include some other services commissioned from GPs and primary care contractors (eg Out of Hours services). A breakdown of this spend is shown below.



Other programme costs - mainly consist of non-acute services such as re-ablement schemes and other mental health services, as well as front line IT schemes.

Administration - represents the departments that support the process of commissioning the healthcare services described above. By understanding the needs of our community, we strive to obtain high quality and valued services. We also ensure management of those contracts throughout the lifecycle of a service is of the highest possible standards. These costs represent just 1.5% of the CCG's overall budget.

The following summary statements show the key financial reports for the CCG.

Statement of comprehensive net expenditure (summary)

	2014-15				2013-14		
£000's	**Admin**	**Programme**	**Total**		**Admin**	**Programme**	**Total**
Employee Benefits	1,506	715	**2,221**		1,307	536	**1,843**
Operating Expenses	2,078	224,787	**226,865**		2,177	220,659	**222,836**
Other operating revenue	0	(591)	**(591)**		17	(855)	**(838)**
Net Operating expenditure	**3,584**	**224,911**	**228,495**		**3,501**	**220,340**	**223,841**

This financial statement shows our total net expenditure split between direct healthcare spend (programme) and administrative spend.

Statement of financial position (summary)

£000's	2014-15	2013-14
Non Current Assets	43	58
Current Assets	1,310	2,140
Total Assets	**1,353**	**2,198**
Current Liabilities	(17,198)	(18,353)
Non Current Assets less Net Current Liabilities	**(15,845)**	**(16,155)**
Non-Current Liabilities	(414)	0
Assets less Liabilities	**(16,259)**	**(16,155)**
Total Taxpayers Equity	**(16,259)**	**(16,155)**

The statement of financial position provides a snapshot of the CCG's assets and liabilities as at 31 March 2015. The negative balance reported against total taxpayers equity is a consequence of timing payments as opposed to any adverse financial performance.

Statement of changes in taxpayers equity for the year ended 31 March 2015 (summary)

£'000s	Total Reserves
Balance at 1st April 2014	(16,154)
Changes in NHS CCG Taxpayers Equity for 2014-15	
Net Operating Expenditure for the financial year	(228,494)
Net Recognised NHS CCG Expenditure for the Financial Year	**(244,648)**
Net Funding	228,389
Balance at 31 March 2015	**(16,259)**

This statement reflects the gains or losses that have not been reflected in the operating cost statement.

Statement of cash flows for the year ended 31 March 2015 (summary)

£'000s	2014-15	2013-14
Cash Flows from Operating Activities		
Net Operating Expenditure for the financial year	(228,494)	(223,841)
Depreciation and Amortisation	16	73
(Increase)/Decrease in trade and other receivables	802	(1,950)
Increase/(Decrease) in trade and other payables	(1,155)	18,353
Increase/(Decrease) in Provisions	414	0
Net Cash Inflow / (Outflow) from Operating Activities	**(228,417)**	**(207,365)**
Net Cash Inflow / (Outflow) from Investing Activities	**0**	**0**
Net Cash Inflow / (Outflow) before Financing	**(228,417)**	**(207,365)**
Cash Flows from Financing Activities		
Grant Aid Funding Received	228,389	207,555
Net Cash Inflow / (Outflow) from Financing Activities	**228,389**	**207,555**
Net Increase / (Decrease) in Cash and Cash Equivalents	**(28)**	**190**
Cash and Cash Equivalents at the Beginning of the Financial Year	190	0
Cash and Cash Equivalents at the End of the Financial Year	**162**	**190**

This Statement explains the movements in cash balances during the financial year.

Better Payment Practice Code

	2014-15		2013-14	
	Number	Value	Number	Value
Non NHS Payables	90.6%	89.2%	87.6%	87.1%
NHS Payables	91.9%	99.3%	87.5%	98.4%

We are required to pay all trade creditors in accordance with the national Better Payment Practice Code (BPPC). The target is to pay relevant creditors within 30 days of receipt of goods or a valid invoice unless other payment terms have been agreed with the supplier. The CCG is a signatory to the Prompt Payment Code, details of which can be seen at www.promptpaymentcode.org.uk . The CCG is striving to improve its performance to ensure that it meets its targets in the future.

Pensions liabilities

The full financial statements and accompanying notes and policies provide full details of the pension scheme.

PwC are the auditors of NHS South Sefton CCG and the fees charged for 2014-15 were £60,000 (exc' VAT). No further fees were payable for additional, non-statutory work.

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.

NHS South Sefton CCG member practices
Aintree Road Medical Centre
Bootle Village Surgery
Moore Street Medical Centre
North Park Health Centre
The Strand Medical Centre
Park Street Surgery
Concept House Surgery
42 Kingsway
Liverpool Rd Medical Practice
Azalea Surgery
Eastview Surgery
Blundellsands Surgery
Crosby Village Surgery
Kingsway Surgery
Thornton SSP Practice
Crossways SSP Practice
Hightown Village Surgery
Broadwood Surgery
High Pastures Surgery
Maghull Health Centre (Dr Sapre)
Westway Medical Centre
Maghull Health Centre
Maghull SSP Practice
Glovers Lane Surgery
Bridge Road Medical Centre
Orrell Park Medical Centre
Ford Medical Practice
15 Sefton Road*
Seaforth Village Practice
Litherland Town Hall Health Centre
Rawson Road Medical Centre
Netherton SSP Practice
Litherland Primary Care Walk-In Service

* Our membership reduced to 33 practices in 2014-2015 through the merger of 129 Sefton Road Surgery with Concept House.

Governing Body membership

The table below shows the people who made up our Governing Body in 2014-2015, their roles and the committees[15] they were a part of.

Name	Role	Governing Body	Audit Committee	Finance and Resources Committee	Remuneration Committee	Quality Committee	Service Improvement and Redesign Committee
Dr Clive Shaw	Chair	Yes					
Graham Morris	Vice Chair & Lay Member, Finance Management & Audit	Yes	Chair	Yes	Chair		
Dr Craig Gillespie	Clinical Vice-Chair, GP	Yes			Yes	Chair	
Lin Bennett	Practice Manager	Yes	Yes		Yes until 27/03/2015	Yes until 27/03/2015	
Fiona Clark	Chief Officer	Yes		Ex officio member		Ex officio member	
Roger Driver	Lay Member, Engagement and Patient Experience	Yes	Yes	Chair	Yes		
Debbie Fagan	Chief Nurse	Yes		Yes	Yes	Yes	
Dr Dan McDowell	Secondary Care Doctor	Yes	Yes				Yes
Martin McDowell	Chief Finance Officer	Yes		Yes		Yes	
Sharon McGibbon	Practice Manager	Yes		Yes			
Dr Andrew Mimnagh	GP	Yes		Yes	Yes	Yes	
Dr Paul Thomas	GP	Yes		Yes			Yes
Dr John Wray	GP	Yes		Yes			
Dr Ricky Sinha	GP	Yes from Jan 2015					

[15] More details about members of the Governing Body and any conflicts of interest can be found on page 67 in the Remuneration Report. The membership of our other committees and sub-committees can be found on page 72 in our annual Governance Statement.

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.

External auditors

Our external auditor is PricewaterhouseCoopers LLP. During 2014-2015 the external auditor has received fees totalling £60,000 as a result of undertaking the following work:

- Audit services - the statutory audit and services carried out in relation to the statutory audit, fee £60,000
- Further assurance services – nil
- Other services – nil

Disclosure of serious untoward incidents

In 2014-2015, 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.

Health and safety

We are a low risk organisation with a positive health and safety culture. We have effective policies and procedures in place, which helps us to set and maintain sensible and proportionate standards of health and safety management. This ensures we effectively support the wellbeing of our staff and others who may be affected by our activities, and to minimise the losses to our organisation from ill health and injury.

Sickness absence rates

Rates of sickness absence in our organisation are low. Our annual rolling sickness absence at the end of March 2014 was 6.1%. We have policies in place that set out how we manage and support staff through periods of illness or other types of leave.

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.

Disabled employees

We ensure our disabled staff are treated equality, without discrimination and shown due regard. More information can be found on pages 43 and 49.

Remuneration report

The Remuneration Committee membership is made up of four Governing Body Members. It met once during the year (November 2014). No fee was paid for this advice.

Name	Title	Membership Period	Attendance at Meetings eligible to attend
Roger Driver	Governing Body Lay Member	All Year	1/1
Graham Morris	Chair and Governing Body Lay Member	All Year	1/1
Craig Gillespie	Vice Chair, GP and Clinical Vice Chair of Governing Body	All Year	1/1
Andy Mimnagh	GP and Governing Body Member	All Year	1/1
Lin Bennett	Practice Manager and Governing Body Member	Until 27/03/2015	1/1

Policy on remuneration of senior managers

In the absence of national guidance, we have worked with other CCGs in the North West and commissioned the Hay Group to provide guidance on appropriate remuneration for the GP, practice manager and lay members of our Governing Body.

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 our 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 managers' performance is managed through the application of our personal development review (PDR) 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 2014-2015.

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 and Title	Salary & Fees	Taxable Benefits	Performance Pay and bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total	Prior Year Total*
	(bands of £5,000)	(to nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	**(bands of £5,000)**	(bands of £5,000)
	£000	£00	£000	£000	£000	**£000**	£000
Dr Clive Shaw Chair & GP Clinical Director	50-55	0	0	0	0	**50-55**	25-30
Dr Craig Gillespie Clinical Vice-Chair	15 - 20	0	0	0	0	**15-20**	25-30
Graham Morris Deputy Chair & Lay member - Governance	10 - 15	0	0	0	0	**10-15**	0-5
Fiona Clark Chief Officer	60 - 65	68	0	0	2.5-5	**65-70**	270-275
Martin McDowell Chief Finance Officer / Deputy Chief Officer	50 - 55	0	0	0	5-7.5	**55-60**	120-125
Debbie Fagan Chief Nurse	35 - 40	0	0	0	12.5-15	**50-55**	70-75
Dr John Wray GP Clinical Director	10 – 15	0	0	0	0	**10-15**	10-15
Dr Andrew Mimnagh GP Clinical Director	10 – 15	0	0	0	0	**10-15**	20-25
Dr Ricky Sinha GP Clinical Director	5 – 10	0	0	0	0	**5-10**	10-15
Dr Paul Thomas GP Clinical Director	15 – 20	0	0	0	0	**15-20**	20-25
Dr Dan McDowell Secondary Care Clinician	20 – 25	0	0	0	0	**20-25**	20-25
Lin Bennett Practice Manager	0 - 5	0	0	0	0	**0-5**	0-5
Sharon McGibbon Practice Manager	0 – 5	0	0	0	0	**0-5**	0-5
Roger Driver Lay Member, Patient and Public Involvement	5 – 10	0	0	0	0	**5-10**	5-10

**The figures in 2013/14 for pensions reflect a change to the calculation of pension entitlement between the opening and closing entitlements multiplied by 20. This resulted in large pension related benefits being shown in contrast to the current year.*

We have a joint management arrangement with neighbouring NHS Southport and Formby 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 £125,000 to £130,000 and £5,000 to £7,500 all pension related benefits
- Martin McDowell £100,000 to £105,000 and £12,500 to £15,000 all pension related benefits
- Debbie Fagan £75,000 to £80,000 and £25,000 to £27,500 all pension related benefits

The total remuneration of the chief officer and chief financial officer includes a 20% supplement on their basic salary paid in accordance with NHS England guidance and agreed by our Remuneration Committees to recognise the joint roles that they undertake, as

officers covering two CCGs. They hold the same positions with NHS Southport and Formby CCG.

Pension benefits

Name and 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 2015	Lump sum at age 60 related to accrued pension at 31st March 2015	Cash equivalent transfer value at 1st April 2014	Cash equivalent transfer value at 31st March 2015	Real increase in cash equivalent transfer value	Employers contribution to stakeholder 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
Fiona Clark Chief Officer	0-2.5	2.5-5	50-55	155-160	902	958	55	0
Martin McDowell Chief Finance Officer / Deputy Chief Officer	0-2.5	2.5-5	25-30	75–80	368	398	30	0
Debbie Fagan Chief Nurse	0-2.5	5-7.5	20-25	70-75	343	379	37	0

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.

Certain members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for certain members.

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 the Governing Body in NHS South Sefton CCG in the financial year 2014-15 was £125,000 to £130,000. (2013-14: £125,000 to £130,000)

This was 3.59 times (2013-14: 3.12) the median remuneration of the workforce, which was £35,058 (2013-14: £40,329).

In 2014-2015, no employees (2013-14: 0) received remuneration in excess of the highest paid member of the Governing Body. Banded Remuneration ranged from £5,000 to £10,000 (2013-14, £5,000 to £10,000) to £125,000 to £130,000 (2013-14, £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 2015, 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 2015	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 2014 and 31 March 2015	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 Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed “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 member's were a member of during the year can be found in the Members' Report.

Name	How long been based / working in South Sefton	Clinical / Business role on the Governing Body	Declared Interests and Conflicts	Nature of Interest	Date Declared
Dr Clive Shaw		Governing Body Chair	GP Partner, 30 Kingsway	Personal	16 May 2013
Dr Craig Gillespie	Lived in south Sefton 15 years, worked in south Sefton 9 years	Governing Body Clinical Vice Chair Lead for CVD	GP Partner, Blundellsands Surgery Receipt of Honorarium from Cheshire & Merseyside Strategic Clinical Network Chief Officer 3TC (Vol Sector) Liverpool Community Health NHS Trust Employee	Personal Personal Friend Friend	17 Mar 2014 17 Mar 2014 17 Mar 2014 17 Mar 2014
Graham Morris	Been with south Sefton CCG since Dec 2013, previously Director of Finance for Urgent Care 24	Governing Body Deputy Chair and Lay Member from 1 Dec 2013	None		11 Dec 2013
Dr John Wray		GP Governing Body Member	GP Partner, Westway Medical Practice	Personal	29 Sep 2014
Dr Andy Mimnagh	South Sefton GP since 1994	GP Governing Body Member	GP Partner, Eastview Surgery Liverpool Learning and Health Partnership	Personal Personal	29 Sep 2014 29 Sep 2014
Dr Paul Thomas		GP Governing Body Member	GP Partner, High Pastures Surgery Director, ENC Medical Services	Personal Personal	20 May 2013 20 May 2013
Dr Ricky Sinha		GP Governing Body Member	GP Partner, North Park Health Centre Member of Sefton LMC Responsible Officer/Medical Director Aspire Locums Northwest Ltd	Personal Personal Personal	4 May 2013 4 May 2013 12 Nov 2013

Name	How long been based / working in South Sefton	Clinical / Business role on the Governing Body	Declared Interests and Conflicts	Nature of Interest	Date Declared
Dr Dan McDowell	Retired Consultation Physician in Care of the Elderly at University Hospital Aintree (1976-2011).	Governing Body Member Hospital Medical Representative	None		14 May 2013
Lin Bennett	Worked in south Sefton – 13 years	Practice Manager Governing Body Member Chair of CCG Practice Managers Group	Practice/Business Manager Ford Medical Practice	Personal	30 Sep 2014
Sharon McGibbon	Practice Manager for 5 years	Practice Manager Governing Body Member	Practice Manager Eastview Surgery Self Employed Contractor, Driver Trainer/Risk Assessor Sefton MBC	Personal Family	16 May 2013 16 May 2013
Canon Roger Driver	Many years living and working in Sefton Valuable link between local community and CCG regarding patients views	Lay Member Governing Body Co-Chair of EPEG	Minister in the Church of England Chair Sefton Health & Social Care Forum Team Rector, Bootle Team Ministry Area Dean, Bootle Deanery Hon Canon, Liverpool Cathedral Trustee, Together Liverpool	Personal Personal Personal Personal Personal	13 May 2013 13 May 2013 13 May 2013 13 May 2013 13 May 2013
Fiona Clark		Chief Officer Governing Body Member	Dual role as Chief Officer between South Sefton CCG and Southport and Formby CCG	Personal	3 May 2013
Debbie Fagan		Chief Nurse Governing Body Member	Dual role as Chief Nurse between South Sefton CCG and Southport and Formby CCG	Personal	13 May 2013
Martin McDowell	Over 20 years' experience in NHS Finance, joined the CCG in August 2012.	Chief Finance Officer Governing Body Member	Dual role as Chief Finance Officer and Deputy Chief Officer between South Sefton CCG and Southport and Formby CCG Liverpool Community Health NHS Trust Employee	Personal Family	2 May 2013 2 May 2013

Certifications by our accountable officer

We certify that the strategic report, members' report and remuneration report presented as part of the CCG's Annual Report have been prepared in accordance with the guidance contained in the NHS England Annual Accounts Guidance 2014-15 issued on 23 March 2015 and the Department of Health Group Manual for Accounts updated March 2015.

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 South Sefton CCG

May 2015

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 South Sefton CCG

May 2015

Governance Statement

Introduction and context

The clinical commissioning group was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

The clinical commissioning group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the clinical commission group taking on its full powers.

As at 1 April 2014, the clinical commissioning group was licensed **without** conditions, and remains so at the date of this report.

The clinical commissioning group is a clinically led membership organisation made up of general practices

The functions that the group is 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 clinical commissioning group's continued aspirations to comply with the principles set out in code.

For the financial year ended 31 March 2015, and up to the date of signing this statement, we continued to work towards full compliance with the provisions set out in the code, and to apply the principles of the code.

The clinical commissioning group governance framework

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

The CCG comprises membership from the practices in the following table.

Practice Name and Senior Partner
Aintree Road Medical Centre, **Dr Sunil Sapre**
Bootle Village Surgery, **Dr Sarah Stephenson**
Moore Street Surgery, **Dr A W Roberts**
North Park Health Centre, **Dr Oliver**
Park Street Surgery, **Dr Barry J Stanley**
The Strand Medical Centre, **Dr Sharon Oliver**
Concept House, **Dr David Own Goldberg**
Misra, Bird & Kassha, 41 Moss Lane, **Dr Misra**
Concept House/Sefton Road Surgery, **Dr David Own Goldberg**
Crosby Village Surgery, **Dr M Taylor**
42 Kingsway Practice, **Dr Vitty**
30 Kingsway Practice, **Dr Clive Shaw**
Azalea Surgery, 20 Kingsway Practice, **Dr Clare Doran**
Crossways SSP Health, **Dr Prema Sharma**

Eastview Surgery, **Dr M I Hughes**
Thornton SSP Health, **Dr R IBreck**
Hightown SSP Health, **Dr Hassan Marzu**
Blundellsands Surgery, **Dr Craig Gillespie & Dr Nigel Tong**
Misra, Bird & Kassha, 133 Liverpool Road Medical Practice, **Dr Misra**
Maghull Family Health Centre, **Dr Sapre**
Maghull Family Health Centre, **Dr Sapre**
Broadwood Surgery, **Dr B Thomas & Dr P J Thomas**
High Pastures, **Dr C M Thomson**
Westway Medical Centre, **Dr John Wray**
Parkhaven SSP Health, **Dr Pitalia**
Rawson Road Medical Centre, **Dr Pitalia**
Seaforth SSP Health, **Dr Pitalia**
15 Sefton Road, **Dr McElroy**
Litherland Darzi GP Practice, **Dr Pitalia**
Litherland SSP Health, **Dr Pitalia**
Bridge Road Medical Centre, **Dr Martin J Vickers**
Ford Medical Practice, **Dr Noreen Williams**
Netherton GP Practice, **Dr N Choudhary**
Glovers Lane Surgery, **Dr Peter Goldstein**
Orrell Park Medical Centre, **Dr Pitalia**

The clinical commissioning group is a clinically led membership organisation made up of general practices. The member practices of the CCG are responsible for determining the governing arrangements for the organisation which are set out its Constitution[16].

[16] NHS South Sefton Clinical Commissioning Group *Constitution* (November 2014)

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 and the Constitution has been developed with the member practices and localities.

The CCG functions in respect of the geographical area defined as south Sefton.

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 the CCG's business. The chair is responsible for the leadership 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. A record of attendance is provided in the table below.

Membership	Designation	May 2014	Jul 2014	Sep 2014	Nov 2014	Jan 2015	Mar 2015
Dr Craig Gillespie	Chair & GP Clinical Director	✓	A	✓	✓	✓	✓
Dr Andrew Mimnagh	Clinical Vice Chair & Governing Body Member	✓	A	✓	✓	✓	✓
Graham Morris	Deputy Chair & Lay Member - Governance	✓	✓	✓	✓	✓	✓
Lin Bennett	Practice Manager	✓	✓	✓	✓	✓	N/A
Fiona Clark	Chief Officer, South Sefton CCG	✓	✓	✓	✓	✓	✓
Roger Driver	Lay Member, Patient & Public Involvement	✓	A	✓	✓	✓	✓
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓	✓	✓	✓
Margaret Jones	Consultant in Public Health, Sefton MBC	✓	A	✓	A	✓	✓
Maureen Kelly	Chair, Healthwatch Sefton *(co-opted member)*	A	✓	✓	✓	✓	✓
Dr Dan McDowell	Secondary Care Doctor	✓	✓	✓	✓	✓	✓
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓	✓
Sharon McGibbon	Practice Manager & Governing Body Member	A	A	✓	✓	✓	✓

Membership	Designation	May 2014	Jul 2014	Sep 2014	Nov 2014	Jan 2015	Mar 2015
Peter Morgan	Deputy Chief Executive, Sefton MBC *(co-opted member)*	A	✓	✓	A	✓	✓
Dr Clive Shaw	GP Clinical Director & Governing Body Member	A	✓	✓	A	✓	✓
Dr Ricky Sinha*	GP Clinical Director & Governing Body Member	✓	A				
Dr Paul Thomas	GP Clinical Director & Governing Body Member	✓	A	✓	✓	✓	✓
Dr John Wray	GP Clinical Director & Governing Body Member	A	✓	A	A	A	A

**Dr Ricky Sinha was on a sabbatical from the CCG during 2014/15*

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 was assured of its effectiveness by holding development sessions with an external provider that enabled discussion and reflection on performance, achievement of objectives, future programmes of work and on the effective leadership of Governing Body in delivering the CCG's strategy.

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, compliance with Controlled Drugs Regulations 2013, 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
- An assessment of the Committee's effectiveness

The committee also reviewed and scrutinised the following:

- Early warning dashboards
- Provider quality reports
- Safeguarding arrangements
- Complaints management arrangements
- Complaints trends

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.

Name	Title	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Dr Craig Gillespie	Chair and Governing Body Member	√	√	√	A	√	√	A	√	√	A	A	√
Steve Astles	Head of CCG Development	A	A	A	A	√	A	A	√	√	A	√	√
Lin Bennett	Practice Manager Governing Body Member	√	A	√	√	√	√	√	A	A	√		
Malcolm Cunningham	Head of Contract and Procurement	√	A	√	√	√	√	√	√	√	A	√	A
Roger Driver	Lay Member	√	√	√	√	A	√	√	√	√	√	√	A
Debbie Fagan	Chief Nurse & Quality Officer	√	√	√	√	√	√	√	√	A	√	√	A
Dr Gina Halstead	Clinical Lead for Quality	√	√	A	√	A	A	√	√	√	√	√	A
Martin McDowell	Chief Finance Officer	√	√	√	√	√	A	√	A	√	√	A	√
Sharon McGibbon	Practice Manager / Governing Body Member											√	√
Dr Andrew Mimnagh	Clinical Governing Body Member	A	√	√	A	A	√	√	√	√	√	√	√

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
- Approved complaints management arrangements
- Reviewed Continuing Health Care systems and processes. Internal Audit provided significant assurance on the arrangements in place.

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

The Chief Officer stepped down as a substantive member and became and ex-officio member in September 2014.

Audit Committee

Role of the 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 effective internal control arrangements are in place. In addition, the Committee provides constructive support to senior officers to achieve the strategic aims of the clinical commissioning group.

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 the CCGs activities to support the delivery of the CCGs objectives, and
ii) To review and approve the arrangements for discharging the CCGs statutory financial duties

The committee met and was attended by substantive members as follows:

Name	Membership	May 14	Jun 14	Jul 14	Oct 14	Jan 15
Members						
Graham Morris	Lay Member – Governance (Chair)	✓	✓	✓	✓	A

Name	Membership	May 14	Jun 14	Jul 14	Oct 14	Jan 15
Roger Driver	Lay Member – Patient Experience (Deputy Chair)	A	✓	✓	✓	A
Lin Bennett	Practice Manager *(Resigned Jan 2015)*	✓	✓	✓	✓	✓
Dan McDowell	Secondary Care Doctor (became a substantive member with effect from September 2014)		✓	✓	A	✓
Attendees						
Martin McDowell	Chief Finance Officer	✓	✓	✓	✓	✓
Debbie Fagan	Chief Nurse & Quality Officer	✓	✓	✓	✓	✓
David Bacon	Interim Deputy Chief Finance Officer	N	✓			
David Smith	Deputy Chief Finance Officer				✓	✓
Ken Jones	Chief Accountant	✓	✓	N	✓	N
Fiona Clark	Chief Officer *(for accounts sign-off meeting)*		✓			
Roger Causer	Senior Local Counter Fraud Specialist, MIAA	✓		N	✓	N
Wendy Currums	Local Counter Fraud Specialist, MIAA	N		N	✓	✓
Adrian Poll	Audit Manager, MIAA	✓		✓	✓	✓
Rachael McIlraith	Audit Director, PricewaterhouseCoopers	✓	✓	✓	✓	
Elizabeth Tay	Audit Manager, PricewaterhouseCoopers				✓	✓
Mark Jones	Audit Director, PricewaterhouseCoopers				A	A
Ian Roberts	Senior Manager, PricewaterhouseCoopers					✓

✓ Present A Apologies N Non- attendance

The committee comprises three members of the clinical commissioning group Governing Body:

- Lay member (governance) (chair)
- Lay member (patient experience and engagement)
- Practice manager Governing Body Member
- Secondary Care Doctor

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 MIAA
- Audit director PWC
- Local counter fraud officer MIAA

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 Governing Body 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.

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 2014-15 Mersey Internal Audit Agency (MIAA) have reviewed the operations of the CCG, have found no major issues and concluded that overall it has met its requirements. They have 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.

External audit

Role - The objectives of the external auditors are to review and report on the CCG's financial statements and on its statement on internal control.

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

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 Audit Committee plan for approval during 2014-15 and provided regular updates at meetings.

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
- Register of interest
- Information governance toolkit compliance report
- Minutes of the sub committees of the Governing Body
- An assessment of the Committee's effectiveness

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 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 second full financial year in which the CCG has 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 the CCGs objectives and that arrangements for discharging the CCGs 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 the publication of the Annual Audit Letter to the Governing Body in its September 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.[17] The committee reviews and agrees appraisal and remuneration of CCG officers:

During the year the committee has agreed levels of remuneration for GP support specific programmes of CCG work and to consider pay for Very Senior Managers (VSM). The Remuneration Committee met in full quorum for all meetings during the year.

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.

Service Improvement and Re-design Committee

This committee has been established as a sub-committee of the Governing Body to enable thorough and open discussion about all service improvement and re-design priorities of the CCG. It provides a forum for the CCG localities, their practices clinical leads, CCG locality leads and practice representatives to identify potential areas of improvement and support plans and proposals for implementation.

[17] 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

The clinical commissioning group 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 on-going 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 which is regularly reviewed and scrutinised by the senior management team, Corporate Governance Support Group, Quality Committee, Audit 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.

The CCG commissions 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.

The clinical commissioning group internal control framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group 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 asset 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 the CCG.

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 the CCG.

The Head of Audit's opinion on the Assurance Framework determined that: *An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.*

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

The CCG places 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 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.

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 the clinical commissioning group complies with the required public sector equality duty set out in the Equality Act 2010.

Sustainable development obligations

The CCG is developing plans to assess risks, enhance performance and reduce its 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. As Accountable Officer I will ensure the clinical commissioning group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012. The CCG will also set out its commitments as a socially responsible employer.

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

NHS South Sefton CCG has 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

NHS South Sefton CCG has established a number of mechanisms for identifying and managing risks including risk profiling methodology, incident reporting, complaints and litigation data, and staff concerns or 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.

Key new risks identified during 2014-15 are

- CSU sustainability of services following the unsuccessful bid by NW CSU to join the Lead Provider Framework
- Potential conflicts of interest arising as a result of joint commissioning arrangements
- Capacity across CCG and council to deliver a robust and co-ordinated one year and three year plan

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

The CCG seeks to gain best value through all of its contracting and procurement processes. The CCG has 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.

The CCG buys procurement expertise and support from the North West 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 clinical commissioning group.

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 chief corporate delivery and integration officer. Expertise and support is also procured from the North West Commissioning Support Unit (the CSU) that offers advice to all staff on the identification and management of risk.

The senior management team (SMT) has 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.

The CCG fosters a culture of openness and encourages 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 clinical commissioning group 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, Finance and Resources Committee and Service Improvement and Re-design Committee. The Quality Committee approves relevant policies following review and assessment by the Corporate Governance Support Group 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 clinical commissioning group, the head of internal audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The head of internal audit opinion concluded that; *An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provide reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.*

Data quality

The North West Commissioning Support Unit "the CSU" is commissioned to provide the CCG 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 the CCG to challenge providers if inconsistencies are identified.

The CCG's 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.

Internal audit provided an assessment of significant assurance on data quality and performance management of the CCG.

Business critical models

Officers of the CCG have reviewed the Macpherson report to consider the implications for the CCG. The CCG's internal auditors have also undertaken a review of management accounting practices including estimation techniques and forecasting and reported that are appropriate arrangements 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. The CCG's internal auditors (MIAA) provided an assessment of significant assurance on the submission.

NHS South Sefton CCG has 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

The statutory functions of the CCG and the way in which the CCG discharges those duties are explained within the group's constitution that has been approved by NHS England.

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

Responsibility for each duty and power has been clearly allocated to a lead director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group'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
May 2015

Independent auditors' report to the Members of South Sefton 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 2015 and of its net operating costs and cash flows 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 as being relevant to the National Health Service in England.

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 South Sefton Clinical Commissioning Group ("CCG"), comprise:

- the Statement of Comprehensive Net Expenditure for the year then ended;
- the Statement of Financial Position as at 31 March 2015;
- the Statement of Changes in Taxpayers' Equity for the year then ended;
- the Statement of Cash Flows for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

The financial reporting framework that has been applied in their preparation is the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State as being relevant to the National Health Service in England.

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.

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

- the table of salaries and allowances of senior managers and related narrative notes on page 64;
- the table of pension benefits of senior managers and related narrative notes on page 65; and
- the table of pay multiples and related narrative notes on page 66.

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 reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

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 2014/15, issued on 24 February 2015 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 71 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 South Sefton 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 on 13 October 2014, we have no matters to report with respect to whether South Sefton CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

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 on 13 October 2014, as to whether the CCG has proper arrangements for:

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

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

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

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, having regard to the criteria specified by the Audit Commission on 13 October 2014.

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

Certificate

We certify that we have completed the audit of the financial statements of South Sefton 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.

Mark Jones (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
8 Princes Parade
St Nicholas Place
Liverpool
L3 1QJ

May 2015

(a) The maintenance and integrity of the South Sefton 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.

Entity name:	NHS South Sefton Clinical Commissioning Group
This year	2014-15
This year ended	31 March 2015
This year commencing:	1 April 2014

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The Primary Statements:

Notes to the Accounts

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

	Note	2014-15 £000	2013-14 £000
Total Income and Expenditure			
Employee benefits	4.1.1	2,120	1,843
Operating Expenses	5	226,965	222,837
Other operating revenue	2	(591)	(839)
Net operating expenditure before interest		**228,494**	**223,841**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**228,494**	**223,841**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**228,494**	**223,841**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	1,405	1,307
Operating Expenses	5	2,178	2,177
Other operating revenue	2	0	17
Net administration costs before interest		**3,583**	**3,501**
Programme Income and Expenditure			
Employee benefits	4.1.1	715	537
Operating Expenses	5	224,787	220,659
Other operating revenue	2	(591)	(856)
Net programme expenditure before interest		**224,911**	**220,340**

Other Comprehensive Net Expenditure		2014-15 £000	2013-14 £000
Impairments and reversals	22	0	0
Net gain/(loss) on revaluation of property, plant & equipment		0	0
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Movements in other reserves		0	0
Net gain/(loss) on available for sale financial assets		0	0
Net gain/(loss) on assets held for sale		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Share of (profit)/loss of associates and joint ventures		0	0
Reclassification Adjustments		0	0
On disposal of available for sale financial assets		0	0
Total comprehensive net expenditure for the year		**228,494**	**223,841**

The notes on pages 100 to 140 form part of this statement

Statement of Financial Position as at 31 March 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant and equipment	13	43	58
Intangible assets	14	0	0
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		**43**	58
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	1,518	1,950
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	162	190
Total current assets		**1,680**	2,140
Non-current assets held for sale	21	0	0
Total current assets		**1,680**	2,140
Total assets		**1,723**	2,198
Current liabilities			
Trade and other payables	23	(17,568)	(18,353)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(352)	0
Total current liabilities		**(17,920)**	(18,353)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(16,197)**	(16,155)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(62)	0
Total non-current liabilities		**(62)**	0
Assets less Liabilities		**(16,259)**	(16,155)
Financed by Taxpayers' Equity			
General fund		(16,259)	(16,155)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(16,259)**	(16,155)

The notes on pages 99 to 139 form part of this statement

The financial statements on pages 95 to 139 were approved by the Governing Body on 21st May 2015 and signed on its behalf by:

Chief Officer (Accountable Officer)
Fiona Clark

Chief Finance Officer / Deputy Chief Officer
Martin McDowell

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	(16,155)	0	0	**(16,155)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(16,155)**	**0**	**0**	**(16,155)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	(228,494)			(228,494)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(244,649)**	**0**	**0**	**(244,649)**
Net funding	228,389	0	0	228,389
Balance at 31 March 2015	**(16,259)**	**0**	**0**	**(16,259)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	**0**	**0**	**0**	**0**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**131**	**0**	**0**	**131**
Adjusted NHS Commissioning Board balance at 1 April 2013	**131**	**0**	**0**	**131**
Changes in NHS Commissioning Board taxpayers' equity for 2013-14				
Net operating costs for the financial year	(223,841)			(223,841)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Commissioning Board Expenditure for the Financial Year	**(223,710)**	**0**	**0**	**(223,710)**
Net funding	207,555	0	0	207,555
Balance at 31 March 2014	**(16,155)**	**0**	**0**	**(16,155)**

The notes on pages 100 to 140 form part of this statement

Statement of Cash Flows for the year ended 31 March 2015

	Note	2014-15 £000	2013-14 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(228,494)	(223,841)
Depreciation and amortisation	5	16	73
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	432	(1,950)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(785)	18,353
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	414	0
Net Cash Inflow (Outflow) from Operating Activities		**(228,417)**	(207,365)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	0
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(228,417)**	(207,365)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		228,389	207,555
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**228,389**	207,555
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(28)**	190
Cash & Cash Equivalents at the Beginning of the Financial Year		**190**	0
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**162**	190

The notes on pages 100 to 140 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

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

1.1 **Going Concern**

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

1.2 **Accounting Convention**

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

1.3 **Acquisitions & Discontinued Operations**

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

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

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

1.5 **Charitable Funds**

From 2014-15, 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.

Notes to the financial statements

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.

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.

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

1.10 **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.

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.

Notes to the financial statements

1.12 **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.

1.13 **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.

1.14 **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.

1.15 **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 o classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.
The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.
Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 **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.

Notes to the financial statements

1.16.1 **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.

1.16.2 **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.

1.17 **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 **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.

1.19 **Cash & Cash Equivalents**

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

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

1.20 **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.

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.

1.21 **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.

1.22 **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.

1.23 **Continuing healthcare risk pooling**

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

1.24 **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

1.25 **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 amoun of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.27 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the 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.

Notes to the financial statements

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).

1.32 **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.

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

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

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

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

2 Other Operating Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	5	0	5	5
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	586	0	586	73
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	0	0	0	761
Total other operating revenue	**591**	**0**	**591**	**839**

The main element of Non-Patient care income in 2014-15 relates to recoveries of healthcare costs for patients residing outside of NHS South Sefton CCG .

3 Revenue

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
From rendering of services	591	0	591	839
From sale of goods	0	0	0	0
Total	**591**	**0**	**591**	**839**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	1,715	1,694	21	1,142	1,071	71	573	623	(50)
Social security costs	160	160	0	108	108	0	52	52	0
Employer Contributions to NHS Pension scheme	245	245	0	155	155	0	89	89	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,120**	**2,099**	**21**	**1,405**	**1,334**	**71**	**714**	**764**	**(50)**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**2,120**	**2,099**	**21**	**1,405**	**1,334**	**71**	**714**	**764**	**(50)**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,120**	**2,099**	**21**	**1,405**	**1,334**	**71**	**714**	**764**	**(50)**

4.1.2 Recoveries in respect of employee benefits

2014-15	Total £000	Permanent Employees £000	Other £000
Employee Benefits - Revenue			
Salaries and wages	0	0	0
Social security costs	0	0	0
Employer contributions to the NHS Pension Scheme	0	0	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total recoveries in respect of employee benefits	**0**	**0**	**0**

4.2 Average number of people employed

	2014-15			2013-14
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**42**	**41**	**1**	38
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	187	60
Total Staff Years	40	29
Average working Days Lost	**5**	**2**

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	0	0
	£000	**£000**
Total additional Pensions liabilities accrued in the year	0	n/a

Ill health retirement costs are met by the NHS Pension Scheme

4.4 Exit packages agreed in the financial year

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	Departures where special payments have been made	
	Number	£
Less than £10,000	0	0
£10,001 to £25,000	0	0
£25,001 to £50,000	0	0
£50,001 to £100,000	0	0
£100,001 to £150,000	0	0
£150,001 to £200,000	0	0
Over £200,001	0	0
Total	**0**	**0**

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	0	0
Mutually agreed resignations (MARS) contractual costs	0	0
Early retirements in the efficiency of the service contractual costs	0	0
Contractual payments in lieu of notice	0	0
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval*	0	0
Total	**0**	**0**

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 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

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

	2014-15 Total £000	2014-15 Admin £000	2014-15 Programme £000	2013-14 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	1,923	1,208	715	1,701
Executive governing body members	197	197	0	142
Total gross employee benefits	**2,120**	**1,405**	**715**	**1,843**
Other costs				
Services from other CCGs and NHS England	2,813	1,050	1,763	1,816
Services from foundation trusts	105,031	0	105,031	104,064
Services from other NHS trusts	59,632	0	59,632	60,954
Services from other NHS bodies	131	0	131	251
Purchase of healthcare from non-NHS bodies	22,400	0	22,400	22,266
Chair and Non Executive Members	179	179	0	318
Supplies and services – clinical	772	0	772	991
Supplies and services – general	928	176	751	715
Consultancy services	65	1	64	21
Establishment	2,358	190	2,168	1,679
Transport	0	0	0	0
Premises	493	289	204	170
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	16	0	16	73
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets	0	0	0	0
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	0	0	0	0
Other non statutory audit expenditure				
· Internal audit services	32	32	0	32
· Other services	60	60	0	79
General dental services and personal dental services	0	0	0	0
Prescribing costs	28,758	0	28,758	28,207
Pharmaceutical services	0	0	0	0
General ophthalmic services	8	0	8	2
GPMS/APMS and PCTMS	1,671	0	1,671	909
Other professional fees excl. audit	171	(102)	273	25
Grants to other public bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	573	4	568	124
Change in discount rate	0	0	0	0
Provisions	414	290	124	0
CHC Risk Pool contributions	333	0	333	0
Other expenditure	127	7	120	141
Total other costs	**226,965**	**2,178**	**224,787**	**222,837**
Total operating expenses	**229,085**	**3,583**	**225,502**	**224,680**

6.1 Better Payment Practice Code

Measure of compliance	**2014-15 Number**	**2014-15 £000**	**2013-14 Number**	**2013-14 £000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	5,564	23,374	5,383	21,503
Total Non-NHS Trade Invoices paid within target	5,039	20,854	4,715	18,720
Percentage of Non-NHS Trade invoices paid within target	**90.56%**	**89.22%**	**87.59%**	**87.06%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,844	171,121	1,676	164,698
Total NHS Trade Invoices Paid within target	1,694	169,977	1,467	162,083
Percentage of NHS Trade Invoices paid within target	**91.87%**	**99.33%**	**87.53%**	**98.41%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2014-15 £000**	2013-14 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

The Clinical Commissioning Group does not undertake and 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

12.1 As lessee

12.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payments recognised as an expense					
Minimum lease payments	0	468	6	**474**	3
Contingent rents	0	0	0	**0**	0
Sub-lease payments	0	0	0	**0**	0
Total	**0**	**468**	**6**	**474**	**3**

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

12.1.2 Future minimum lease payments

	Land £000	Buildings £000	Other £000	2014-15 Total £000	2013-14 Total £000
Payable:					
No later than one year	0	0	6	**6**	7
Between one and five years	0	0	0	**0**	7
After five years	0	0	0	**0**	0
Total	**0**	**0**	**6**	**6**	**14**

12.2 As lessor

12.2.1 Rental revenue

The Clinical Commissioning Group does not have any lease arrangements in this capacity.

13 Property, plant and equipment

2014-15	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2014	0	0	0	0	74	0	57	0	131
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation At 31 March 2015	**0**	**0**	**0**	**0**	**74**	**0**	**57**	**0**	**131**
Depreciation 1 April 2014	0	0	0	0	16	0	57	0	73
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	16	0	0	0	16
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2015	**0**	**0**	**0**	**0**	**32**	**0**	**57**	**0**	**89**
Net Book Value at 31 March 2015	**0**	**0**	**0**	**0**	**43**	**0**	**0**	**0**	**43**
Purchased	0	0	0	0	43	0	0	0	43
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**43**	**0**	**0**	**0**	**43**
Asset financing:									
Owned	0	0	0	0	43	0	0	0	43
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	**0**	**0**	**0**	**0**	**43**	**0**	**0**	**0**	**43**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The Clinical Commissioning Group does not hold any 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:

	2014-15 £000	2013-14 £000
Land	0	0
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	0	0
Furniture & fittings	0	0
Total	**0**	**0**

13.9 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	1	3
Information technology	0	0
Furniture & fittings	0	0

14 Intangible non-current assets

The Clinical Commissioning Group does not have any intangible non-current assets.

14 Intangible non-current assets cont'd

14.1 Donated assets

The Clinical Commissioning Group does not hold any donanted non-current assets.

14.2 Government granted assets

The Clinical Commissioning Group does not hold any government granted non-current assets.

14.3 Revaluation

The Clinical Commissioning Group does not have any intangible non-current assets to revalue.

14 Intangible non-current assets cont'd

14.4 Compensation from third parties

The Clinical Commissioning Group has not received any compensation from third parties.

14.5 Write downs to recoverable amount

The Clinical Commissioning Group has not written down any items.

14.6 Non-capitalised assets

The Clinical Commissioning Group does not hold any significant non-capitalised assets.

14.7 Temporarily idle assets

The Clinical Commissioning Group does not hold any temporarily idle assets.

14.8 Cost or valuation of fully amortised assets

The Clinical Commissioning Group does not hold significant fully amortised assets.

15 Investment property

The Clinical Commissioning Group does not hold any investment properties.

16 Inventories

The Clinical Commissioning Group had no inventories as at 31 March 2015.

17 Trade and other receivables	**Current 2014-15 £000**	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	850	0	835	0
NHS receivables: Capital	0	0	0	0
NHS prepayments and accrued income	186	0	690	0
Non-NHS receivables: Revenue	236	0	42	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments and accrued income	234	0	364	0
Provision for the impairment of receivables	0	0	0	0
VAT	14	0	20	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	(2)	0	(1)	0
Total Trade & other receivables	**1,518**	**0**	**1,950**	**0**
Total current and non current	**1,518**		**1,950**	
Included above:				
Prepaid pensions contributions	0		0	

17.1 Receivables past their due date but not impaired	**2014-15 £000**	2013-14 £000
By up to three months	60	140
By three to six months	0	25
By more than six months	47	0
Total	**107**	**165**

£83k of the amount above has subsequently been recovered post the statement of financial position date.

17.2 Provision for impairment of receivables

The Clinical Commissioning Group held no provisions for the impairment of receivables at 31 March 2015.

18 Other financial assets

18.1 Current

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	0	0
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment reversals	0	0
Transferred from non-current financial assets	0	0
Disposals	0	0
Transfer (to)/from other public sector body	0	0
At 31 March 2015	**0**	**0**

18.2 Non-current

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	0	0
Additions	0	0
Revaluation	0	0
Impairments	0	0
Impairment reversals	0	0
Transferred from non-current financial assets	0	0
Disposals	0	0
Transfer (to)/from other public sector body	0	0
At 31 March 2015	**0**	**0**

18.3 Non-current: capital analysis

	2014-15 £000	2013-14 £000
Capital revenue	0	0
Capital expenditure	0	0

19 Other current assets

The Clinical Commissioning Group had no other current assets as at 31 March 2015.

20 Cash and cash equivalents

	2014-15 £000	2013-14 £000
Balance at 1 April 2014	190	190
Net change in year	(28)	0
Balance at 31 March 2015	**162**	**190**
Made up of:		
Cash with the Government Banking Service	162	190
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**162**	**190**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2015	**162**	**190**
Patients' money held by the clinical commissioning group, not included above	0	0

21 Non-current assets held for sale

The Clinical Commissioning Group held no non-current assets for sale at 31 March 2015.

22 Analysis of impairments and reversals

The Clinical Commissioning Group has not incurred any impairments or reversed any impairments in the year to 31 March 2015.

23 Trade and other payables	**Current 2014-15 £000**	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	0	0	0	0
NHS payables: revenue	2,441	0	1,589	0
NHS payables: capital	0	0	0	0
NHS accruals and deferred income	2,531	0	5,151	0
Non-NHS payables: revenue	3,423	0	1,724	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals and deferred income	7,141	0	9,689	0
Social security costs	39	0	47	0
VAT	0	0	0	0
Tax	31	0	31	0
Payments received on account	0	0	0	0
Other payables	1,961	0	122	0
Total Trade & Other Payables	**17,567**	**0**	**18,353**	**0**
Total current and non-current	**17,567**		**18,353**	

Other payables include £64k outstanding pension contributions at 31 March 2015

24 Other financial liabilities	**Current 2014-15**	**Non-current 2014-15**	Current 2013-14	Non-current 2013-14
Embedded derivatives at fair value through the statemen	0	0	0	0
Financial liabilities carried at fair value through profit and	0	0	0	0
Amortised cost	0	0	0	0
Total	**0**	**0**	**0**	**0**
Total current and non-current	**0**		**0**	

25 Other liabilities	**Current 2014-15**	**Non-current 2014-15**	Current 2013-14	Non-current 2013-14
Private finance initiative/LIFT deferred credit	0	0	0	0
Lease incentives	0	0	0	0
Other	0	0	0	0
Total	**0**	**0**	**0**	**0**
Total current and non-current	**0**		**0**	

26 Borrowings

The Clinical Commissioning Group does not have any borrowings at 31 March 2015.

27 Private finance initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group does not have 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 have any receivables in respect of finance leases.

30 Provisions

	Current 2014-15 £000	**Non-current 2014-15 £000**	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	0	0	0	0
Other	352	62	0	0
Total	**352**	**62**	**0**	**0**
Total current and non-current	**414**		**0**	

	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 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Arising during the year	0	0	0	0	0	0	0	0	414	414
Utilised during the year	0	0	0	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	0	0	0	0	0	0
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**414**	**414**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	0	352	352
Between one and five years	0	0	0	0	0	0	0	0	62	62
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**414**	**414**

The "Other" provisons held relate to Administration charges is respect of CHC Restitution cases, and Commissioning Support transformation costs.

31 Contingencies

Contingent liabilities

The Clinical Commissioning Group does not have any contingent liabilities.

Contingent assets

The Clinical Commissioning Group does not have any contingent assets.

32 Commitments

32.1 Capital commitments

The Clinical Commissioning Group does not have any capital commitments.

32.2 Other financial commitments

The Clinical Commissioning Group does not have any other finanical commitments.

33 Financial instruments

33.1 Financial risk management

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

Because NHS 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 NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and internal auditors.

33.1.1 Currency risk

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

33.1.2 Interest rate risk

The Clinical Commissioning Group borrows from government for capital expenditure when required, 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 NHS Clinical Commissioning Group revenue comes via parliamentary funding, the NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.4 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2014-15 £000	**Loans and Receivables 2014-15 £000**	**Available for Sale 2014-15 £000**	**Total 2014-15 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	850	0	850
· Non-NHS	0	236	0	236
Cash at bank and in hand	0	162	0	162
Other financial assets	0	(2)	0	(2)
Total at 31 March 2015	**0**	**1,246**	**0**	**1,246**

	At 'fair value through profit and loss' 2013-14 £000	Loans and Receivables 2013-14 £000	Available for Sale 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	836	0	836
· Non-NHS	0	42	0	42
Cash at bank and in hand	0	190	0	190
Other financial assets	0	(1)	0	(1)
Total at 31 March 2014	**0**	**1,067**	**0**	**1,067**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £000	**Other 2014-15 £000**	**Total 2014-15 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	4,973	4,973
· Non-NHS	0	12,525	12,525
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**17,498**	**17,498**

	At 'fair value through profit and loss' 2013-14 £000	Other 2013-14 £000	Total 2013-14 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	6,740	6,740
· Non-NHS	0	11,413	11,413
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2014	**0**	**18,153**	**18,153**

34 Operating segments

	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Commissioning of Healthcare Services	229,085	(591)	**228,494**	1,723	(17,982)	**(16,259)**
	0	0	**0**	0	0	**0**
Total	**229,085**	**(591)**	**228,494**	**1,723**	**(17,982)**	**(16,259)**

Reconciliation between Operating Segments and SoCNE

	31-Mar-15 £'000
Total net expenditure reported for operating segments	228,494
Reconciling items:	
0	0
Total net expenditure per the Statement of Comprehensive Net Expenditure	228,494

Reconciliation between Operating Segments and SoFP

	31-Mar-15 £'000
Total assets reported for operating segments	1,723
Reconciling items:	
0	0
Total assets per Statement of Financial Position	**1,723**

	31-Mar-15 £'000
Total liabilities reported for operating segments	(17,982)
Reconciling items:	
0	0
Total liabilities per Statement of Financial Position	**(17,982)**

35 Pooled budgets

The Clinical Commissioning Group were not party to any formal pooled budget arrangements during 2014-15.

36 NHS Lift investments

The Clinical Commissioning Group does not hold any LIFT investments at 31 March 2015.

37 Intra-government and other balances

	Current Receivables 2014-15 £000	**Non-current Receivables 2014-15 £000**	**Current Payables 2014-15 £000**	**Non-current Payables 2014-15 £000**
Balances with:				
· Other Central Government bodies	0	0	74	0
· Local Authorities	51	0	0	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	0	0	0	0
· NHS Trusts and Foundation Trusts	1,035	0	4,973	0
Total of balances with NHS bodies:	**1,035**	**0**	**4,973**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	432	0	12,521	0
Total balances at 31 March 2015	**1,518**	**0**	**17,568**	**0**

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	20	0	78	0
· Local Authorities	0	0	528	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	820	0	564	0
· NHS Trusts and Foundation Trusts	706	0	6,179	0
Total of balances with NHS bodies:	**1,526**	**0**	**6,743**	**0**
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	404	0	11,007	0
Total balances at 31 March 2014	**1,950**	**0**	**18,356**	**0**

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 Clive Shaw					
	THE KINGSWAY SURGERY	156	0	0	0
	DR CLIVE SHAW	12	0	0	0
Dr Craig Gillespie					
	THE BLUNDELLSANDS SURGERY	297	0	1	0
Dr Paul Thomas					
	HIGH PASTURES SURGERY	196	0	38	0
Dr John Wray					
	THE WESTWAY MEDICAL CENTRE	342	0	1	0
Dr Andrew Mimnagh					
	EASTVIEW SURGERY	115	0	0	0
Dr Ricky Sinha					
	DR RK SINHA	23	0	5	0
	NORTH PARK MEDICAL CENTRE	75	0	0	0
Lin Bennett					
	THE FORD MEDICAL PRACTICE	152	0	0	0
Sharon McGibbon					
	EASTVIEW SURGERY	115	0	0	0
Susanne Lynch					
	DOVEHAVEN NURSING HOMES	21	0	1	0

The transactions listed above are payments made to organisations with which the Governing Body member or employee quoted has a connection, and has declared an interest. They are not payments made directly to the individuals concerned unless quoted otherwise.

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 which are paid to all 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.

39 Events after the end of the reporting period

There are no post balance sheet events which have taken place which will have a material effect on the financial statements of the Clinical Commissioning Group.

40 Losses and special payments

The Clinical Commissioning Group has not incurred any lossed or special payments in the year to 31 March 2015.

41 Third party assets

The Clinical Commissioning Group held no assets on behalf of other parties during the year to 31 March 2015.

42 Financial performance targets

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

NHS South Sefton Clinical Commissioning Group's performance against those duties was as follows:

	2014-15 Target	**2014-15 Performance**	2013-14 Target	2013-14 Performance
Expenditure not to exceed income	1% Surplus	1.2% Surplus	1% Surplus	1.0% Surplus
Capital resource use does not exceed the amount specified in Direction:	No CRL	N/A	No CRL	N/A
Revenue resource use does not exceed the amount specified in Direction:	RRL £231.3m	£228.5m	RRL £226.2m	£223.8m
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	No CRL	N/A	No CRL	N/A
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	£227.3m	£224.9m	£223.9m	£223.8m
Revenue administration resource use does not exceed the amount specified in Directions	£4.058m	£3.584m	£3.680m	£3.501m

43 Impact of IFRS

	2014-15 £'000	2013-14 £'000
Depreciation charges	0	0
Interest expense	0	0
Impairment charge: Annually Managed Expenditure	0	0
Impairment charge: Departmental Expenditure Limit	0	0
Other Expenditure	0	0
Revenue receivable from subleasing	0	0
Total IFRS Expenditure (IFRIC 12)	**0**	**0**
Revenue consequences of private finance initiative/LIFT schemes under UK GAAP/ESA95 (net of any sublease revenue)	0	0
Net IFRS Change (IFRIC 12)	**0**	**0**
Capital Consequences of IFRS: private finance initiative/LIFT and other service concession arrangements under IFRIC 12		
Capital expenditure 2014-15	0	0
UK GAAP capital expenditure 2014-15 (reversionary interest)	0	0

44 Analysis of charitable reserves

The Clinical Commissioning Group does not hold any charitable reserves at 31 March 2015.

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