NHS
Eastern Cheshire
Clinical Commissioning Group

GOVERNING BODY MEETING

28 May 2014 **Agenda Item 2.1**

Paper Title	NHS Eastern Cheshire Clinical Commissioning Group Annual Report and Accounts 2013-2014

Purpose of paper / report

This paper introduces to the Governing Body the final draft of first Annual Report and Accounts of the Clinical Commissioning Group (CCG).

Key points

- All CCGs are required to publish annually a suite of documents outlining the performance of the organisation in the previous year. The key elements are:
  - Annual Report, including Remuneration Report;
  - Statements by the membership, Accountable Officer, including Annual Governance Statement
  - Annual Accounts

- The Governing Body is required to review and approval the final draft version and take into account external audit opinion.

The Governing Body is asked to:			
Approve	☑	Decide	
Ratify		Note for information	
Endorse			

Benefits / value to our population / communities

The annual report and accounts is the key way in which CCGs demonstrate their effective stewardship of public money and discharge their accountability to tax payers.

Report Author

Jerry Hawker
Chief Officer

Contributors

Matthew Cunningham
Corporate Services Manager
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Technical Accountant

NHS Eastern Cheshire Clinical Commissioning Group Annual Report and Accounts 2013-2014

1. Executive Summary

1.1 Clinical Commissioning Groups (CCGs) have a statutory duty[1] to produce an annual report and accounts.

1.2 The annual report and accounts is the key way in which CCGs demonstrate their effective stewardship of public money and discharge their accountability to tax payers.

1.3 The annual report and accounts is a single document which should present the story of the CCG's activities during the previous financial year ending 31st March 2014. The form and content of the annual report and accounts is directed by NHS England.[2] CCGs must meet the requirements of the Department of Health's manual for accounts (MfA).[3] In practice, this is achieved by following NHS England's annual reporting guidance (ARG).[4]

1.4 The CCG's annual report and accounts must contain:

- an annual report
- a statement of the accountable officer's responsibilities
- a governance statement
- four primary financial statements
- notes to the accounts
- a report and opinion from an independent auditor

1.5 It is the responsibility of the CCG's Accountable Officer to prepare the annual report and accounts.

1.6 In approving the annual report and accounts, the members of the Governing Body confirm that they are satisfied they present the CCG's year in an appropriate, comprehensive, balanced and coherent way.

1.7 Before 30th September 2014 each CCG must present its annual report and accounts to stakeholders, including members of the public, at an annual general meeting.

2. Recommendation(s)

2.1 The Governing Body is asked:

- note external audit opinion
- approve the final draft for publication

[1] Paragraph 17 of Schedule 2 of the Health and Social Care Act 2012 ('the 2012 Act').
[2] http://www.england.nhs.uk/wp-content/uploads/2013/03/b-directions-ccgs.pdf
[3] www.info.doh.gov.uk/doh/finman.nsf/4db79df91d978b6c00256728004f9d6b/af01c57de5465a5480257b7c0054c281?OpenDocument
[4] www.england.nhs.uk/resources/resources-for-ccgs

3. Reasons for Recommendation(s)

3.1 CCGs have a statutory duty to produce an annual report and accounts, publish it and communicate its publication to members of the public and key stakeholders.

4. Peer Group Area / Town Area Affected

4.1 All.

5. Population Affected

5.1 All Eastern Cheshire residents

6. Context

6.1 This is the first Annual Report and Accounts for NHS Eastern Cheshire Clinical Commissioning Group as a statutory NHS body.

7. Finance

7.1 The Annual Report and Accounts presents the final view of the CCG's achievements in 2013/14.

8. Quality and Patient Experience

8.1 The Annual Report and Accounts provides a statement from the CCG on how it is meeting its duties around quality and patient experience.

9. Consultation and Engagement (Public/Patient/Carer/Clinical/Staff)

9.1 Staff and our member practices have been consulted in the production of this Annual Report and Accounts.

10. Equality

10.1 The Annual Report and Accounts provides a statement from the CCG on how it is meeting its Public Sector Duty.

11. Legal

11.1 The Annual Report and Accounts provides evidence that addresses a number of key legal duties required of the CCG.

12. Communication

12.1 The Annual Report and Accounts will be public documents and therefore need to be presented in an accessible format for patients and carers.

12.2 Upon approval of the Governing Body, the Annual Report and Accounts will be formatted and designed to further improve its accessibility and readability.

13. Background and Options

13.1 CCGs have a statutory requirement to prepare an annual report which sets out how they have discharged their duties in the previous financial year. NHS England has directed that CCGs must comply with its ARG when preparing their annual reports. Whilst the ARG

prescribes the contents of the annual report, it is for each CCG to decide how best to present that information in order to tell the story of their year.

13.2 The annual report consists of several sub-reports:

- Member practices' introduction
- The strategic report
- The members' report
- The remuneration report

13.3 **Member Practices Introduction**. This is an independent report produced collectively by the GP practices which make up the membership of the CCG. The content of the report is for the GP practices to decide themselves.

13.4 **Strategic report and members' report**. The contents of these reports are based on the requirements of sections 414A, C and D and section 416 of the Companies Act 2006 tailored to be relevant to CCGs. The strategic report should stand alone but can include summarised information cross referenced to other parts of the annual report. The ARG sets out the required content for the strategic report and the members' report.

13.5 **Remuneration report.** The remuneration report is a disclosure of payments made by the CCG to all members of its Governing Body and 'council of members' (GPs, Clinicians working for the CCG). The report covers everyone who has been a member of the Governing Body or council of members during the financial year and the prior year, even if not for the full period. It is often the part of the annual report and accounts subjected to most public scrutiny.

13.6 There are two parts to the remuneration report. The first, remuneration committee report and the remuneration policy, is not subject to audit, although the auditor does read it to assess its consistency with other knowledge gained from the audit. The second, the remuneration tables, is audited by the external auditor and reported on in the auditor's report.

13.7 **Governance Statement.** The governance statement reflects the arrangements the CCG has put in place to manage and mitigate the risks that it faced throughout the financial year. The governance statement should give the reader a clear sense of the risks which faced the CCG and the controls in place to manage them. Whilst the governance statement has been prepared by the CCG at the end of the year, it has been built up from processes designed, run and tested throughout the year.

13.8 **Statement of Accountable Officer's Responsibilities**. The CCG is required by statute to have an accountable officer. The accountable officer is responsible for ensuring that the CCG exercises its functions in a way which provides good value for money and complies with its obligations to:

- Ensure that the regularity and propriety of expenditure is discharged – this means that money should only be spent on things which the CCG has the power to spend money on

- Keep proper accounting records
- Prepare its annual accounts in accordance with the directions of NHS England
- Safeguard the CCG's assets.

13.9 The accountable officer must sign a statement which says that to the best of his/her abilities they have discharged these responsibilities. This responsibility cannot be delegated to any other member of the Governing Body.

13.10 **Independent Auditor's Report.** The CCG's accounts must be audited by an independent external auditor who is currently appointed by the Audit Commission. Following their work, the auditor signs a formal report which the CCG must include in its annual report and accounts.

13.11 **The Financial Statements**. The accounts (or financial statements) consist of four primary statements:

- A statement of comprehensive net expenditure
- A statement of financial position
- A statement of changes in taxpayer's equity
- A statement of cash flows.

13.12 These are accompanied by notes to the accounts which provide further information on the financial activities of the CCG. The accounts must include comparative figures for the prior year (where possible) to show how the CCG's financial position has changed year on year.

13.13 Detailed guidance on the form and content of the accounts is included in the ARG prepared by NHS England.

14. Access to further information

14.1 For further information relating to this report contact:

Name	Jerry Hawker
Designation	Chief Officer
Date	23/05/2014
Telephone	01625 663764
Email	jerry.hawker@nhs.net

15. Appendices

Appendix One	Annual Report and Accounts 2013 - 2014
Appendix Two	Financial Statements

Governance

Prior Committee Approval / Link to other Committees
Draft Annual Report and Accounts has been approved, subject to amendments, at the Executive Team meeting 21st May 2014.

CCG Health Needs Priorities addressed by this report – please indicate			
To protect our citizens from harm	☑	To make care more integrated & co-ordinated	☑
To prevent alcohol related harm	☑	To ensure high quality and effective mental health services are available to all	☑
To prevent people dying prematurely	☑	To address inequalities across our towns and villages	☑

CCG 2013/14 Annual Plan programme of work this report is linked to			
Caring Together	☑	Quality Improvement	☑
Mental Health & Alcohol	☑	Other	

Key Implications of this report – please indicate			
Strategic	☑	Consultation & Engagement	☑
Finance	☑	Equality	☑
Quality & Patient Experience	☑	Legal	☑
Staff / Workforce	☑		

CCG Values supported by this report – please indicate			
Valuing People	☑	Innovation	☑
Working Together	☑	Quality	☑
Investing Responsibly	☑		

NHS Constitution Values supported by this report – please indicate			
Working together for patients	☑	Compassion	☑
Respect and dignity	☑	Improving lives	☑
Commitment to quality of care	☑	Everyone counts	☑

NHS
Eastern Cheshire
Clinical Commissioning Group

Annual Report and Accounts

2013 – 2014

Draft

Inspiring Better
Health and Wellbeing

CCG Information Reader Box

Document Purpose	For information
CCG Website Link	www.easterncheshireccg.nhs.uk
Title	NHS Eastern Cheshire Clinical Commissioning Group Annual Report and Accounts 2013 - 2014
Author	NHS Eastern Cheshire Clinical Commissioning Group
Publication date	May 2014
Target Audience	NHS England, General Practice's, NHS Clinical Commissioning Group Executives & Governing Body, NHS Trust Executives & Board Members, Local Authority Executives, Councillors, Local Area Partnership Chairs, Patient & Public Representative Groups, Voluntary, Community and Faith Sector representatives, Cheshire & Merseyside Commissioning Support Unit, Healthwatch Cheshire East
Description	The NHS Eastern Cheshire Clinical Commissioning Group Annual Report and Accounts 2013 – 2014 is the first annual report and accounts of the Clinical Commissioning Group.
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For recipients use	

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Foreword

Dr Paul Bowen
GP Chair

It is with great pleasure that I present the Annual Report and Accounts 2013-2014 for NHS Eastern Cheshire Clinical Commissioning Group – the first time that we have published such a report.

On the 1st April 2014 we celebrated our first year as a statutory NHS body. It has been an extremely challenging but enjoyable year where we have had to navigate through an ever changing and developing health and care environment, continue to meet our constitutional and statutory duties whilst also planning how we intend to radically transform how health and care is delivered in Eastern Cheshire so as to meet future need, maintain high quality services and ensure a financially sustainable health and care economy.

The Health and Social Care Act 2012 gave added impetus and power to local clinicians to inform, influence, shape and lead the design of health and care services so as to best meet the needs of our patients. During the development of the CCG and over the last year I have continued to be amazed and draw strength and encouragement from the dedication my collaborators in health – those working in primary care, secondary care, community care , social care, the third sector and our public - have given to help work towards achieving this. The vision of the CCG is *"inspiring better health and wellbeing".* I have been inspired. Our partners have been inspired. Our public have been inspired.

Despite the financial pressures and challenges we face here in Eastern Cheshire, we have managed our finances successfully and delivered a small but significant surplus of £204,000 thus achieving our financial duties. These challenges will only increase over the next five years which is why the CCG and its partners have driven and supported our Caring Together transformation programme.

The level of change envisaged by the Caring Together programme is not only required so as to improve the quality of services available to residents of Eastern Cheshire - but is a key part to enable us to achieve a financial sustainability – not just for the CCG but for the whole health and care economy in Eastern Cheshire.

This is not going to be easy and it will not be based on short term fixes. Many difficult decisions will have to be made but those decisions will only be made through being informed by everyone who is interested in and values having health and wellbeing services that are the best possible for Eastern Cheshire.

I am proud of the work that the CCG has completed over the last year and this report demonstrates many of the successes.

1. Member Practice Introduction

The member practices of Eastern Cheshire had been very active in helping to shape the structure and strategy of NHS Eastern Cheshire Clinical Commissioning Group (CCG) even before it came in to being in April 2013. The hearts and minds of the members have been brought together since 2012/13 through the CCG in shadow format. This has been challenging and at times difficult, but also rewarding and productive.

There is a local drive to shape care and commissioning for our population. The member practices are grouped as peer groups around town localities where local priorities can help shape local strategy as well as steer wider CCG strategic development. This has allowed practices to have greater influence, as smaller town groups, on local needs and address inequalities and - through the town representatives to the Governing Body - on wider strategic issues and oversight.

Through this model of town based care we are better able to review strategic needs and engage with our neighbourhoods/communities. This has involved wider discussion with social care, community care, secondary care and third sector organisations as well as primary care providers. The member practices have a pivotal role in informing these discussions at practice and neighbourhood levels and it allows engagement of key individuals working in the neighbourhoods including patients themselves.

In a time of increasing health and social care pressures, the members have seized every opportunity to engage with and challenge the CCG's commitment to patient care, through commissioning, whilst embracing the need for change.

Through our CQUIN[1] we have encouraged activation and involvement by all member practices and stakeholders. Members are in a position to be ahead of the game in creating an environment for proactive care to flourish and be taken forward the principles of integration effectively and enthusiastically.

A significant part of this work has been at the heart of our Caring Together programme, which will see us working in a far more integrated and proactive way across our health and social care economy. Through the Caring Together Programme we have taken the opportunity, as member practices to, support individuals to manage their health and wellbeing. This has been a local priority across the CCG, to increase the proportion of people feeling supported – empowered - to manage their condition and has been achieved through the embedding of shared decision making and supported self management. Member practices, through peer groups, have been supportive and active in encouraging local leadership to make this a reality.

This has only been possible with the hard work of all involved. The ‘empowered person’ is at the very centre of what we do and all our commissioning efforts would come to nothing if this were not the case. As member practices we are proud of our strong clinical and patient (Empowered Person) focus and strive to maintain this moving into a changing and better future.

General Practice Locality Peer Group Leads

Dr Mike Clark, Macclesfield
Dr Jennifer Lawn, Knutsford
Dr James Milligan, Alderley Edge, Chelford, Handforth and Wilmslow Group
Melanie Lyman, Congleton and Holmes Chapel
Angela Wales, Bollington, Disley and Poynton

[1] CQUIN - Commissioning Quality and Innovation

2. Strategic Report

The accounts in this report are the first produced by NHS Eastern Cheshire Clinical Commissioning Group (CCG) as a statutory body and have been prepared under a direction issued by NHS England (formerly NHS Commissioning Board) under the National Health Service Act 2006 (as amended). The main factors likely to affect the future development, performance and position of our business are set out throughout this report.

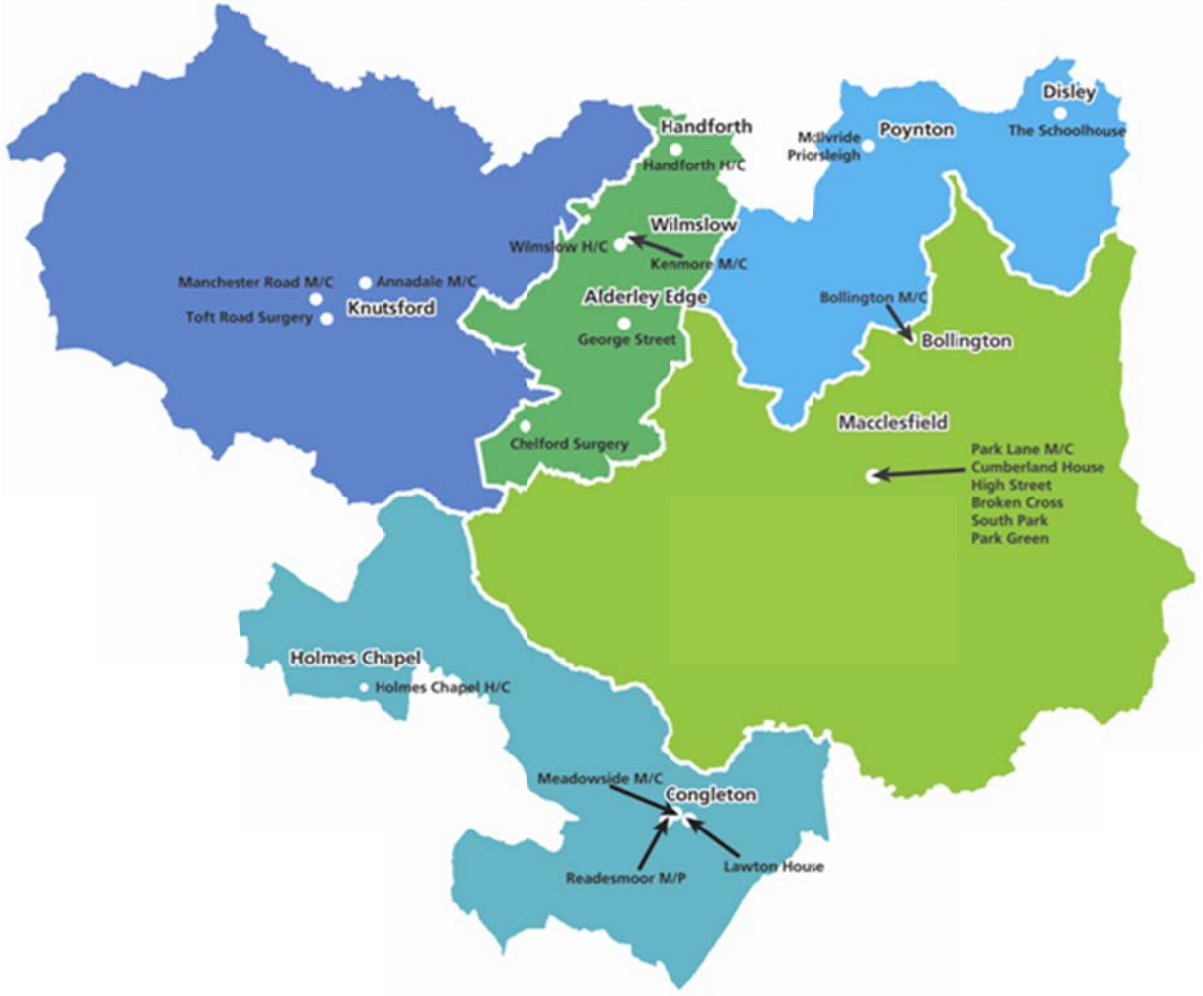
The CCG was established and became operational as a statutory NHS Body on the 1st April 2013 following 12 months of operation in shadow form. Previously the population of Eastern Cheshire had been served by the Central and Eastern Cheshire Primary Care Trust.

The CCG was licenced with one condition related to the appointment of a secondary care doctor to the Governing Body (Criteria 1.3B 14C). The CCG was able to provide evidence that all conditions had been resolved and NHS England confirmed that the condition had been resolved and closed in July 2013.[2]

2.1 Our membership

NHS Eastern Cheshire CCG is a membership organisation made up of 23 Eastern Cheshire based GP practices, working within five localities, as shown in Figure One.

Figure One



[2] https://www.easterncheshireccg.nhs.uk/Downloads/About-Us/20130722_EasternCheshire_FullAuth%20Letter.pdf

Our five localities, known as General Practice Locality Peer Groups, are:

- Alderley Edge, Chelford, Handforth, and Wilmslow
- Bollington, Disley, and Poynton
- Congleton and Holmes Chapel
- Knutsford
- Macclesfield

The main purpose of the CCG is to commission (buy) the highest quality of health care services within available funds, and monitor the quality of these services. We are responsible for commissioning health services to meet all the reasonable requirements of our local population, with the exception of certain services commissioned directly by NHS England, health improvement services commissioned by Cheshire East Council, and health protection and promotion services provided by Public Health England.

Our main commissioning responsibilities include:

- elective hospital care
- rehabilitation care
- urgent and emergency care, including GP Out of Hours and NHS 111
- most community health services
- mental health and learning disability services
- prescribing and medicine optimisation
- emergency and patient transport ambulance services
- NHS continuing healthcare and NHS funded nursing care

We also have the responsibility for commissioning emergency and urgent care services for the population within our boundaries as well as for commissioning services for any unregistered patients who live in our area.

Our statutory responsibilities

The CCG's full statutory responsibilities are detailed within its constitution.[3] The main responsibilities include:

- upholding the NHS Constitution,[4] CCG Constitution and governance standards
- quality assurance and quality improvement of commissioned services
- quality improvement of GP services in partnership with NHS England
- safeguarding children and vulnerable adults
- reducing health inequalities
- Public Sector Equality Duty
- public involvement in CCG and promotion of choice
- training, innovation and research
- environmental sustainability
- delivering on relevant areas of the Governments mandate to NHS England and the NHS England planning guidance 'Everyone Counts'[5]
- achieving financial balance

NHS Eastern Cheshire CCG is currently meeting its statutory duties.

2.2 Our structure

The CCG currently employs 40 staff who work alongside the clinicians and staff of the 23 practices to commission, plan and monitor health services. At the end of March 2014 NHS Eastern Cheshire CCG had 26 Female staff which equates to 65% of the workforce and of

[3] http://www.easterncheshireccg.nhs.uk/downloads/publications/Strategies/ECCCGConstitution1.3March14.pdf
[4] http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx
[5] http://www.england.nhs.uk/everyonecounts/

these 21 were Full Time and five were Part Time. There were also 14 Male staff which equates to 35% of the workforce and of these nine were Full Time and five were Part Time.

The CCG Governing Body has eight male members, which equates to 57% of the membership of the Governing Body. There are six female members, which equates to 43% of the membership of the Governing Body. The CCG has two Very Senior Managers, both are male.

Throughout 2013/14 staff have been aligned to teams to deliver on the Corporate, Clinical, Business and Finance functions and requirements of the CCG. The management of the CCG was structured around these teams. At the latter end of 2013/14 it became necessary to review and strengthen the CCG Organisation to meet the increasing scale of the transformation challenge facing the local health economy. These include:

- **Caring Together**[6] – Our local transformation programme for improving care across the system for the whole population of Eastern Cheshire
- **Connecting Care across Cheshire**[7] – NHS Eastern Cheshire CCG together with its partner CCG's in Cheshire and the two Local Authorities were successful in becoming a national integrated care pioneer - one of only 14 nationally
- **Healthier Together**[8] – The CCG is an associate to the Greater Manchester Healthier Together transformation programme which is aiming raise standards of hospital care and integrated care across Manchester
- **South Sector Challenged Health Economy** – An initiative sponsored by NHS England, Monitor and the NHS Trust Development Authority to develop plans to support the transformation of services across Eastern Cheshire, Stockport, South Manchester and Tameside and Glossop with a particular focus on establishing long term sustainable acute care

An assessment of the current skill base and capacity of the CCG workforce, has resulted in the CCG strengthening its core commissioning team and establishing a Transformation Directorate to support the CCG and the Governing Body in leading and delivering these substantial transformation programmes.

The CCG, in addition, has developed a successful partnership with McKinsey[9] and Carnell Farrar LLP[10] to support its transformation work and contracted with the Cheshire and Merseyside Commissioning Support Service[11] for a limited number of services that have supported the CCG in the delivery of its objectives and day to day operations.

2.3 Vision and Values

The vision of the CCG ***"inspiring better health and wellbeing"*** is a central tenet of its Constitution. It shapes the direction and behaviour of the CCG, its membership and its staff. This vision is embedded in all that we do and underpins all of the commissioning and business decisions that we undertake on behalf of our population. Our way of working is also guided by and measured against the values and principles of the CCG:

2.4 Values

- valuing people
- working together
- investing responsibly
- innovative
- quality

[6] http://www.caringtogether.info
[7] https://www.easterncheshireccg.nhs.uk/About-Us/integration.htm
[8] https://healthiertogethergm.nhs.uk/
[9] http://www.mckinsey.com
[10] http://carnallfarrar.com
[11] https://www.cheshiremerseysidecsu.nhs.uk/

2.5 Principles

- clinical leadership
- local experts in health needs and improving health outcomes
- local leadership and community engagement
- expertise in local provider relations and quality improvement
- local assurance in finance, performance and governance

2.6 Strategic Objectives

Our strategic objectives are:

- to lead the development of a shared vision for the health and social care economy
- to use the knowledge and experience of clinicians and managers to improve care
- to work effectively with our members
- to place patients at the centre of our commissioning decisions
- to commission safe, effective care that continues to improve patient experience
- to continue to develop the effectiveness of the organisation
- to ensure financial sustainability for the health economy

2.7 Working in partnership

The CCG is a major partner with Cheshire East Council and neighbouring CCG's (such as NHS South Cheshire CCG) in local (and sub-regional) work to improve both the health of and the care provided to the population of Eastern Cheshire. Examples include the successful achievement of submitting and being identified as one of 14 Integrated Care Pioneer sites within England, development of the Better Care Fund Plan[12] and the development of the Joint Commissioning Board.

The CCG is a statutory member of the Cheshire East Health and Wellbeing Board, with the CCG GP Chair being the deputy Chair of the Board. Through its membership of the Health and Wellbeing Board the CCG is responsible for the production and use of the Cheshire East Joint Strategic Needs Assessment (JSNA).[13] The information and priorities identified by the JSNA inform the commissioning intentions and decisions of the CCG and were instrumental in helping us to determine our priorities for 2013/14 and for 2014/15. The CCG has also continued to provided funding to Community Voluntary Services Cheshire East to undertake engagement work with the voluntary sector to help inform the JSNA through the qualitative experiences of the this sector.

The CCG, and its partners on the Cheshire East Health and Wellbeing Board, has also been responsible for the production of the Cheshire East Health and Wellbeing Strategy 2013/14.[14] The CCG has influenced and contributes in its day to day operation and strategic delivery to the priorities of the strategy, which are:

Outcome One – starting and developing well
Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive
Outcome Two – working and living well
Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough
Outcome Three – ageing well
Enabling older people to live healthier and more active lives for longer

[12] https://www.gov.uk/government/publications/better-care-fund
[13] http://www.cheshireeast.gov.uk/jsna
[14] http://www.cheshireeast.gov.uk/pdf/Health_and_Wellbeing_Strategy.pdf

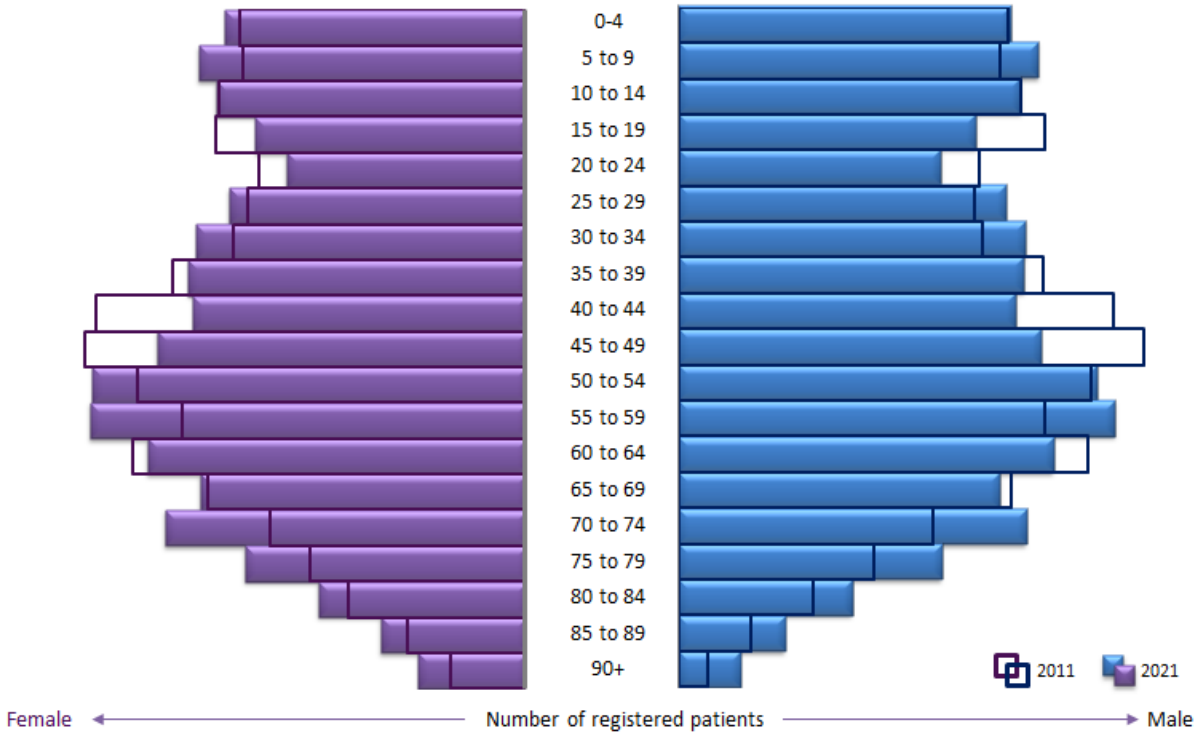
The CCG has encouraged and supported the development of Eastern Cheshire Community HealthVoice, the public/patient reference group for the CCG and which is a formal advisory committee to the CCG Governing Body. Members of this group play a proactive part in the development of CCG policies and strategies, have been instrumental in the prioritisation of the CCG commissioning intentions and provide public/patient represention on a variety of CCG meetings and groups, such as the Urgent Care Working Group, Caring Together Care Model Design Groups.

2.8 Our area

Eastern Cheshire is located in the North West of England and includes towns such as Macclesfield, Knutsford, Wilmslow, Poynton and Congleton as well as many villages and rural areas. It has a population of 201,000 and most local people are classed as 'white British'. The CCG area has 53% of the population of Cheshire East Borough Council. With NHS South Cheshire CCG, the two CCG's are co-terminous with the boundaries of the Council.

Eastern Cheshire has the fastest ageing population in the North West[15] with more than one in five people being over 65 (Figure Two). This ratio is higher than the national average, and will become nearer to one in four people by 2021.[16] The number of very elderly people is growing even more rapidly, with a higher estimated average annual growth rate when compared to England (2.7% vs. 2.3%).

Figure Two

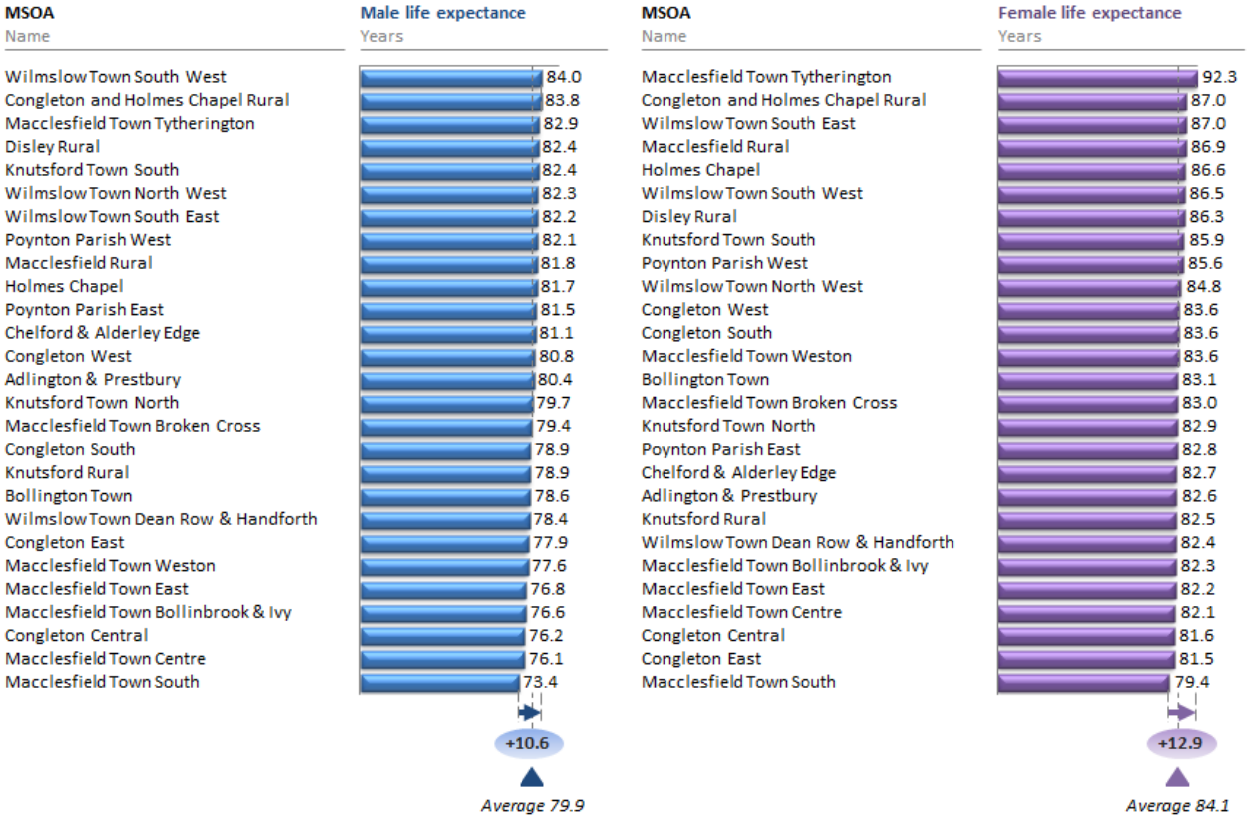


Although deprivation levels in Eastern Cheshire are lower than the national average, 4.5% of local people live in a Lower Super Output Area (LSOA) that is in the 20% most deprived in England. People living in these more deprived areas experience worse health than those living in those that are in the least deprived, and there are some startling differences. For example, a woman living in Macclesfield Town South LSOA is likely to die almost 13 years

[15] Cheshire East Joint Strategic Needs Assessment Sep 2012, population projections, 2010
[16] 21% vs. 18% 2011, 23 % in 2021, Office for National Statistics

earlier than a woman living a couple of miles away in Macclesfield Town Tytherington LSOA (Figure Three).

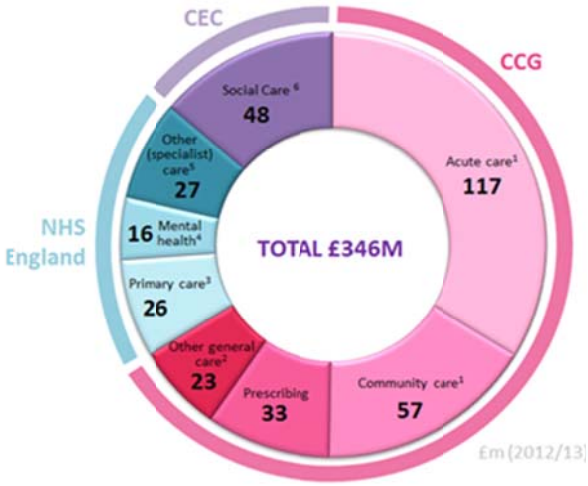
Figure Three



2.9 Healthcare spending

Health and social care spending on residents of NHS Eastern Cheshire CCG is around £346 million per year.[17] Around a third of this is spent on hospital care, a thirteenth on GP practices (Primary Care), one sixth on community care, one seventh on social care, one twentieth on mental health and the rest on other services such as prescribing and specialist care (Figure Four).

Figure Four



[17] Estimated spend 2012/13 by NHS Eastern Cheshire CCG, Cheshire East Council, East Cheshire NHS Trust, NHS England (December 2013)

2.10 Access to services

In Eastern Cheshire there are 38 Pharmacies, 42 Dentists and 48 Opticians. There is one District General Hospital in Macclesfield and two community hospitals (Congleton and Knutsford). The hospitals and community health services (e.g. District Nurses who visit patients in their homes) are managed by East Cheshire NHS Trust. The population in the north of the CCG also access hospital services across Greater Manchester. Mental health services are managed by the Cheshire and Wirral Partnership NHS Foundation Trust.

The proximity of Eastern Cheshire to Greater Manchester provides the Eastern Cheshire population with significant access and choice of general acute services and access to a range of specialist care providers. There is already an innovative model of providing specialist services locally with larger, specialist hospitals like The Christie Hospital NHS Foundation Trust enabling chemotherapy to be administered at East Cheshire NHS Trust, and a number of other services such as:

Mid Cheshire Hospitals NHS Foundation Trust Ophthalmology Diabetes Pathology	**University Hospital South Manchester NHS Foundation Trust** Vascular Services Oral Surgery Ear, Nose and Throat
Salford Royal NHS Foundation Trust Neurosurgery Neurology	**Stockport NHS Foundation Trust** Urology Orthodontics

Some Specialist Paediatric Services are also delivered by Alder Hey Children's NHS Foundation Trust Hospital or Central Manchester University Hospitals NHS Foundation Trust. It is also not unusual for patients to travel to other hospitals like The Christie, or even further afield for specialist services or access to medical or surgical specialists

The CCG has a commitment to ensuring an active provider market seeking to secure the highest quality of care whilst recognising the need to ensure local access to services commensurate with an ageing population.

For the populations of NHS Eastern Cheshire CCG, and the neighbouring NHS South Cheshire CCG, local authority services, including Children, Families and Adult social care, are provided in the main by Cheshire East Council.

2.11 Forward view - Transforming Care in Eastern Cheshire

People now live for longer in Eastern Cheshire than they have ever done before which is a cause for celebration. An ageing population is also a hugely significant challenge because older people are more likely to develop long term conditions such as diabetes, heart disease and breathing difficulties, and are more at risk of strokes, cancer and other health problems[18] – which all means people tend to need more care and more treatment as they get older.

There are over 2,000 people in nursing homes in Eastern Cheshire, up from 1,500 in 2001[19] and national data suggests more than half of people aged over 60 have at least one long term health condition.[20] For example, an ageing population means increasing incidence of

[18] Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie: Epidemiology of multimorbidity and implications for healthcare, research, and medical education: A cross-sectional study, The Lancet, Volume 380, Issue 9836, Pages 37 - 43, 7 July 2012

[19] Communal establishments residents 2001/2011

[20] GP practice profiles 2011; DH Long term conditions compendium of information, 3rd edition (58%)

dementia – there are already 1,545 people in Eastern Cheshire with dementia, a figure set to double by 2030[21] – and it is believed that the real scale of this condition could be almost twice as large as those figures, with up to half of those actually with dementia not diagnosed.

In Eastern Cheshire we also know that around half of hospital expenditure,[22] and around half of spending on adult social care,[23] is used for people aged over 65, even though they represent only one fifth of the population. So it is important to make sure that what money the CCG receives is spent well.

Over the last 18 months local commissioners and providers have united behind a common vision and purpose of transforming care services in Eastern Cheshire. This has been driven by a shared desire to join up care, improve outcomes and our population's experience of care whilst responding to increasing clinical and financial sustainability challenges within an environment of one of the fastest ageing populations in England.

Quite simply, the transformation programme, called Caring Together, is about organisations and people working together to make care as straightforward and integrated (joined up) as possible.

Our local clinical, health and social care partners believe that:

- people in Eastern Cheshire deserve services that are high quality and delivered as locally as possible.
- Patients should sit at the heart of a proactive care system centred on them.
- Carers are one of the most important resources which allow people to be independent and believe that they need to be supported to provide this care.
- Local people should be supported to take responsibility for their own health as much as possible.

Over the next five years the Caring Together programme will achieve this vision through the commissioning of a radical and innovative new care system, built on four environments of care, and delivered through each of the following elements:

- transformation of primary care *(in partnership with NHS England Cheshire Warrington and Wirral Area Team and our involvement in the Challenge Fund)*
- development of a new integrated community care model *(whole system partnership in Eastern Cheshire and aligned to the Connecting Care across Cheshire Pioneer programme and the Better Care Fund).*
- reconfiguration of acute care *(in partnership with the Greater Manchester Healthier Together programme and the "Challenged Economy" initiative)*
- a range of productivity initiatives to underpin the transformation programme.

Our ambitions for the future can be summarised as being to:

- increase the number of people having a positive experience of care
- reduce the inequalities in health and social care across Eastern Cheshire
- ensure our citizens access care to the highest standards and are protected from avoidable harm
- ensure that all those living in Eastern Cheshire should be supported by new, better integrated community services
- increase the proportion of older people living independently at home and who feel supported to manage their condition

[21] Cheshire East Joint Strategic Needs Assessment Sep 2012 (using data from PANSI, POPPI and QOF - 100% in Cheshire East (from 2010 to 2030)
[22] Payment by result spend – Hospital Episode Statistics 2012/2013
[23] Cheshire East Council social care data (November 2013) and Hospital Episode Statistics 2012/2013

- improve the health-related quality of life of people with one or more long term conditions, including, mental health conditions
- secure additional years of life for the people of Eastern Cheshire with treatable mental and physical health conditions.

2.12 Our financial challenge

NHS Eastern Cheshire CCG has successfully delivered a small but significant surplus of £204,000 for its first year of operation whilst working with an historical inherited deficit. In delivering its surplus for the financial year 2013/14, the CCG adopted an agreed approach with NHS England of using all of its revenue allocation (income) to cover its expenditure.

The impact of this agreement had two key components:-

- plan to deliver £5.9million QIPP (Quality, Innovation, Productivity & Prevention) savings in- year in order to achieve planned surplus
- agreement to vary the application of NHS England's Business Rules which requires each CCG to set aside 3.5% (equivalent to £7.7million in for NHS Eastern Cheshire CCG) of their 2013/14 allocation to deliver the following
  - 1% Surplus (£2.2m)
  - 2% Non Recurrent Headroom (£4.4m)
  - 0.5% Contingency (£1.1m)
- agreement to deliver a "balanced" income and expenditure position with a small planned surplus of £0.2million

During 2013/14, NHS England introduced a new method of allocating money to CCG's. The principal adopted in setting the new allocations were based on equity and fairness and took into account three main factors in healthcare needs: population growth, deprivation and the impact of an ageing population. This approach starts to address the underlying, historical deficit which NHS Eastern Cheshire CCG inherited along with the Caring Together transformation programme.

For 2014/15 NHS Eastern Cheshire CCG has been set at an allocation of £1,073 per head of population (£220.4 million) which is 6.2% below our notional allocation as derived from the new funding formula of £1,145 per head of population. NHS England has set CCG allocations for two years which include a differential uplift for those CCG's who are significantly below their notional target - known as a "pace of change". For 2015/16, NHS Eastern Cheshire CCG's allocation will increase to £1,098 per head of population (5.2% below notional target). It is expected that a pace of change will be adopted for 2016-2019 to enable CCG's to reach there notional allocations.

Looking forward five years. NHS Eastern Cheshire CCG has set its five year financial plan for 2014 – 2019 which reinforces the challenging position ahead. In recognition of the local economies financial position, NHS Eastern Cheshire CCG has engaged on a system wide transformation programme called Caring Together.

One of the key aims of this programme is to ensure that Eastern Cheshire has high quality health and social care services for its population which are financially sustainable for the future. This is also supported by the Challenged Health Economy work which is aiming to provide a list of options that deliver sustainable acute (hospital) services across South Manchester, including the local provider of hospital services in Eastern Cheshire - East Cheshire NHS Trust.

All of these programmes are being supported both locally and nationally and NHS Eastern Cheshire CCG is recognised as leading one of the leading transformational programmes in England.

In setting the five year financial plan for the CCG, there are two key distinctions to make. The CCG would have a small but increasing surplus over the five year period on our normal business activities and crucially living within its financial allocations (Figure Five) if the 2014/15 (one off) programme costs associated with Caring Together are excluded. It is only after the investment in the Caring Together programme necessary to deliver services that are financially sustainable with costs of £2.3 million, that the CCG forecasts a loss (deficit) in 2014/15 of £2million. The CCG has to finalise the work which identifies the savings / efficiencies required to deliver a minimum of £17 million QIPP savings over the five year period.

Figure Five

£'000	2014/15	2015/16	2016/17	2017/18	2018/19
Income	225,551	234,895	242,029	246,708	252,116
Programme Expenditure	(220,412)	(229,895)	(237,043)	(241,105)	(245,235)
Running Costs	(4,839)	(4,400)	(4,386)	(4,372)	(4,359)
Underlying Surplus	**300**	**600**	**600**	**1,231**	**2,522**
Caring Together Programme Costs	(2,300)	(200)			
Underlying Surplus	**(2,000)**	**400**	**600**	**1,231**	**2,522**

Finally, with the exception of the planned deficit in 2014/15 only, NHS Eastern Cheshire CCG has an improving underlying surplus of £300,000, which increases over the five years to £2,522,000 - which represents 1% of the CCG allocation (as defined by NHS England).

It is therefore the opinion of NHS Eastern Cheshire CCG that the CCG has a financially stable future, supported by the Caring Together programme, concluding that the CCG is operating as a going concern.

2.13 Going concern basis

As explained in note one to the financial statements, it remains appropriate to adopt the going concern basis for preparing the financial statements.

2.14 Key performance indicators

Finance

Delivering a balanced financial position against agreed revenue resource limit	
Revenue administration spending not to exceed the resources made available	
Ensure that suppliers are paid promptly in accordance with the better payments code of practice	

Other performance indicators are provided throughout this report.

2.15 Our commitment to quality

The NHS defines quality as effectiveness, safety and the provision of an excellent patient experience. High quality care encompasses all three aspects with equal importance being placed on each.

NHS Eastern Cheshire CCG views quality as the golden thread that runs through everything that we do. Ensuring the delivery of compassionate, high quality care focused on achieving positive patient centred and beneficial outcomes is at the very heart of our clinical values. By establishing a shared understanding of quality and a commitment to place it at the centre of

everything we do, the aspiration of high quality of care for all of our commissioned services will be achieved

We see high quality care as:
"When patients are ill they will receive care that is as safe as we can make it, care that is based on the best clinical evidence that ensures they have the best outcome and that this care is delivered in an integrated and holistic way. Patients and their families will be treated with dignity and respect during the delivery of this care and involved in care decisions. Patients will have a positive experience of care."

As a CCG this means we will hold the patient at the centre of everything we do and seek out and listen to what they are telling us and what they need. We will ensure that the services we commission for patients are as safe as possible, in line with best practice, in order to achieve the best reasonable outcomes for these patients and a good patient experience.

The CCG has developed innovative processes to capture feedback from patients (including views from seldom heard groups), clinicians, the CCG Governing Body Sub-committee – the Quality and Performance Committee, and Governing Body and ensures that this feedback is utilised to continuously improve services. This information includes complaints, concerns, compliments or safeguarding concerns received either directly from service users, from other NHS commissioners and regulators or from health care professionals involved in co-ordinating or delivering care.

2.16 Quality Strategy Development

The NHS Constitution sets out the key principles that guide the NHS and the values we should be working to. This is one of the key documents considered when developing the NHS Eastern Cheshire CCG Quality Strategy, especially in relation to our responsibilities as NHS staff as we commission care. National guidance sets out the responsibility CCG's have in relation to improving quality in primary care. NHS Eastern Cheshire CCG sees this as a fundamental part of developing care in Eastern Cheshire, in order to achieve the aims of proactive integrated care, our commissioning strategic priorities, and the NHS Eastern Cheshire CCG Quality Strategy.

The NHS Eastern Cheshire CCG Quality Strategy describes how NHS Eastern Cheshire CCG will work to ensure that the services we commission are safe, effective and provide a positive patient experience.

The Quality Strategy sets the scene in relation to approaches that the CCG will lead on for ensuring improving quality throughout the patient journey. When developing the strategy equal consideration was given to:

- local and national quality improvement priorities
- priorities identified within the Cheshire East Joint Health and Wellbeing Strategy and Cheshire East JSNA
- safeguarding children
- safeguarding vulnerable adults
- equality, diversity and human rights
- learning from a range of reports including Francis, Winterbourne and Keogh

The Clinical Quality and Performance Committee oversee the implementation of the CCG quality priorities which are identified in the annual plan.

2.17 Ensuring and improving quality throughout the patient journey

The CCG uses a range of evidence to identify local quality improvement priorities such as pressure ulcers and serious incidents. The specific objectives and initiatives that underpin

this aim are as follows:

- development of a whole health economy approach to prevent and effectively manage pressure ulcers including a review of the community equipment service
- reduce rates of healthcare acquired infections (MRSA and C)
- development of all services to ensure high quality "24-7" care
- continued development of services for Military Veterans
- reduce the incidence of falls with a specific focus on those occurring in a hospital setting
- ensuring systems support consistently safe prescribing practice
- development of the Eastern Cheshire prescribing formulary
- working with the academic health science network to increase the number of people engaging in research
- develop and implement a quality framework for care homes

2.18 Compassionate high quality care

NHS Eastern Cheshire CCG is committed to supporting compassionate and high quality care as advocated by the Chief Nursing Officer for England through *Compassion in Practice*[24] - a strategy that aims to achieve excellent health and wellbeing outcomes. It builds on the existing NHS Constitution and the 6C's (which details six values):

- Care
- Compassion
- Communication
- Courage
- Competency
- Commitment

Towards demonstrating our commitment we have created a NHS Eastern Cheshire NHS Staff pledge:
"We will care with compassion, ensuring we communicate effectively, have the necessary competence to under- stand your health and social care needs and the courage to speak up for you. We will demonstrate our commitment by working together, combining our knowledge, skills and expertise to maximise opportunities for innovation and excellence."

The CCG has committed to developing and embedding the 6C's in all of its work and has taken an active role nationally and locally in its promotion, including an innovative scheme to share best practice between local care homes.

2.19 Working in partnership to improve quality

In order for the NHS Eastern Cheshire CCG Quality Strategy to be successful in delivering its aims and effective in improving quality of care, NHS Eastern Cheshire CCG must take a whole systems approach to quality and work in partnership to achieve this. Working in partnership to develop and support a culture of quality improvement across the whole healthcare economy in Eastern Cheshire so that it is focused on the needs of patient and carers is a key priority of the CCG.

Partners include the nursing homes sector where the CCG continues to invest to support continuous improvement. These initiatives include implementation of an enhanced primary care services (GP) and the ongoing development of a quality framework for care homes. The CCG also works in close partnership with NHS England, Care Quality Commission, Cheshire East Council, NHS Trust Development Agency, Monitor, Healthwatch Cheshire East and other relevant partners through the Cheshire Warrington and Wirral Quality Surveillance Group. The Cheshire East Health and Wellbeing Board also binds the CCG's and Local Authority (CEC) into a partnership arrangement, with joint aims and objectives around quality

[24] http://www.england.nhs.uk/nursingvision/

identified through the JSNA and articulated through the joint health and wellbeing strategy.

2.20 Quality premium

The 'quality premium'[25] was established to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing health inequalities. The quality premium payment for achieving in 2013/14 will be invested locally during 2014/15. A summary of the position to date for 2013/14 is shown below in Figure Six.

Figure Six

National/Local	Measure	Status
National	Emergency Admissions	Achieving
National	Clostridium Difficile	Achieving
National	Friends and Family Test	Achieved
National	Potential Years Life Lost	Awaiting
Local Priority	Readmissions	Failing
Local Priority	Primary Mental Health	Achieved
Local Priority	Feeling Supported	Awaiting

2.21 Safeguarding

The CCG is committed to ensuring that safeguarding is embedded within the organisation and in the services commissioned from all its providers. However, we also recognise that our responsibilities extend well beyond our local statutory duties and boundaries and have been an active member of the Cheshire East Safeguarding hub working with NHS South Cheshire CCG, Cheshire East Council and Cheshire Police. The CCG Executive Nurse and safeguarding team have worked closely with the Cheshire East Children's and Cheshire East Adult's safeguarding boards to continuously improve the way we work and ensure safeguarding policies, frameworks are embedded in everything we do.

2.22 Promoting innovation

The CCG is a founding member of the Greater Manchester Academic Science Research Network[26] and has worked closely with them in their formative year and in ensuring the network supports active innovation and clinical research across Eastern Cheshire.

The CCG is also part of a European project called "Stop and Go" looking to increase the innovation, development and implementation of new Assistive Technologies.

2.23 Promoting Education and Training

As a CCG, we have a duty when exercising our functions, to have regard to the need to promote education and training for our employees (Section 14Z NHS Act 2006). We actively encourage our staff to attend organisational and personal development opportunities. We have adopted an annual appraisal system in order to support performance and development

[25] http://www.england.nhs.uk/ccg-ois/qual-prem/
[26] http://www.gmahsn.org/index.php

of our staff, which is further underpinned by regular 1-1's with line managers.

2.24 Progress against agreed targets

Our 2013-2014 Prospectus[27] articulated the national and local measures that would demonstrate how we would be making a difference to improve health and care in Eastern Cheshire. Our measures included:

National

- 27% reduction in Clostridium Difficile levels against Department of Health baseline
- reduce potential years of lost life by 3.2%
- reduce emergency admissions by 5% by 2016, with no increase in 2013/14
- 100% introduction of Friends and Family Test

Local

- reduce by 5% the number of avoidable emergency admissions within 30 days
- increase the proportion of people entering Primary Mental Health Services by 15%
- increase to 55% the proportion of people feeling supported to manage their condition
- achieve a 7.5% reduction in falls and falls related injuries
- achieve >80% of appropriate staff to undergo identification and brief advice training so as to deliver alcohol brief advice to patients
- achieve a 30% reduction in the incidence of new pressure ulcers (>grade2)
- reduce the proportion of cancers diagnosed through an emergency presentation by 30% by 2015
- reduce by 15% the number of people waiting longer than 28 days to access mental health services
- achieve recurrent financial balance by 2016

NHS Eastern Cheshire CCG is proud of the improvements that have been made in the period 2013/14 and it is a positive reflection of the commitment of our members and staff to focus on the need for both short term continuous improvement in the quality and access to care whilst leading substantial long term transformation programmes.

The CCG recognises that more needs to be done to address those areas where the CCG has yet to achieve the improvement we have set ourselves. These will become the areas of additional focus during 2014/15.

Figure Seven indicates the progress we have made to date (March 2014) against these measures.

[27] http://www.easterncheshireccg.nhs.uk/downloads/publications/Strategies/Eastern%20Cheshire%20Prospectus%202013%20-%20FINAL2.pdf

Figure Seven

National/Local	Measure	Status	Comments
National	Emergency Admissions	**Achieving**	The CCG is on target to achieve its three year objective
National	Clostridium Difficile	**Achieving**	The CCG achieved a significant reduction
National	Friends and Family Test	**Achieved**	FFT was rolled out to A&E, Inpatient Wards and Maternity
National	Potential Years Life Lost	**Awaiting**	Data not available until September 2014
Local Priority	Readmissions	**Failing**	Levels did not fall by the 5% projected remaining consistent with the levels in the previous year
Local Priority	Primary Mental Health	**Achieved**	15% more people gained access to IAPT[28] and CAMHS[29]
Local Priority	Feeling Supported	**Awaiting**	Data not available until July 2014
Other Local	Pressure Ulcer Reduction	**Failed**	The CCG did not see the level of reduction planned for, although this may be partially due to "improved reporting"
Other Local	Falls Reduction in Hospital	**Part Achieved**	Although there were reductions in "all falls" and "falls with harm" the rate of reduction was lower than planned in the "falls with harm" category
Other Local	Emergency Cancer Presentation	**Achieving**	The CCG is on target to achieve its 2 year objective
Other Local	IAPT Waiting Times	**Failed**	Although an improvement was seen by the end of the year the CCG still needs to further reduce treatment waiting time
Other Local	Alcohol "brief interventions"	**Achieved**	East Cheshire NHS Trust and Primary Care trained the planned clinical staff to deliver "IBA"[30]

[28] IAPT - Improving Access to Psychological Therapies
[29] CAMHS - Children's and Adults Mental Health Services
[30] IBA - Identification and Brief Advice

2.25 Legislative Requirements

CCG Assurance Framework. The CCG Assurance Framework[31] has been established to ensure that CCG's are continuing to meet their on-going responsibilities to patients and the public. The framework sets out how quarterly checkpoints contribute to an annual assessment focussed on broader measures of organisational health.

Over the past year NHS Eastern Cheshire CCG has achieved assurance at each of our Checkpoint visits from the NHS England Area Team. Figure Eight demonstrates the outcome of our most recent (Quarter 3 – March 2014) assurance review. This review is consistent with the feedback from NHS England at the Quarters One and Two Reviews.

Figure Eight

Domain	Checkpoint Three	Achievements / Examples of Good Practice
Are patients receiving clinically commissioned high quality services?		The CCG has delivered good performance against the NHS Constitutional standards
Are patients and the public actively involved?		Members of Eastern Cheshire Community HealthVoice have actively been involved in the CCG's commissioning intentions prioritisation process, Urgent Care Working Group and Caring Together Care Design Groups
Are CCG plans delivering better outcomes for patients?		The CCG has successfully implemented a system to highlight clinical risks associated with prescribing in primary care which has led to better prescribing and treatment outcomes for patients
Does the CCG have robust governance arrangements?		During 2013/14 the CCG has undertook a review of governance arrangements in relation to monitoring quality of service delivery. The CCG has received assurance through internal and external audit.
Are CCG's working in partnership with others?		The CCG is leading a whole health and social care economy programme to improve care. Caring Together partners include our public, providers of health and care services and other commissioners of care (NHS England and Cheshire East Council).
Does the CCG have strong and robust leadership?		The CCG is clinically led with clear links from our member practices into our Governing Body.

Assured Assured with support

NHS Eastern Cheshire CCG is committed to achieving the continued assurance of NHS England and actively support and participate in the quarterly checkpoint visits for 2014 – 2015.

Delivering against the NHS Constitution. NHS Eastern Cheshire CCG has delivered the NHS Constitutional targets consistently well across all indicators (Figure Nine). The only exceptions are:

[31] http://www.england.nhs.uk/wp-content/uploads/2013/05/ccg-af.pdf

- diagnostics within six weeks where the CCG fell 0.03% below the 99% standard. This dip in performance was influenced by issues with provision of a community ultrasound service. The CCG responded promptly to address these issues and sourced additional capacity to rectify the issue in the short term whilst undertaking a procurement process to address this in the longer term
- during the year the CCG worked closely with our main provider of services, East Cheshire NHS Trust, to ensure that improved performance was achieved in both 18 weeks Referral to Treatment and four hour wait in A&E were achieved. This resulted in a successful full year performance for the CCG.

Figure Nine

Referral to Treatment Waiting Times	**Target**	**Performance**	**Comment**
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	91.80%	
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	97.14%	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	94.56%	
Diagnostic waiting Times	**Target**	**Performance**	**Comment**
Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	98.97%	Awaiting March 2014 data for final end of year figure
A & E Waits			
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	95.25%	Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department
Cancer Waits – 2 Week Wait	**Target**	**Performance**	**Comment**
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	97.20%	Awaiting March 2014 data for final end of year figure
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	96.24%	Awaiting March 2014 data for final end of year figure
Cancer Waiting – 31 days	**Target**	**Performance**	**Comment**
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	97.99%	Awaiting March 2014 data for final end of year figure
Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	99.46%	Awaiting March 2014 data for final end of year figure
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100%	Awaiting March 2014 data for final end of year figure

Referral to Treatment Waiting Times	Target	Performance	Comment
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100%	Awaiting March 2014 data for final end of year figure
Cancer waits – 62 days	**Target**	**Performance**	**Comment**
Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	86.51%	Awaiting March 2014 data for final end of year figure
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	91.36%	Awaiting March 2014 data for final end of year figure
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	No standard set	95.38%	Awaiting March 2014 data for final end of year figure
Category Ambulance Calls	**Target**	**Performance**	**Comment**
Category A calls resulting in an emergency response arriving within 8 minutes - Red 1	75%	75.90%	North West Ambulance Service (NWAS) Overall Performance
Category A calls resulting in an emergency response arriving within 8 minutes - Red 2	75%	77.40%	NWAS Overall Performance
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%	95.80%	NWAS Overall Performance
Mixed Sex Accommodation Breaches	**Target**	**Performance**	**Comment**
Minimise Breaches		2	Awaiting March 2014 data for final end of year figure
Cancelled Operations	**Target**	**Performance**	**Comment**
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.	0	0	Awaiting March 2014 data for final end of year figure
Mental Health	**Target**	**Performance**	**Comment**
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	95%	Q1: 96.3% Q2: 96.6% Q3: 95.5%	Awaiting Q4 data for final end of year figure

2.26 Risk Management and principal risks and uncertainties

NHS Eastern Cheshire CCG adopts an embedded risk management framework, as detailed in the annual governance statement. On **page 46** the Annual Governance Report identifies the following key risks and uncertainties together with related controls:

- Caring Together Programme - Case for Change
- business information systems
- underlying financial deficit

- delivery of the operational plan.

2.27 Equality Report

Equality is about creating a fairer society where everyone can participate and has the opportunity to fulfil their potential. Equality means treating individuals in a way that is appropriate to their needs, with dignity and worth regardless of their protected characteristics. Diversity builds on equality and focuses on how individual differences and their strengths can be valued for the benefit of both society and the individual.

One of the key principles of the NHS Constitution is that *'the NHS provides a comprehensive service, available to all - irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population'.*

This principle is often summarized in terms of:
- equal access to services
- equal treatment
- equal health outcomes

The Health and Social Care Act 2012[32] states that 'each commissioning group must, in the exercise of its functions have the regard to the need to:
- reduce inequalities between patients with respect to their ability to access health services
- reduce inequalities between patients with respect to the outcomes achieved for them by provision of health services
- promote the involvement of patients and their careers in decisions about provision of the health services to them
- enable patients to make choices with respect to aspects of health services provided to them'

The CCG is required to pay due regard to the Public Sector Equality Duty[33] as defined by the Equality Act 2010.[34] Failure to comply has legal, financial and reputational risks. The key functions that enable NHS Eastern Cheshire CCG to make informed and equitable commissioning decisions and monitor the performance of their providers have to demonstrate the needs of protected groups have been considered in:
- its commissioning and de-commissioning processes
- consultation and engagement processes
- procurement functions
- contract specifications
- quality contract and performance schedules
- governance systems

The CCG recognises and take seriously our responsibilities and duties under the Equality Act 2010. It is committed to making sure equality and diversity is a priority when we plan and commission local healthcare services.

To do this we work closely with our communities and our partners in health and care to understand needs and how best to commission the most appropriate services to meet those

[32] http://www.legislation.gov.uk/ukpga/2012/7/enacted
[33] https://www.gov.uk/government/publications/public-sector-equality-duty
[34] http://www.legislation.gov.uk/ukpga/2010/15/contents

needs. We have also commissioned specific work to help us understand further the needs and health activity of seldom heard groups (Figure Ten).

Figure Ten: Pathways Community Interest Company (CiC)

Eastern Cheshire has an increasing Black and Minority Ethnic (BME) population and as a CCG it is important that we continue to work closely with our local populations to gain their views and experiences of local services, so that we can ensure that our commissioning plans reflect the needs of our population.

NHS Eastern Cheshire CCG has commissioned Pathways CiC to undertake community development work with our BME communities to help us understand how our population access services, and what support is needed to promote positive health and wellbeing.

The role of a Community Development Worker is to ensure that BME communities are made aware of the health services and to how to access them. They are responsible for establishing strong communication between service users, service commissioners and health professionals by gathering patient and carer stories to ensure that services are accessible and well resourced. They also promote health within BME communities and strengthen their involvement in the planning and design in services

The communities that Pathways CiC have been working with include Eastern European, Chinese, Bangladeshi, Afro-Caribbean, African and the travelling community in Eastern Cheshire.

Further information:
www.easterncheshireccg.nhs.uk/About-Us/equality.htm

All key providers of services commissioned by the CCG, including East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, have undertaken the EDS assessment and have set equality objectives in accordance with their requirements. The performance of providers in relation to them meeting the Public Sector Duty is taken into account through contract monitoring.

As an employer we are committed to ensuring that we have a diverse workforce by providing fair and equal access to all NHS Eastern Cheshire CCG jobs, including access to career development and training opportunities for existing and future staff. To do this we aim to recruit the best talent that we can and remove any barriers to ensure that we have the widest possible pool of talent to draw from.

As an employer we are also committed to ensuring that our staff have access to and undertake training around our Public Sector Duty with regards equality and diversity. We have also ensured that we have robust arrangements in place for staff to report any occasions where they or their colleagues have been subject to any intentional or unintentional discrimination in the workplace or when undertaking their duties when representing the CCG.

The CCG places a high priority on ensuring that it discharges its obligations as a good corporate citizen and takes into account its responsibilities towards serving and meeting the needs of our local population, including safeguarding their human rights.

Equality Objectives. Towards meeting our Specific Duty we are required to prepare an Equality and Diversity Strategy for the CCG[35] and publish equality objectives which are specific and measurable and which can be updated on an annual basis.

To help set our Equality Objectives we have used the NHS Equality Delivery System (EDS)[36] self assessment. NHS Eastern Cheshire CCG commissioned specific support from the Cheshire and Merseyside Commissioning Support Unit to undertake the EDS assessment on behalf of the CCG. Our submission of EDS evidence in 2013[37] resulted in the CCG being assessed as *'Developing'* reflecting its status as a relatively new statutory NHS organisation.

Our 2013/2014 equality objectives were:

- to ensure accessibility to services and information
- to develop joint consultation and engagement
- to ensure the equality of opportunity in employment and training provision
- to improve the JSNA to provide a greater understanding of the Eastern Cheshire population

2.28 Sustainability Report

NHS Eastern Cheshire CCG intends to develop and implement a CCG Sustainability Development Management Plan which will be put forward early in 2014 for consideration by the Governing Body. Consideration will be given with regards to how CCG policies and strategies, such as flexible working, lease car polices and Information and Communication Technology strategy can contribute towards meeting our sustainability obligations.

As a new organisation, the CCG will work towards ensuring that it meets its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.[38] This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. The CCG is also progressing towards setting out its commitments as a socially responsible employer.

The CCG recognises that its biggest impact can be made with regards to how it commissions and procure services. The CCG is committed to ensuring that within all of its commissioning and procurement processes that it will ask all of its providers to ensure that they are committed to delivering the sustainability agenda, as detailed by NHS England and the NHS Sustainable Development Unit.[39]

Meeting the needs of today without compromising the needs of tomorrow is a key driver of the CCGs major programme of transformative work – the Caring Together Programme. This programme of change typifies the CCG's approach to commissioning for sustainable development in that end goals include saving money, saving resources and benefiting staff and patients.

We lease our office building from NHS Property Services and our business address is New Alderley House, Victoria Road, Macclesfield. It is based on the Macclesfield District General Hospital site which is run by East Cheshire NHS Trust. We currently do not have access to information such as our utilities usage for 2013/14. Subject to NHS Property Services being able to provide the necessary information, we hope to publish such data in our 2014/15 Annual Report and Accounts.

[35] https://www.easterncheshireccg.nhs.uk/Downloads/Publications/Policies/Business-Conduct/ECCCG_Equality_and_Diversity_Strategy_Aug_2012.pdf
[36] http://www.england.nhs.uk/ourwork/gov/edc/eds/
[37] https://www.easterncheshireccg.nhs.uk/Downloads/About-Us/Equality/East_Equality_delivery_system_completed_template_2013_Eastern_cheshire.pdfv
[38] http://www.legislation.gov.uk/ukpga/2012/3/enacted
[39] http://www.sduhealth.org.uk/

2.29 Strategic Report Self Certification, Accountable Officer

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

I certify that NHS Eastern Cheshire Clinical Commissioning Group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The Clinical Commissioning Group regularly reviews and makes improvements to its major incidence plan, proportionate to its duties/responsibilities as a category 2 responder, and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

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

Signed

_____

Jerry Hawker – Chief Officer (Accountable Officer)
Date:

3. Members' Report

This report is prepared by the Governing Body on behalf of the members.

3.1 Our member practices

Figure Eleven includes details of the 23 GP Practices that comprise the membership of NHS Eastern Cheshire CCG.

Figure Eleven

Locality Peer Group	Member Practices
Alderley Edge, Chelford, Handforth, Wilmslow	Alderley Edge Medical Practice, Chelford Surgery, Handforth Health Centre, Kenmore Medical Centre, Wilmslow Health Centre
Bollington, Disley, Poynton	Bollington Medical Centre, Mcllvride Medical Practice, Priorslegh Medical Centre, The School House Surgery
Congleton, Holmes Chapel	Holmes Chapel Health Centre, Lawton House Surgery, Meadowside Medical Centre, Readesmoor Group Practice
Knutsford	Annandale Medical Centre, Manchester Road Medical Centre, Toft Road Surgery
Macclesfield	Broken Cross Surgery, Cumberland House, High Street Surgery, Park Green Surgery, Park Lane Surgery, South Park Surgery, Vernova Healthcare CIC

3.2 Chair and Accountable Officer

For the year 2013/14 the office of GP Chair of the CCG has been held by Dr Paul Bowen and Chief Officer (Accountable Officer) of the CCG by Jerry Hawker.

3.3 Governing Body

Figure Twelve indicates the composition of the voting members of the Governing Body of NHS Eastern Cheshire CCG for the year 2013/14.

Figure Twelve

Governing Body Member	Position
Dr Paul Bowen	GP Chair
Jerry Hawker	Chief Officer
Alex Mitchell	Chief Finance Officer
Dr James Milligan	General Practice Locality Peer Group Lead
Dr Mike Clark	General Practice Locality Peer Group Lead
Dr Jennifer Lawn	General Practice Locality Peer Group Lead
Melanie Lyman	General Practice Locality Peer Group Lead
Angela Wales	General Practice Locality Peer Group Lead
Gill Boston	Lay Member (Public and Patient Involvement)
Bill Swann	Lay Member (Public and Patient Involvement)
Gerry Gray	Lay Member (Governance and Audit) Deputy Chair
Sally Rogers	Registered Nurse
Duncan Matheson	Secondary Care Doctor
Julie Sin	Consultant in Public Health and Medicine

A biography of each member of the Governing Body can be seen in Appendix One.

The CCG Governing Body has eight male and six female members. There have been 13 Governing Body meetings during 2013/14, six have been in public and seven have been informal – all of which have been quorate.

Attendance Record

Name / Date	2013									2014		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Paul Bowen												
Jerry Hawker												
Alex Mitchell												
James Milligan												
Mike Clark												
Angela Wales												
Jennifer Lawn												
Melanie Lyman												
Gerry Gray												
Gill Boston												
Bill Swann												
Sally Rogers												
Duncan Matheson												
Julie Sin												

Attended	Absent
Meeting took place before member was in place	
Meeting held in private	Meeting held in public

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

3.4 Governance and Audit Committee Membership

Figure Thirteen details the composition of the Governance and Audit Committee.

Figure Thirteen

Committee Member (Voting)	Position
Gerry Gray	Lay Member for Governance & Audit (Chair)
Gill Boston	Lay Member for Public and Patient Involvement
Bill Swann	Lay Member for Public and Patient Involvement
Dr James Milligan	General Practice Locality Peer Group Lead (Executive GP for Business Management Team)
Melanie Lyman	General Practice Locality Peer Group Lead
In attendance	**Position**
Alex Mitchell	Chief Finance Officer
Mike Purdie	Corporate Governance manager

A biography of each voting member of the Governance and Audit Committee can be seen in Appendix One.

3.5 Clinical Quality and Performance Committee Membership

Figure Fourteen details the composition of the Clinical Quality and Performance Committee.

Figure Fourteen

Committee Member (Voting)	***Position***
Dr James Milligan	General Practice Locality Peer Group Lead (Executive GP for Business Management Team)
Dr Julia Huddart	Executive GP for Clinical Leadership Team
Duncan Matheson	Governing Body Member -Secondary Care Doctor
Andrew Binnie	Quality Performance Manager
Jacki Wilkes	Head of Clinical Developments and Health Outcomes
Sally Rogers	Registered Nurse
Neil Evans	Head of Business Management
Gill Boston	Lay Member for Public and Patient Involvement
In attendance	**Position**
Mary Barlow	Quality Lead (CSU) – Continuing Health Care and Care Homes
Debbie Lowe	Locality Lead (CSU) – Complaints, Incidents and Concerns
Anita Mottershead	Quality and Performance Analyst
Andy Wilson	Quality and Performance Analyst

A biography of each voting member of the Clinical Quality and Performance Committee can be seen in Appendix One.

3.6 Remuneration Committee Membership

Figure Fifteen details the composition of the Remuneration Committee.

Figure Fifteen

Committee Member (Voting)	**Position**
Gerry Gray	Lay Member for Governance & Audit (Chair)
Gill Boston	Lay Member for Public and Patient Involvement
Bill Swann	Lay Member for Public and Patient Involvement
Duncan Matheson	Secondary Care Doctor
Sally Rogers	Registered Nurse
Dr Jennifer Lawn	General Practice Locality Peer Group Lead
Angela Wales	General Practice Locality Peer Group Lead
(Non-voting) (By invitation)	**Position**
Jerry Hawker	Chief Officer
Alex Mitchell	Chief Finance Officer
Lisa Kelly	CMCSU HR Lead

A biography of each voting member of the Remuneration Committee can be seen in Appendix One.

3.7 Political and charitable donations

No political or charitable donations were made in the year.

3.8 Events since the year end

No significant events have occurred between the year end and the date of this report that affect the Clinical Commissioning Group.

3.9 Likely future developments

Likely future developments are set out throughout the strategic report included within this annual report.

3.10 Research and development

As a commissioning organisation, we do not carry out research and development activities ourselves.

3.11 Branches outside UK

We have no branches outside the UK.

3.12 Pension liabilities

Details of pension liabilities are set out in note one and four to the financial statements.

3.13 Sickness absence data

Sickness absence data is set out in note four to the financial statements. This indicates that the sickness level was below the average for NHS organisations. In 2013/14 there have been no significant rates of sickness absence which have required managerial intervention.

3.14 External Auditor

The external auditor in the year was Grant Thornton LLP. Fees for external audit services are set out in note five to the financial statements. These fees relate to the audit of the financial statements and the provision of a statutory report on value for money. No further assurance services or other services were provided by external auditors.

3.15 Serious untoward incidents

As identified in the Annual Governance Report on page 45 there have been no serious untoward incidents in relation to data losses.

3.16 Cost allocation and setting of charges

The Governing Body of NHS Eastern Cheshire CCG can certify that the CCG has complied with HM Treasury's guidance on cost allocation and setting of charges for information.

3.17 Complaints and Principles for Remedy

The CCG seeks to resolve and remedy any complaints as quickly as possible. In doing so, we adhere to the principles set out by the Parliamentary and Health Service Ombudsman. Good practice with regard to remedies means:

- getting it right
- being customer focused
- being open and accountable
- acting fairly and proportionately
- putting things right
- seeking continuous improvement

These principles are applied to every complaint received.

3.18 Employee consultation

As a relatively small employer based in one office, our Governing Body and Senior Managers have day to day contact with all of our employees. In addition we systematically provide information on matters of concern to employees through:

- a weekly Chief Officers briefing
- monthly whole "team brief" meetings

- sharing of information on CCG intranet and via direct email on matters relating to such things as development opportunities, fraud awareness's, employment matters
- use of web based engagement/survey technologies, such as Survey Monkey and information sharing platforms, such as Twitter, that allows engagement and consultation of CCG staff and other staff within partner organisations
- regular 1:1's between staff and managers

Where appropriate, employees views are canvassed prior to key decisions being made and all employees receive formal letters of notification where any matters influence employment terms and conditions.

3.19 Disabled employees

As an employer we are committed to ensuring that we have a diverse workforce by providing fair and equal access to all NHS Eastern Cheshire CCG jobs, including access to career development and training opportunities for existing and future staff. To do this we aim to recruit the best talent that we can and remove any barriers to ensure that we have the widest possible pool of talent to draw from.

The CCG has approved policies where reasonable adjustments to an employees working conditions due to an identified disability can be approved following agreement between employee and manager.

As an employer we are also committed to ensuring that our staff have access to and undertake training around our Public Sector Duty with regards equality and diversity. We have also ensured that we have robust arrangements in place for staff to report any occasions where they or their colleagues have been subject to any intentional or unintentional discrimination in the workplace or when undertaking their duties when representing the CCG.

3.20 Emergency preparedness, resilience and response

Under guidance issued by NHS England and under the Civil Contingencies Act (2004) CCG's are classed as Category Two responders in emergencies. This means that the CCG must provide reasonable assistance when requested to do so. The CCG is also required to ensure that day to day health services are maintained by our providers in the event of an emergency. The CCG is also required to maintain and test a business continuity plan.

The CCG has ensured that our contracts with providers contain relevant emergency preparedness, resilience and response elements and seek assurance on those providers fulfilling contractual obligations. This is reported back on a regular basis to NHS England.

The CCG liaises with NHS England through its area team to support it in its role as co-ordinator of the Emergency resilience and response plan preparedness through the Local Health Resilience Partnership (LHRP) of which the CCG is a member and of its sub-committees. The CCG also provides a point of escalation for the LHRP should a provider fail to maintain the capacity required.

The CCG maintains a 24/7 365 day a year on-call rota.

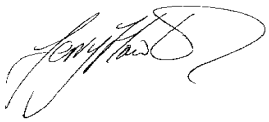
Our self-certification is included in the accounting officer's statement in the strategic report.

3.21 Disclosure to Auditors

Each individual who is a member of the Governing Body at the time of the Members' Report is approved confirms: so far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and
that the member has taken all the steps that they ought to have taken as a member in order to make themself aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

Signed on behalf of the members by:

Dr Paul Bowen – Chair
Date:



Jerry Hawker – Chief Officer
Date:

4. Remuneration Report

4.1 Introduction

Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, requires NHS bodies to prepare a Remuneration Report containing information about directors' remuneration. The report is in respect of the Senior Managers of the NHS body. 'Senior Managers' are defined as: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the clinical commissioning group as a whole, rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.'

The Remuneration Committee determines remuneration for the CCG Governing Body members.

4.2 The Remuneration Committee

The terms of reference for the Remuneration Committee were approved by the Governing Body in March 2013 under the establishment of the CCG Constitution. The membership of the Remuneration Committee at the date of this report consists of: the Chair of the Audit Committee and the lay members of the Governing Body as follows:

Chair:	Gerry Gray – Lay Member for Governance & Audit
Other members	Gill Boston – Lay Member for Public and Patient Involvement
	Dr Jennifer Lawn – Governing Body Member - General Practice Locality Lead
	Duncan Matheson - Governing Body Member – Secondary Care Doctor
	Sally Rogers – Governing Body Member - Registered Nurse
	Bill Swann – Lay Member for Public and Patient Involvement
	Angela Wales - Governing Body Member - General Practice Locality Lead

In the absence of the Committee Chair of the committee a nominated Governing Body member acts as Chair. The Committee met on three occasions during the year, with attendance as follows (Figure Sixteen):

Figure Sixteen

Member	Meetings		
	June 2013	September 2013	January 2014
Gerry Gray	Yes	Yes	Yes
Gill Boston	Yes	Yes	Yes
Sally Rogers	Yes	Yes	Yes
Bill Swann	Apols	Apols	Yes

4.3 Policy on Remuneration of Senior Managers

Amendments to salary are determined annually by the Remuneration Committee. Senior Manager performance is monitored through the formal appraisal process, based on organisational and individual objectives.

As required the committee has access to professional advice from the CCG's professionally qualified HR manager and also the CCG legal advisers Hill Dickinson LLP.

In setting policy for current and future years, the committee has access to guidance, best practice and benchmarking information from NHS Employers, NHS England and comparative CCGs. Account is also taken of the pay and conditions of service that apply to other employees in the CCG.

4.4 Senior Managers performance related pay

Currently performance related pay is not an element of Senior managers' remuneration package. The Committee is considering options.

4.5 Senior Manager Contracts

Senior Manager (officer) contracts are subject to six months' notice. Governing Body members have been appointed to varied fixed terms of office, details of which can be found on page 36.

4.6 Past Senior Managers

No payments have been made to any past senior managers or for loss of office during 2013/14.

4.7 Pay Multiples

The full time equivalent of the banded remuneration of the highest-paid Senior Manager in the financial year 2013-14 was £170k to £175k. This was 5.3 times the median remuneration of the workforce, which was banded £30 - £35k.

In 2013-14 no employees received remuneration in excess of the highest-paid Senior Manager. The Full time equivalent of banded remuneration across the organisation ranged from £15-£19k to £170-175k.

For these calculations, remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind. It does not include employer pension contributions and the cash equivalent transfer value of pensions. It is pro rata the contracted hours and not the actual amounts paid.

4.8 Duration of contracts, notice periods and termination payments

The Accountable Officer and Chief Finance Officer are employed on contracts of service and are employees. Executive Governing Body members' contracts can be terminated by either party with up to 6 months' notice. Details of fixed term contracts are set out in section 9 below.

There are no special contractual compensation provisions for the early termination of Governing Body members' contracts. Early termination by reason of redundancy or, 'in the interests of the efficiency of the service' is subject to the provisions of the Agenda for Change NHS Terms and Conditions Handbook.

Employees above the minimum retirement age who themselves request termination by reason of early retirement, are subject to the normal provisions of the NHS Pension Scheme.

4.9 Governing Body Members

The majority of members were appointed on fixed terms on dates prior to the existence of the CCG. For these members, the start date is shown as the first day of the CCG's existence. Dates of contracts and unexpired terms of office for the Governing Body members are as follows (Figure Seventeen):

Figure Seventeen

Name	Appointment Start Date	Appointment End Date
Dr Paul Bowen	1st April 2013	June 2018 (4 year tenure renewed)
Dr Mike Clark	1st April 2013	May 2017 (3 year tenure renewed)
Jerry Hawker	1st April 2013	Permanent Contract
Alex Mitchell	1st April 2013	Permanent Contract
Duncan Matheson	1 May 2013	30 April 2017
Dr James Milligan	1st April 2013	17 May 2014
Angela Wales	1st April 2013	1 January 2016
Melanie Lyman	1st April 2013	17 May 2014
Bill Swan	1st April 2013	31 August 2016
Gerry Gray	1st April 2013	18 September 2016
Gill Boston	1st April 2013	28 February 2017
Jennifer Lawn	1st April 2013	30 September 2015
Dr Julie Sin	1st April 2013	Nominated member
Sally Rogers	1st April 2013	18 September 2016
Joanne Morton	17th May 2014	31 May 2017

4.10 Remuneration

Figure Eighteen

2013-14						
Name and title	**Salary and fees (bands of £5,000) £000**	**Taxable benefits (rounded to the nearest £00) £00**	**Annual Performance related bonuses (bands of £5,000) £000**	**Long -term Performance related bonuses (bands of £5,000) £000**	**All pension Related Benefits (bands of £2,500) £000**	**Total (Bands of £5,000) £000**
Dr Paul Bowen - Chairman	85 - 89	-	-	-		85 – 89
Dr Mike Clark	35 - 39					35 - 39
Jerry Hawker – Chief Officer	120 - 124	12				120 – 124
Alex Mitchell – Chief Finance Officer	90 - 95	27				95 – 99
Duncan Matheson	5 - 10					5 - 10
Dr James Milligan	30 - 35					30 - 35
Angela Wales	5 - 9					5 - 9
Melanie Lyman	15 - 19					15 - 19
Bill Swan	5 - 10					5 - 10
Gerry Gray	5 - 10					5 - 10
Gill Boston	10 - 14					10 - 14
Jennifer Lawn	15 - 19					15 - 19
Dr Julie Sin	5 - 10					5- 10
Sally Rogers	20 -25					20 -25

As the Clinical Commissioning Group did not exist in the previous year, there is no comparative table for prior year.

4.11 Pension disclosures

Figure Nineteen

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £00
Dr Paul Bowen*- Chairman	5 – 7.5	15 – 17.5	5 – 9	20 - 24	91	22	69	-
Jerry Hawker – Chief Officer	2.5 – 5	15 – 17.5	10 – 14	35 - 39	220	131	89	-
Alex Mitchell – Chief Finance Officer	2.5 - 5	10 – 12.5	25 - 29	75 - 79	409	338	70	-

*Figures for Dr Paul Bowen include changes in benefits that arise from employer's contributions funded by the CCG and contributions funded by the Medical Practice in which Dr Bowen is a partner.

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

4.12 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 membership of the pension scheme. This may be for more than 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.

4.13 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.

4.14 Off Payroll engagements

During the year ended 31st March 2014, the CCG had no off-payroll engagements that cost more than £220 per day and that last longer than six months.

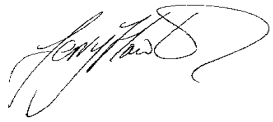
4.15 Biographies of the members

Biographies of the voting members of the Remuneration Committee can be seen in Appendix One. Details of the specific job titles and membership of committees is set out in the members report

4.16 Declared interests

Declared interests are published on our website at https://www.easterncheshireccg.nhs.uk/.

Signed



Jerry Hawker
Chief Officer (Accountable Officer)
Date:

5. 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.

Signed

Jerry Hawker
Chief Officer (Accountable Officer)
Date:

6. Annual Governance Statement

6.1 Introduction and Context

NHS Eastern Cheshire Clinical Commissioning Group (CCG) is made up of 23 Eastern Cheshire based GP practices and has a population of over 201,000 residents in the towns of Alderley Edge, Bollington, Chelford, Congleton, Disley, Handforth, Holmes Chapel, Knutsford, Macclesfield, Poynton, Wilmslow and the surrounding villages and rural areas.

With our allocation of over £222 million, our main purpose is to ensure for our residents the availability of and access to high quality health care by commissioning (buying) appropriate health care services and monitoring the quality of the care which is provided.

We are a major partner leading work to integrate local health and social care services so as to help improve the health and care experience and outcomes of our population and to ensure that we continue to have a safe, effective, high quality and financially sustainable healthcare economy now and in the future. Health and social care spending on residents of Eastern Cheshire is around £346 million per year. Around a third of this is spent on hospital care, a thirteenth on GP practices (Primary Care), one sixth on community care, one seventh on social care, one twentieth on mental health and the rest on other services such as prescribing and specialist care.

Within Eastern Cheshire there are 42 dentists, 38 pharmacies, 48 opticians and over 56 voluntary and community sector groups, which are all run independently. There is also a hospital in Macclesfield, community hospitals in Knutsford and Congleton, a mental health provider providing hospital and community services. Social care services are provided across a range of sectors including Cheshire East Council and the private and voluntary sectors. The range of services include 62 residential and nursing care homes, day services, tenancy schemes with care support, care at home and services focused on recovery and rehabilitation. In addition, a number of faith and community groups provide a range of low-level support and social activities which provide much needed support in local communities.

The main hospital in Eastern Cheshire is in Macclesfield but people also go to Greater Manchester, Staffordshire and elsewhere in Cheshire for general hospital services General hospital services include A&E, general medicine, general surgery, local specialist services such as cancer, renal (kidney), maternity and paediatric (children's) services and trauma and orthopaedics.

People in Eastern Cheshire already go further afield to receive treatment by more specialist services. For example, major trauma (such as road accident injury) is treated by the University Hospital of South Manchester NHS Trust (UHSM), treatment for hyper acute stroke is provided by Stockport NHS Foundation Trust, Salford Royal NHS Foundation Trust and the University Hospital of North Staffordshire NHS Trust (UHNS). Acute myocardial infarction (heart attack) is treated at UHSM, Central Manchester University Hospitals NHS Foundation Trust (CMFT) and UHNS. The Christie NHS Foundation Trust provides specialist cancer services in Manchester.

6.2 Authorisation

NHS Eastern Cheshire CCG operated in shadow form prior to 1st April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to taking on its full statutory powers. ECCCG was licenced from 1st April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006. It was licensed with just one condition:

- Governing Body must include nurse and secondary care doctor

On the 22nd July 2013, NHS Eastern Cheshire CCG received confirmation from NHS England of full authorisation without conditions following the removal of this one condition due to appointment to its Governing Body of a Secondary Care Doctor.

6.3 Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS Eastern Cheshire CCG 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 CCG Accountable Officer Appointment Letter.

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

6.4 Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.'

For the financial year ending 31st March 2014, and up to the date of signing this statement, we (NHS Eastern Cheshire CCG) complied with the provisions set out in the Code, and applied the principles of the Code. It should be recognised that NHS Eastern Cheshire CCG is at an early stage of development and the expectation is that compliance with Governance standards are subject to a continuous programme of improvement as the organisation matures.

6.5 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."

NHS Eastern Cheshire CCG is a clinically led membership organisation made up of 23 practices. The members of NHS Eastern Cheshire CCG are responsible for determining the governing arrangements for the organisation and are represented on the Governing Body by elected General Practice Locality Peer Group representatives. The group demonstrates its accountability to its members, local people, stakeholders and NHS England in a number of ways, including:

- publishing its constitution
- appointing independent lay members/persons and non-GP clinicians to its Governing Body
- holding meetings of its Governing Body in public
- publishing a commissioning plan annually
- complying with local authority health and wellbeing overview and scrutiny committee requirements
- meeting annually in public to publish and present its annual report
- producing externally audited annual accounts
- by being a member of the Cheshire East Health and Wellbeing Board and contributing to the development of the local Joint Strategic Needs Assessment and local Joint Health and Wellbeing Plan.

NHS Eastern Cheshire CCG is accountable for exercising the statutory functions of the group and may grant authority to act on its behalf to:

- any of its 23 member practices
- its Governing Body
- its employees
- a committee or sub-committee of NHS Eastern Cheshire CCG

The extent of the authority to act of the respective bodies and individuals depends on the power delegated to them by NHS Eastern Cheshire CCG's Scheme of Reservation and Delegation and/or through the Terms of Reference of the:

- Governing Body
- Governing Body sub-committees,
- Executive team
- Joint committees

NHS Eastern Cheshire CCG remains accountable for all of its functions, including those it has delegated. In discharging the functions of the CCG that have been delegated, it's Governing Body and its committees, joint committees, sub-committees and individuals:

- comply with NHS Eastern Cheshire CCG's principle of good governance
- operate in accordance with ECCCG's Scheme of Reservation and Delegation
- comply with NHS Eastern Cheshire CCG's Standing Orders
- comply with NHS Eastern Cheshire CCG's arrangements for discharging its statutory duties
- where appropriate, ensure the member practices have had the opportunity to contribute to NHS Eastern Cheshire CCG's decision making process

NHS Eastern Cheshire CCG has the following sub-committees which are accountable to the Governing Body:

- Governance and Audit Committee
- Remuneration Committee
- Quality and Performance Committee

The Terms of Reference for each of these Committees can be found in the CCG Constitution.

NHS Eastern Cheshire CCG has three advisory committees to the Governing Body:

- Eastern Cheshire Community HealthVoice
- GP Locality Peer Group/Locality Management Meetings
- Caring Together Executive Board

NHS Eastern Cheshire CCG has entered into joint arrangements with the following groups:

- NHS Vale Royal and NHS South Cheshire CCGs for the provision of Medicines Management
- Joint Commissioning Committee comprises representatives from NHS Eastern Cheshire CCG, representatives from NHS South Cheshire CCG and representatives from Cheshire East Council.

The performance of the Governing Body, its sub-committees and employed staff is routinely assessed for their effectiveness both internally and externally. In-house assessment and appraisal is done through Personal Development Reviews, self appraisal and internal audit. External audit and appraisal of effectiveness and appropriateness is also provided though arrangements with organisations such as Grant Thornton LLP and NHS England.

6.6 The Clinical Commissioning Group Risk Management Framework

NHS Eastern Cheshire CCG's approach to risk management is contained within its Integrated Risk Management Strategy and Policy document, which defines the risk management process, responsibilities and the identification and evaluation of operational and strategic risks.

The identification of risks is the responsibility of all staff and these risks are captured through the following points of consolidation:

- through the work of committees where they are standing agenda items
- programme and Project Boards
- Governing Body and Executive Team
- external providers and stakeholders

These risks are captured on the corporate risk log and then evaluated by the Executive Team, who take a view on the appropriateness of controls, scoring and actions to mitigate the risks.

The Executive Team is also responsible for the publication of the Governing Body Assurance Framework, a document which contains a detailed view of risks that may have a significant impact on the achievement of corporate objectives. Responses to the Assurance Framework by the Governing Body are managed by the Executive Team who monitor and report progress.

The Governance and Audit Committee is responsible for maintaining oversight of the risk management process and reviews the Risk Log and Assurance Framework on a regular basis. This committee is also responsible for gaining assurances that adequate arrangements are in place for countering fraud and reviews the outcomes of counter fraud work.

6.7 The Clinical Commissioning Group Internal Control Framework

The Governing Body Assurance Framework is designed to facilitate the identification of risks that would impact the organisations ability to meet its objectives, which are underpinned by its policies and procedures. The Governing Body reviews the Assurance Framework and feeds back to the Executive Team, Governance and Audit Committee and other Committees and Project/Programme boards, where appropriate. The Executive team is then responsible for facilitating any mitigating actions or update to the risk information.

6.8 Information Governance

NHS Eastern Cheshire CCG has implemented an Information Governance (IG) Framework incorporating key policies and procedures for identifying, improving and embedding IG issues and improvements. NHS Eastern Cheshire CCG has been approved for Stage One Accredited Safe Haven (ASH) status to allow processing of a limited amount of pseudonymised data. NHS Eastern Cheshire CCG has ensured that all staff and Governing Body members undertake annual IG training. The Governance and Audit Committee has responsibility for IG within its Terms of Reference; it meets on a bi-monthly basis and reports into the Governing Body.

The IG process is supported by key staff roles, including the Corporate Programmes and Governance Manager (delegated Caldicott Guardian) and Chief Finance Officer (delegated Senior Information Risk Owner, (SIRO). The Cheshire and Merseyside Commissioning Support Unit (CSU) provides IG support and works with NHS Eastern Cheshire CCG to ensure compliance with the IG Strategy. The CSU IG lead attends the Governance and Audit Committee when required. The scores and evidence for the toolkit are reviewed by the Governance and Audit Committee prior to reporting to the Governing Body for sign off.

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 IG Framework is supported by an IG 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.

6.9 Serious untoward incidents

ECCCG has placed a high importance on ensuring that there are robust information governance systems and processes in place as well as for incident reporting and investigation of serious incidents, including those related to data losses. There were no such incidents in the year.

6.10 Pension Obligations

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

6.11 Equality, Diversity and Human Rights Obligations

Control measures are in place to ensure that NHS Eastern Cheshire CCG complies with the required public sector equality duty set out in the Equality Act 2010. A Lay Member for Public and Patient Involvement is the Governing Body equality and diversity champion and the Corporate Services Manager along with myself as Accountable Officer lead on the responsibility of NHS Eastern Cheshire CCG for discharging the public sector equality duty, ensuring that:

- Equality and diversity is embedded into NHS Eastern Cheshire CCG's culture, values, processes and behaviours
- the CCG publishes information to demonstrate its compliance with the equality duty
- the CCG staff undertake equality and diversity training
- the CCG completes equality analysis where appropriate
- the providers of services that we commission pay due regard to their equality duty and provide information to the CCG

6.12 Sustainable Development Obligations

ECCCG is developing plans to ensure that it meets its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

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

Meeting the needs of today without compromising the needs of tomorrow is a key driver of NHS Eastern Cheshire CCG's major programme of transformative work – the Caring Together Programme. This programme of change typifies NHS Eastern Cheshire CCG's approach to commissioning for sustainable development in that end goals include saving money, saving resources and benefiting staff and patients.

6.13 Risk Assessment in Relation to Governance, Risk Management & Internal Control

The system of internal control and governance within NHS Eastern Cheshire CCG is based on an on-going risk management process that is embedded in the organisation and combines the following elements:

- the CCG has a published Integrated Risk Management Strategy and Policy document that is available to all staff on the CCG's Intranet. The purpose of this policy is to ensure that the CCG manages risk in all areas using a systematic and consistent approach.
- the CCG has strengthened its control of risk by ensuring that all risks are reviewed by the Executive Team on a regular basis, thus ensuring that the level of risk reporting is in line with expectations and policy, as well as ensuring that adequate and timely mitigating actions are being undertaken.
- the Assurance framework is the key risk identification tool for the group. It contains the significant risks to the achievement of the organisation's objectives as identified by the Governing Body and staff within the organisation. The Assurance Framework enables the Governing Body to monitor the effectiveness of controls and governance arrangements required to minimise the principal risks.

6.14 Significant Risks include:

- **Caring Together Programme – Case for Change:** The Caring Together Programme represents a significant investment by NHS Eastern Cheshire CCG to realise substantial benefits. The future viability of the health economy and success of NHS Eastern Cheshire CCG in meeting its standing financial and other statutory duties is largely dependent on the success of this programme. This programme therefore represents a significant strategic, financial and reputational risk to the organisation.

Controls: Caring Together Executive Board includes representation from the Governing Body. Monthly Programme reports to Governing Body following review and recommendation from Caring Together Executive Board. Programme plan and governance structure in place for Caring Together which controls the programme

- **Business Information Systems:** The development of a Business Information System is critical to support NHS Eastern Cheshire CCG deliver against its financial duties and responsibilities under contract management. The service is provided by the Cheshire and Merseyside Commissioning Support Unit (CSU) and has been in development for circa 18 months. Currently, there is limited information being generated by the system, i.e., little data from Providers within the Manchester area and as such no robust data directly available to monitor contracts perform contract query etc. This requires significant estimates to be used in relation to reporting NHS Eastern Cheshire CCG's financial position both year to date and forecast outturn.

Controls: Weekly meetings with the CSU are addressing highlighted issues and monitor agreed set of deliverables.

- **NHS Eastern Cheshire CCG's Underlying Financial Deficit:** In agreement with NHS England, ECCCG has adopted an approach which delivers a balanced underlying financial position (income v expenditure) and excludes the need to deliver the business rules that are outlined by NHS England. This approach has been adopted in delivering the 2013/14 position, as well as forming the basis on how the 2014-2019 5 year financial plan was calculated.
- In adopting this approach ECCCG has set its 5 year financial plan which has two distinct components-

- An underlying small surplus in 14/15 of £300k rising to a 1% surplus of £2,522 in 2018/19 for its normal on going activities, which in turn starts to address elements of the afore mentioned business rules.
- Caring Together programme costs have been invested by ECCCG in order to deliver longer term benefits. This investment equates to £2.3m in 2014/15 and £0.2m in 2015/16.
- When combined, this results in a planned deficit for 2014/15 of £2m. In order to deliver the planned surplus there still remains a significant QIPP challenge of circa £17m over the next five years which will be partly addresses by reviewing efficiencies, whilst the majority will be derived from our system transformation programme called Caring Together.

Controls: the 5 year financial plans have been prepared with the support of NHS England following close, continual dialogue. The 5 year plans will continually be refreshed following key events I.e. End of a financial year, Integration of Caring Together assumptions etc which will enable a continual jp to date long term view. Progress will be monitored via the Governing Body and Finance Committee which is being created for 2014/

- **Delivery of the Operational Plan:** There are some key performance related risks attached to the delivery of the Operational Plan. The severity of the risks will vary by season and resources available, but overall these comprise achievement of measures against: A&E performance, IAPT, Health Care Acquired Infection (HCAI), 18 weeks, Cancer Waits and the Quality Premium Measures

Controls: Contract Monitoring across all our main providers. Recovery trajectories are negotiated and contract notices used to enforce the trajectories. NHS Eastern Cheshire CCG plans developed to deliver Quality Premium Measures. The Quality and Performance Committee monitor progress on a monthly basis.

6.15 Review of Economy, Efficiency & Effectiveness of the Use of Resources

NHS Eastern Cheshire CCG has had a challenging year and has successfully delivered a surplus position as agreed with NHS England. This has required us to use our resources to cover our expenditure and not deliver the business rules. These were defined as good practice by NHS England for CCG's, and included:

- need to have 2% of our resources available to spend on one off items
- deliver a surplus of 1%
- include a contingency of 0.5% of our resources

This approach was agreed and supported by the Governing Body as part of the 2013/14 Financial Plan. The progress against this plan has been routinely reported to the Governing Body via the Finance & Performance reports prepared by our Chief Finance Officer.

We have also embarked on our Caring Together programme which aims to redesign the Health and Social care system. Its objective is to deliver a long term sustainable future both in terms of quality and money within the next five years. This is the key Quality, Innovation, Productivity and Prevention (QIPP) scheme for ECCCG and is due to reach a conclusion during the summer of 2014. In addition, we have a range of smaller schemes aimed at ensuring services are being provided efficiently i.e. Prescribing.

We have also used Mersey Internal Audit to provide assurance on a number of areas around our overall use of resources:

- Core Financial Services which reviewed our financial systems and controls and provided significant assurance on our systems, whilst outlining 7 medium to low risk recommendations.

- Quality, Innovation, Productivity, Performance audit looked at our arrangements to deliver efficiencies across the economy. Overall, whilst achieving 74% of our plan for year a number of recommendations were made around strengthening our governance arrangements.

6.16 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 NHS Eastern Cheshire CCG.

6.17 Capacity to Handle Risk

The Governing Body is responsible for the overall governance of the organisation and is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. The Governing Body has ratified the various risk based policies through the Governance and Audit Committee. These include Standards of Business Conduct, Safeguarding Adults and Children, Counter Fraud process and Information Governance policies as well as reviewing the Integrated Risk Management Strategy.

Mandatory staff training includes Safeguarding, Counter Fraud, Information Governance as well as Safety Awareness training. Staff are encouraged to seek, be mindful of and adopt best practice guidance to minimise and manage risk – both personal and corporate.

6.18 Review of Effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the CCG's internal auditors (Mersey Internal Audit Agency (MIAA)) and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me.

Following completion of the planned audit work for the financial year for NHS Eastern Cheshire CCG, the Director of Audit for MIAA issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. *Whilst the opinion does not imply that MIAA has reviewed all risks and assurances relating to the organisation the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework – and as such it is one component that I have taken into account in making the Annual Governance Statement*.

The Director of Audit concluded that:

- **Significant Assurance** can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of particular objective at risk.
- An Assurance Framework has been established which is designed and operating to meet the requirements of the Annual Governance Statement and provides reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the organisation.
- Assurance across the organisation's critical business systems include:

Access to services	• Significant Assurance in respect of the key controls in operation within the CCG's core financial systems • Limited assurance for QIPP but the CCG has plans to significantly strengthen QIPP governance and delivery mechanisms

Transparency and Governance	• An assurance framework has been developed and agreed at Governing Body • Significant assurance over committee arrangements with feedback from members being taken forward by the CCG
Patient Participation and Customer Service	• Systems for engagement and communication with member practices were found to be operating effectively
Informed Commissioning	• Significant assurance in respect of Information Governance controls and toolkit submission • Data Quality Review achieved significant assurances with control for improvement progressing

- **Contribution to Governance, Risk Management and Internal Control Enhancements**:
  - insight into the overall governance and authorisation conditions gained from liaison throughout the year with management
  - detailed insight into the overall governance and assurance processes gained from liaison throughout the year with the Executive Team, Governance and Audit Committee and early support to facilitate the development of the Assurance Framework
  - involvement with the organisation including regular review of Governing Body papers
  - review and advice on the development of the Governance and Audit Committee and corporate governance documentation
  - on-going discussion with lead officers and Lay Members throughout the year
  - follow up and support with the development of an Audit Tracker Tool demonstrating significant progress against recommendations to improve systems and controls
  - provision of MIAA briefings and CCG involvement through the MIAA events programme

During the year MIAA issued the following audit reports with a conclusion of limited assurance:

- **QIPP Review**: Limited Assurance. There are weaknesses in the design and or operation of controls which could have a significant impact on the achievement of the key system, function of process objectives but should not have a significant impact on the achievement of organisational objectives.

During the year MIAA issued the no audit reports with a conclusion of no assurance.

6.19 Risks:

Roles and Responsibilities:

- **Issue identified**: Ownership roles and responsibilities are not clearly understood and or working effectively. Membership buy-in to plans may not be evident or achieved.
- **Risk Rating**: High
- **Recommendation**: We recommend that the CCG define roles and responsibilities and strategic expectations with regard to the QIPP agenda and plans and provide clarity through cascading to appropriate stakeholders. This should include member practices.
- **Management Response**: (Remedial Action Agreed) Agreed, we will have clearly identified accountable individuals around each Scheme as well as a fully worked up programme and timescales.
- **Responsibility for Action:** Chief Finance Officer
- **Deadline for Action:** 30th April 2014

QIPP Governance Control Design

- **Issue Identified:** the CCG does not currently have any overarching governance arrangements for QIPP, there is no mechanism for regular monitoring and holding schemes to account for delivery. As the CCG does not have a Finance Committee and QIPP does not form part of the remit of the Clinical Quality and Performance Committee there is a reliance on QIPP delivery being scrutinised and monitored at the Executive Team and/or Governing Body meetings. Lack of transparency, rigour and overall governance in the QIPP processes
- **Risk Rating:** High
- **Recommendation:** the CCG needs to develop a mechanism through which there can be more regular scrutiny and holding to account for delivery of QIPP either within the current committee/programme management arrangements or through the development of an Integrated Finance and Performance Committee.
- **Management Response**: (Remedial Action Agreed) Transparency has been via the Governing Body papers. However, we are setting up a Finance Committee and have already drafted a Terms of Reference with the membership to be finalised. One of its remits will be the scrutiny of the QIPP agenda.
- **Responsibility for Action:** Chief Finance Officer
- **Deadline for Action:** 30th April 2014

6.20 Data Quality

Our Governing Body and Members have received a variety of reports throughout the year which are based on good quality information that is both transparent and concise. This has been supported by a number of independent assurance checks via Mersey Internal Audit which looked at two specific areas, both of which support the reporting through to the Governing Body and its Members:

- **Data Quality.** The audit did not identify any high or critical risk areas although ECCCG has committed to a number of actions to further improve the quality of data we use. These include development of a data quality policy, revisions to our contracts with our main business intelligence supplier (CSU) and reviewing the data validation checks we have in place
- **Formal Sub Committee arrangements.** The aim was to evaluate arrangements in place to help ensure each appointed committee fulfills its intended function in providing assurance to the governing body. Whilst 5 medium risk recommendations were highlighted, overall it provided a solid basis from which to work from
- **Membership Reporting.** The overall objective of the review was to evaluate the mechanisms in place to engage with and communicate to the CCG membership. The findings highlighted significant assurance.

6.21 Business Critical Models

Within ECCCG we have a number of business models which are used to support the delivery of our statutory duties. In line with the Macpherson report these models have a underpinning framework that ensure each model has a responsible owner within the CCG who ensures the quality assurance process is compliant and appropriate, that model risks, limitations and major assumptions are understood by users of the model, and the use of the model outputs is appropriate.

6.22 Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

6.23 Discharge of Statutory Functions

During establishment, the arrangements put in place by the CCG were developed to ensure compliance with the all relevant legislation. Legal guidance informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

Responsibility for each duty and power has been clearly allocated to a lead Director or Executive. Directorates have been developed to ensure that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties and emerging responsibility for either leading or contributing to the transformation of health and social care services.

6.24 Conclusion

I would like to thank the role of the Governance and Audit Committee and both Internal and External Audit in providing assurance and advice around our governance arrangements. In conclusion I am happy to confirm that no significant control issues have been identified in the preparation of the 2013/14 Annual Report and Accounts

Signed

Jerry Hawker
Chief Officer (Accountable Officer)
Date:

Appendix One

Biographies of the voting members of NHS Eastern Cheshire Clinical Commissioning Group's Governing Body and Sub-Committee's

Name	**Dr Paul Bowen**
Position	**CCG Chair, Chair of Governing Body**
Meeting membership	**Governing Body**
Biography	Dr Paul Bowen trained at Nottingham University, and completed his hospital and general practice training in Lincolnshire. He moved to Cheshire in 2004 where he worked as a GP in Macclesfield, before becoming a partner at McIlvride Medical Practice in Poynton in 2006. His special interests are in diabetes, elderly care and mental health. Paul became involved in commissioning in 2007 where he became chair of the local practice based commissioning group, and then a member and chair of the PCTs commissioning executive (formally PEC). Paul has a passion for patient centred care, through integrated working across health and social sectors. His interests also lie in the use of technology and IT to bring patients and professionals closer together, through improved communication and collaboration.

Name	**Jerry Hawker**
Position	**Chief Officer (Accountable Officer)**
Meeting membership	**Governing Body**
Biography	Jerry joined the NHS in 2005 through the Department of Health National Gateway to Leadership scheme and held a wide range of executive roles in Central and Eastern Cheshire PCT before joining the CCG. Prior to joining the NHS, he spent over 15 years in the specialty chemical industry and latterly running his own business consultancy company. He graduated as a Polymer Scientist and holds a corporate MBA from Babson College, USA. He is particularly interested in how the NHS can expand its partnership with the Voluntary sector and how the use of patient experiences can underpin continuous improvement both in clinical outcomes and the experience communities have of their local NHS services.

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Name	**Alex Mitchell**
Position	**Chief Finance Officer**
Meeting membership	**Governing Body**
Biography	Alex started his finance career many years ago in 1988 with Marks and Spencers and having developed an interest in this area, applied for a role within the NHS in 1991. he has worked in Acute Hospitals, Community Providers, Primary Care Trust sand now Clinical Commissioning Groups, all of which have provided him with a variety of experience and opportunities. Alex isa member and fellow of the Association of Chartered Certified Accountants and feels that by working within the NHS that he is applying his skills and energy on behalf of the public.

Name	**Gerry Gray**
Position	**Lay Member for Governance and Audit, Deputy Chair of Governing Body, Chair of Governance and Audit Committee, Chair of Remuneration Committee**
Meeting membership	**Governing Body, Governance and Audit Committee, Remuneration Committee**
Biography	Gerry is a graduate of Liverpool University and a Fellow of the Chartered Institute of Management Accountants. He has extensive experience of international business having spent more than 30 years in senior financial roles in blue chip multi-national organisations such as Ford Motor Company, PriceWaterhouse Coopers, Courtaulds and Pilkington, including four years based in the USA. Gerry is a Trustee of St Ann's Hospice, and is Chairman of Community Catalysts, which is a national charity involved in the field of micro social enterprise.

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Name	**Gill Boston**
Position	**Lay Member for Public and Patient Involvement**
Meeting membership	**Governing Body, Governance and Audit Committee, Remuneration Committee, Clinical and Quality Performance Committee**
Biography	Gill works as the programme manager for The National Care Forum and Voluntary Organisations Disability Group on the Department of Health funded Voluntary Sector Organisations Strategic Partnership Programme. She is a qualified social worker and holds and Honours degree in social studies and an MA in Community Care. Gill has worked in various management and monitoring roles for the Local Authority before moving in to higher education where she spent the next 13 years as a senior lecturer in health and social care at the University of Salford before moving to her current role in October 2009.

Name	**Bill Swan**
Position	**Lay Member for Public and Patient Involvement**
Meeting membership	**Governing Body, Governance and Audit Committee, Remuneration Committee, Clinical and Quality Performance Committee**
Biography	

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	Sally Rogers
Position	**Registered Nurse**
Meeting membership	**Governing Body, Governance and Audit Committee, Remuneration Committee, Clinical Quality and Performance Committee**
Biography	Sally is a registered general nurse who completed return to practice, nursing at Manchester University in March 2011. She worked for 13 years in industry before returning to the health service eight years ago leading a regional programme of work for The National Institute for Mental Health England around older peoples mental health. Passionate about the quality of care we deliver, particularly to older people, developing leaders and supporting nurses. Sally is also an Executive Board member of the National Association of Primary Care.

Name	**Duncan Matheson**
Position	**Secondary Care Doctor**
Meeting membership	**Governing Body, Governance and Audit Committee, Remuneration Committee, Clinical and Quality Performance Committee**
Biography	Duncan trained as a medical student at Oxford and St Thomas' Hospital, London and qualified as a doctor in 1970. Following posts in London his surgical training was mostly in Birmingham and the West Midlands and he was appointed Consultant Surgeon in Macclesfield in 1984. Duncan set up a vascular surgical service in East Cheshire as well as working across the breadth of general surgery but as the nature of surgical services changed so did his focus and in his latter years was purely a breast surgeon. Duncan retired as a consultant in 2010.

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Name	**Dr James Milligan**
Position	**General Practice Locality Peer Group Lead Alderley Edge, Chelford, Handforth and Wilmslow**
Meeting membership	**Governing Body, Clinical and Quality Performance Committee**
Biography	Dr James Milligan BM BS graduated from Nottingham University in 1995 and undertook a variety of hospital posts before completing GP training in 2001. He has been partner at Handforth Health Centre since 2002.

Name	**Melanie Lyman**
Position	**General Practice Locality Peer Group Lead Congleton and Holmes Chapel**
Meeting membership	**Governing Body, Governance and Audit Committee, Remuneration Committee**
Biography	Melanie worked in General Practice for the last 32 years, originally training as a Medical Secretary. She gained a Practice Management qualification approximately 25 years ago and has been employed as a Practice Manager working in Eastern Cheshire for all of this time. Melanie has been involved with commissioning of services for the past seven years.

Name	**Dr Mike Clark**
Position	**General Practice Locality Peer Group Lead Macclesfield**
Meeting membership	**Governing Body**
Biography	Dr Mike Clark MB ChB MRCS MRCGP graduated from Manchester University in 1995. A GP Partner at High Street Surgery, Macclesfield since 2005, Mike is a GP with a specialist interest in Urology, vasectomy and minor surgery.

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Name	**Angela Wales**
Position	**General Practice Locality Peer Group Lead Bollington, Disley and Poynton**
Meeting membership	**Governing Body, Governance and Audit Committee, Remuneration Committee,**
Biography	Angela has worked in Health Service for 39 years initially in secondary care then to General Practice. She has worked as a Practice Manager for the past 19 years and is passionate about the NHS. During her career she has had a variety of opportunities working with PCTs, the NHS Alliance and helping guide practices through Practice Based Commissioning. She has experienced fund holding where practices held their own budgets and has seen the advantages that practice based commissioning could achieve - bringing care closer to home for patients. Whilst this has now been replaced, the fundamental ethos remains the same for Clinical Commissioning Groups.

Name	**Dr Jennifer Lawn**
Position	**General Practice Locality Peer Group Lead Knutsford**
Meeting membership	**Governing Body, Governance and Audit Committee, Remuneration Committee,**
Biography	Dr Jennifer Lawn MB Chb Manchester has 22 years experience as a partner at Toft Road Surgery, Knutsford caring for a representative cross section of the local population. I have been Practice Lead attending locality meeting for many years so have been involved in the evolution of CCG and have some understanding of the workings of the governing body and its advisory committees I have good working relationship with other practices in Knutsford I am enthusiastic about improving healthcare in the local community whilst ensuring efficient use of limited resources.

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Name	**Dr Julie Sin**
Position	**Consultant in Public Health and Medicine**
Meeting membership	**Governing Body**
Biography	Julie first joined the NHS over twenty years ago. A graduate of Manchester University her early career spanned the breadth of hospital care, primary care and community health giving her invaluable insights into care across the NHS system. After completing general practice training in 1994 and further work in reproductive healthcare she entered the field of public health medicine. In 2009 she joined Central and Eastern Cheshire PCT to develop and lead its healthcare public health function and was key to the safe transition of the healthcare public health function locally during the 2013 reforms. Combining her breadth of NHS experience and population medicine, Julie has worked with the NHS Eastern Cheshire CCG since its inception, providing advice and support during its early development through to its current fully authorised function. Julie's Governing Body role ensures there is specific challenge to the CCG commissioning strategy so that it has due regard to health gain, evidence-based approaches, and population outcomes.

Name	**Dr Julia Huddart**
Position	**Executive GP for Clinical Leadership Team**
Meeting membership	**Clinical Quality and Performance Committee**
Biography	Dr Julia Huddart MB ChB DCH DRCOG MRCGP qualified has been a GP in Wilmslow since 1983. She has been a trainer in General Practice for over 15 years and has had 20 years' experience in the position of Clinical Assistant Palliative Care at East Cheshire Hospice.

Appendix One

Biographies of the voting members of NHS Eastern Cheshire Clinical Commissioning Group's Governing Body and Sub-Committee's

Name	**Neil Evans**
Position	**Head of Business Management**
Meeting membership	**Clinical Quality and Performance Committee**
Biography	Neil joined the NHS in 2008 having previously worked in a variety of operational, planning and change roles in Financial Services. Neil was recruited to the NHS through a national leadership development programme and initially worked in the Acute Sector in both Operational and Project Management roles before moving to Central and Eastern PCT in August 2009. Neil has been involved in NHS Eastern Cheshire CCG since its inception.

Name	**Jacki Wilkes**
Position	
Meeting membership	**Clinical Quality and Performance Committee**
Biography	Jacki is a qualified nurse, specialising in intensive care with experience in operational management in the acute sector. Her commissioning experience began in 2006 in North Staffordshire and later in Eastern Cheshire where she joined the team to support the development of clinical commissioning. Jacki's interest is in service improvement and redesign and she is currently responsible for continuous quality improvement and joint commissioning. Current priorities include, quality in care homes, access to mental health services and supporting the development of integrated services such as stroke care building on the principles underpinning the Caring Together programme.

Appendix One

Biographies of the voting members of NHS Eastern Cheshire Clinical Commissioning Group's Governing Body and Sub-Committee's

Name	**Andrew Binnie**
Position	**Quality and Performance Manager**
Meeting membership	**Clinical Quality and Performance Committee**
Biography	Andrew has been in post since August 2013 and has over ten years' experience in the health service, in particular with a specialty of performance management. In his previous role at Salford Royal NHS Foundation Trust as Corporate Performance manger he was responsible for all of the Trusts statutory and mandatory performance returns to the Department of Health and also specialised in quality improvement work throughout the Trust. Prior to this position he worked at Tameside and Glossop PCT as the performance manager.

NHS Eastern Cheshire Clinical Commissioning Group

Financial Statements for the year ended

31 March 2014

CONTENTS

Statement of Comprehensive Net Expenditure

for the year ended 31 March 2014

	Note	2013/14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	4	**2,117**
Other costs	5	**220,166**
Other operating revenue	3	**(217)**
Net operating costs before interest		**222,066**
Finance costs	8	**1**
Net operating costs for the financial year		**222,067**
Net operating costs for the financial year including absorption transfers		**222,067**
Of which:		
Administration Costs		
Gross employee benefits	5	**1,865**
Other costs	5	**2,647**
Other operating revenue	2	**(15)**
Net administration costs before interest		**4,497**
Programme Expenditure		
Gross employee benefits	5	**252**
Other costs	5	**217,519**
Other operating revenue	2	**(202)**
Net programme expenditure before interest		**217,569**
Other Comprehensive Net Expenditure		**-**
Total comprehensive net expenditure for the year		**222,067**

The notes on pages 64 to 88 form part of these financial statements.

Notes to the financial statements for the year ended 31 March 2014

	Note	31 March 2014 £000
Total non-current assets		-
Current assets:		
Trade and other receivables	17	**341**
Cash and cash equivalents	20	**459**
Total current assets		**801**
Total assets		**801**
Current liabilities		
Trade and other payables	13	**11,927**
Provisions		-
Total current liabilities		**11,927**
Total Assets less Current Liabilities		**(11,127)**
Non-current liabilities		-
Total Assets Employed		**(11,127)**
Financed by Taxpayers' Equity		
General fund		**(11,127)**
Total taxpayers' equity:		**(11,127)**

The financial statements on pages [ ] to [ ] were approved by the Governing Body on [date] and signed on its behalf by:

Jerry Hawker
Accountable Officer

XX June 2014

The notes on pages 64 to 88 form part of these financial statements.

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

	Note	General fund	Other reserves	Total reserves
		£000	£000	£000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013		-	-	-
Changes in CCG taxpayers' equity for 2013-14				
Net operating costs for the financial year		(222,067)	-	**(222,067)**
Net Recognised CCG Expenditure for the Financial Year		(222,067)	-	**(222,067)**
Net funding		210,940	-	**210,940**
Balance at 31 March 2014		**(11,127)**	**-**	**(11,127)**

The notes on pages 64 to 88 form part of these financial statements.

Statement of Cashflows
for the year ended 31 March 2014

	Note	2013/14 £000
Cash Flows from Operating Activities		
Net operating costs for the financial year		**(222,067)**
(Increase)/decrease in trade & other receivables		**(341)**
Increase/(decrease) in trade & other payables		**11,927**
Net Cash Inflow (Outflow) from Operating Activities		**(210,481)**
Net Cash Inflow (Outflow) from Investing Activities		**-**
Net Cash Inflow (Outflow) before Financing		**(210,481)**
Cash Flows from Financing Activities		
Net funding received		**210,940**
Net Cash Inflow (Outflow) from Financing Activities		**210,940**
Net Increase (Decrease) in Cash & Cash Equivalents	**12**	**459**
Cash & Cash Equivalents at the Beginning of the Financial Year		**-**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**459**

The notes on pages 64 to 88 form part of these financial statements.

Notes to the financial statements for the year ended 31 March 2014

1 Accounting Policies

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

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

1.1 Going Concern

ECCCG has set its 5 year financial plan for 2014 – 2019 which reinforces the challenging position ahead. In recognition of the local economies financial position, ECCCG has engaged on a system wide transformation programme called Caring Together. One of its key aims is to ensure we have high quality Health & Social Care services for our population that are financially sustainable for the future. This is also supported by the Challenged Health Economy work which is aiming to provide a list of options that deliver sustainable Acute Services across South Manchester, including our local hospital East Cheshire Trust. All of these programmes are being supported both locally and nationally and we are recognised as one of the leading transformational programmes.

In setting its 5 year financial plan, there are two key distinctions to make. If we excluded the 2014/15 (one off) programme costs associated with Caring Together then ECCCG would be making a small but increasing surplus over the 5 year period and crucially living within its financial allocations. It is only when we add in the programme costs of £2.3m that the CCG forecasts a loss (deficit) in 2014/15 of £2m. It is expected that we have to finalise the work which identifies the savings / efficiencies of the transformed system; and can be best described as an upfront investment or invest to save initiative.

Finally, with the exception of the 2014/15 planned deficit, ECCCG has an improving underlying surplus of £300,000 which increases over the 5 years to £ 2,522,000 which represents 1% of the CCG allocation (as defined by NHS England). Therefore, it is ECCCG opinion that the CCG has a financially stable future, supported by the Caring Together programme, concluding that ECCCG is operating as a going concern.

Taking the local and national support from NHS England into consideration, it is appropriate that these accounts have been prepared on the going concern basis.

Notes to the financial statements for the year ended 31 March 2014

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

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

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

1.5 Pooled Budgets

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

Notes to the financial statements for the year ended 31 March 2014

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

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

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

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

1.6 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.6.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:
Key judgements in the preparation of the financial statements are:

- ensuring that appropriate estimates are made for areas of estimation uncertainty as set out below,
- ensuring that appropriate policies are in place for recognising contractual liabilities,
- ensuring that appropriate policies are in place for considering any claims legal or for continuing health care.

Notes to the financial statements for the year ended 31 March 2014

1.6.2 Key Sources of Estimation Uncertainty

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

- Claims for continuing health care from 1 April 2013 are provided to the extent that a reasonable estimate can be made for the amount of the claim and the potential success of any claim. As NHS England has assumed responsibility for claims received prior to 31 March 2013, the CCG is responsible only for claims received since that date. The amount of such claims is not significant.
- Data in respect of prescribing costs are usually received two months in arrears and it is necessary to estimate the amount that will be payable for the last two months of the year. This estimate is based on a prescribing spend profile issued by NHS England. The amount estimated at the year end is £4,943,000.
- Partially completed spells are periods of care for which the provider of those services has not billed their costs. The providers provide an estimate of the costs that need to be billed and this estimate is checked to ensure it is reasonable in the light of data in relation to stays. The amount is agreed between the provider and the CCG. The total amounted to £918k.

1.7 Revenue

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

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

1.8 Employee Benefits

1.8.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period. As leave is not carried forward, the estimate amounts to £Nil

Notes to the financial statements for the year ended 31 March 2014

1.8.2 Retirement Benefit Costs

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

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

1.9 Other Expenses

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

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

1.10 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.

1.11 Leases

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

Notes to the financial statements for the year ended 31 March 2014

1.11.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.12 Cash & Cash Equivalents

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

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

1.13 Provisions

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

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

Notes to the financial statements for the year ended 31 March 2014

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.

1.14 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.

1.15 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.

1.16 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.

Notes to the financial statements for the year ended 31 March 2014

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

1.17 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.

1.17.1 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.

1.17.2 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.

1.17.3 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.

Notes to the financial statements for the year ended 31 March 2014

1.17.4 Loans & Receivables

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

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

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

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

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

1.18 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.

Notes to the financial statements for the year ended 31 March 2014

1.18.1 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.

1.18.2 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.

1.18.3 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.

1.19 Value Added Tax

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

1.20 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.

1.21 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).

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

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

Notes to the financial statements for the year ended 31 March 2014

2 Other Operating Revenue

	2013/14 Total	2013/14 Admin	2013/14 Programme
	£000	£000	£000
Non-patient care services to other bodies	**200**	-	200
Other revenue	**17**	15	2
Total other operating revenue	**217**	**15**	**202**

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

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

3 Revenue

	2013/14 Total	2013/14 Admin	2013/14 Programme
	£000	£000	£000
From rendering of services	**217**	**15**	**202**
Total	**217**	**15**	**202**

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

Notes to the financial statements for the year ended 31 March 2014

4 Employee benefits and staff numbers

4.1 Employee benefits

	2013/14 Total	Total Permanent Employees	Other	Total	Admin Permanent Employees	Other	Total	Programme Permanent Employees
	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits								
Salaries and wages	**1,755**	1,650	105	**1,570**	1,516	54	**185**	135
Social security costs	**138**	138	-	**122**	122	-	**16**	16
Employer Contributions to NHS Pension scheme	**224**	224	-	**173**	173	-	**51**	51
Gross employee benefits expenditure	**2,117**	**2,012**	**105**	**1,865**	**1,810**	**54**	**252**	**202**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	-	-	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**2,117**	**2,012**	**105**	**1,865**	**1,810**	**54**	**252**	**202**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-
Net employee benefits excluding capitalised costs	**2,117**	**2,012**	**105**	**1,865**	**1,810**	**54**	**252**	**202**

Notes to the financial statements for the year ended 31 March 2014

4.2 Average number of people employed

	2013/14 Total	Permanently employed	Other
	Number	Number	Number
Total	**43**	39	4
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	-	-

4.3 Staff sickness absence and ill health retirements

	2013/14 Number
Total Days Lost	148
Total Staff Years	0.75
Average working Days Lost	3.7

4.4 Exit packages agreed in the financial year

No exit packages were agreed in the year.

4.5 Pension costs

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

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

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

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

Notes to the financial statements for the year ended 31 March 2014

4.5.1 Full actuarial (funding) valuation

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

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

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

4.5.2 Accounting valuation

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

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

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

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

Notes to the financial statements for the year ended 31 March 2014

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.

Notes to the financial statements for the year ended 31 March 2014

5. Operating expenses

	2013/14 Total £000	2013/14 Admin £000	2013/14 Programme £000
Gross employee benefits			
Employee benefits excluding governing body members	1,927	1,675	252
Executive governing body members	190	190	-
Total gross employee benefits	**2,117**	**1,865**	**252**
Other costs			
Services from other CCGs and NHS England	**1,441**	1,348	93
Services from foundation trusts	**47,986**	-	47,986
Services from other NHS trusts	**102,862**	36	102,826
Services from other NHS bodies	**59**	-	59
Purchase of healthcare from non-NHS bodies	**32,833**	22	32,811
Chair and lay membership body and governing body members	**225**	225	-
Supplies and services – clinical	**249**	-	249
Supplies and services – general	**30**	30	0
Consultancy services *	**1,780**	16	1,764
Establishment	**535**	298	237
Transport	**9**	3	6
Premises	**295**	288	7
Audit fees	**73**	73	-
Prescribing costs	**30,701**	-	30,701
GPMS/APMS and PCTMS	**730**	-	730
Other professional fees excl. audit	**338**	299	39
Education and training	**20**	9	11
Total other costs	**220,166**	2,647	217,519
Total operating expenses	**222,283**	**4,512**	**217,771**

*Consultancy costs, £600k of which were funded by NHS England, are in respect of our Caring Together Programme.

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

Notes to the financial statements for the year ended 31 March 2014

6.1 Better Payment Practice Code

Measure of compliance	2013/14 Number	2013/14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	6,036	32,876
Total Non-NHS Trade Invoices paid within target	5,297	27,855
Percentage of Non-NHS Trade invoices paid within target	87.76%	84.73%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,020	154,096
Total NHS Trade Invoices Paid within target	1,334	141,636
Percentage of NHS Trade Invoices paid within target	66.04%	91.91%

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

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

	2013/14 £000
Amounts included in finance costs from claims made under this legislation	1
Compensation paid to cover debt recovery costs under this legislation	-
Total	1

7 Income Generation Activities

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

8. Finance costs

	2013/14 £000
Interest on late payment of commercial debt	1
Total finance costs	1

Notes to the financial statements for the year ended 31 March 2014

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

No Gain or loss arose on transfer of assets by absorption.

10. Operating Leases

10.1 As lessee

10.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2013/14 Total £000
Payments recognised as an expense				
Minimum lease payments	-	258	13	271
Total	-	258	13	271

10.1.2 Future minimum lease payments

	Land £000	Buildings £000	Other £000	2013/14 Total £000
Payable:				
No later than one year	-	258	-	258
Between one and five years	-	-	-	-
After five years	-	-	-	-
Total	-	258	-	258

11 Trade and other receivables

	Current 2013/14 £000	Non-current 2013/14 £000
NHS receivables: Revenue	23	-
NHS receivables: Capital	-	-
NHS prepayments and accrued income	74	-
Non-NHS receivables: Revenue	150	-
Non-NHS receivables: Capital	-	-
Non-NHS prepayments and accrued income	79	-
Provision for the impairment of receivables	-	-
VAT	10	-
Other receivables	5	-
Total	341	-
Total current and non current	341	
Included above:		
Prepaid pensions contributions	-	

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

Notes to the financial statements for the year ended 31 March 2014

There are no other receivables that are either past due or impaired.

12 Cash and cash equivalents

	2013/14 £000
Balance at 1 April 2013	**-**
Net change in year	**459**
Balance at 31 March 2014	**459**
Made up of:	
Cash with the Government Banking Service	**152**
Cash with Commercial banks	**308**
Balance at 31 March 2014	**459**

Patients' money held by the clinical commissioning group, not included above **-**

13 Trade and other payables

	Current 2013/14 £000	Non-current 2013/14 £000
NHS payables: revenue	**240**	**-**
NHS accruals and deferred income	**1,607**	**-**
Non-NHS payables: revenue	**1,943**	**-**
Non-NHS accruals and deferred income	**6,890**	**-**
Social security costs	**20**	**-**
Tax	**23**	**-**
Other payables	**1,204**	**-**
Total	**11,927**	**-**
Total payables (current and non-current)	**11,927**	

Other payables include £32k for outstanding pension contributions at 31 March 2014.

14 Commitments

14.1 Capital commitments

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

14.2 Other financial commitments

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

Notes to the financial statements for the year ended 31 March 2014

15 Financial instruments

15.1 Financial risk management

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

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

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

15.1.1 Currency risk

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

15.1.2 Interest rate risk

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

15.1.3 Credit risk

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

15.1.3 Liquidity risk

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

Notes to the financial statements for the year ended 31 March 2014

15 Financial instruments cont'd

15.2 Financial assets

	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	2013/14 £000	2013/14 £000	2013/14 £000	2013/14 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	23	-	23
· Non-NHS	-	150	-	150
Cash at bank and in hand	-	459	-	459
Other financial assets	-	5	-	5
Total at 31 March 2014	-	637	-	637

15.3 Financial liabilities

	At 'fair value through profit and loss' 2013/14 £000	Other 2013/14 £000	Total 2013/14 £000
Payables:	-	-	-
· NHS	-	1,847	1,847
· Non-NHS	-	8,834	8,834
Total at 31 March 2014	-	10,680	10,680

16 Operating segments

The clinical commissioning group considers it has only one segment: commissioning of healthcare services.

Notes to the financial statements for the year ended 31 March 2014

17 Pooled budgets

The clinical commissioning group has entered into a pooled budget with Cheshire East Council. The pool is hosted by Cheshire East Council.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for care provided to those with Learning difficulties.

Balances in the clinical commissioning group's Statement of Financial Position that relate to the pool are £308k in Cash and £308k in pool liabilities are included in payables.

The clinical commissioning group's and consolidated group's shares of the income and expenditure handled by the pooled budget in the financial year were:

	2013/14 £000
Income	-
Expenditure	- 3,951

18 Intra-government and other balances

	Current Receivables 2013/14 £000	Non-current Receivables 2013/14 £000	Current Payables 2013/14 £000	Non-current Payables 2013/14 £000
Balances with:				
· Other Central Government bodies	-	-	-	-
· Local Authorities	-	-	-	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	-	-	-	-
· NHS Trusts and Foundation Trusts	97	-	1,847	-
Total of balances with NHS bodies:	97	-	1,847	-
· Public corporations and trading funds	160	-	1,704	-
· Bodies external to Government	84	-	8,376	-
Total balances at 31 March 2014	341	-	11,927	-

Notes to the financial statements for the year ended 31 March 2014

19 Related party transactions

The CCG makes payments to practices for services provided under clinical schemes agreed by the Governing Body. The following represents the gross costs of those services paid to practices where a member of the Governing Body exerts significant control over that practice:

`	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
McIlvride Practice - Dr Paul Bowen - Partner	71	-	-	-
High St Surgery - Dr Mike Clark - Partner	68	-	-	-
Handforth Health Centre - Dr James Milligan - Partner	166	-	-	-
Toft Road Surgery - DR Jennifer Lawn - Partner	106	-	-	-

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 CCG works closely with other NHS Organisations such as NHS Cheshire and Merseyside Clinical Commissioning Support Unit which provides many of our services and Vale Royal CCH which hosts or medicines management team. NHS Organisations where the CCG has had significant transactions above £3m or where we worked closely with those organisations were:

`	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
NHS England	-	210,940	-	-
East Cheshire NHS Trust	94,760	-	954	-
Cheshire and Wirral Partnership NHS Foundation Trust	13,027	-	3	27
University Hospital of South Manchester Foundation Trust	10,776	-	146	-
Stockport NHS Foundation Trust	9,794	-	-	-
Central Manchester Hospitals NHS Foundation Trust	6,221	-	35	-
North West Ambulance NHS Trust	5,821	-	40	-
Mid Cheshire NHS Foundation Trust	4,097	-	58	-
NHS Cheshire and Merseyside Clinical Commissioning Support Unit	1,590	-	30	-
NHS Vale Royal CCG	730	-	32	-

The clinical commissioning group has also had a number of material transactions with other government departments and other central and local government bodies. Most of these

transactions have been with Cheshire East Local Authority in respect of joint enterprises as set out in notes 17 and 18.

20 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the clinical commissioning group or consolidated group.

21 Losses and special payments

The clinical commissioning group had no losses and special payments cases.

22 Financial performance targets

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

The clinical commissioning group's performance against those duties was as follows:

	2013/14 Target Performance	2013/14 Actual Performance
Expenditure not to exceed income	200	204
Capital resource use does not exceed the amount specified in Directions	-	-
Revenue resource use does not exceed the amount specified in Directions	222,271	222,067
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-
Revenue administration resource use does not exceed the amount specified in Directions	4,930	4,498

Based on the above, the clinical commissioning group can confirm that it fulfilled its financial duties.

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